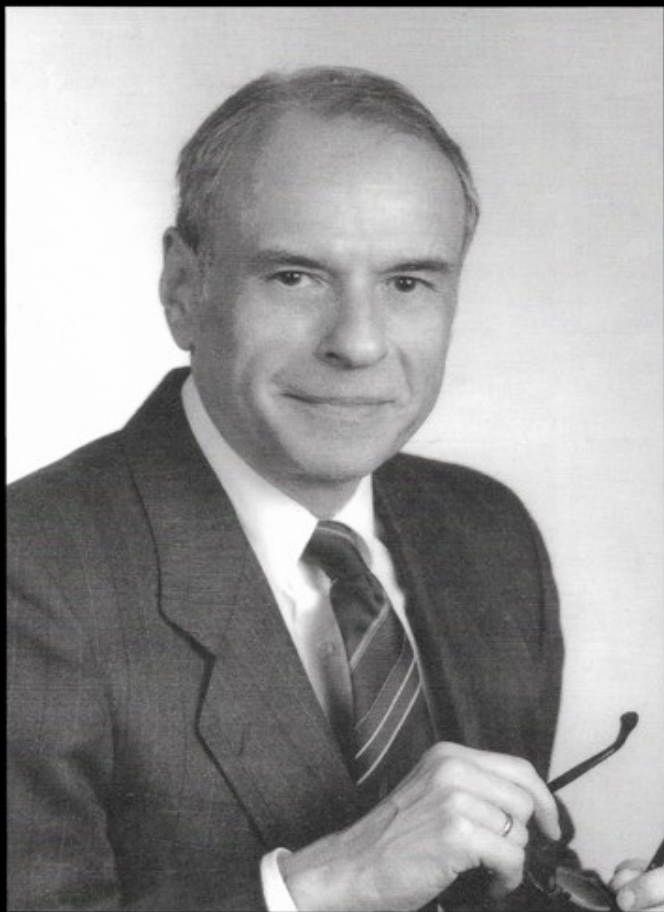


# **PSYCHOANALYTIC CLINICAL PRACTICE**



**Richard Chessick**  
MD, Ph.D

# **PSYCHOANALYTIC CLINICAL PRACTICE**

**SELECTED PAPERS**

**RICHARD D. CHESSICK MD,  
PhD**

Copyright © Richard D. Chessick 2000

e-Book 2019 International Psychotherapy  
Institute

All Rights Reserved

This e-book contains material protected under International and Federal Copyright Laws and Treaties. This e-book is intended for personal use only. Any unauthorized reprint or use of this material is prohibited. No part of this book may be used in any commercial manner without express permission of the author. Scholarly use of quotations must have proper attribution to the published work. This work may not be deconstructed, reverse engineered or reproduced in any other format.

Created in the United States of America

This book is dedicated with love to  
my daughters and their wonderful  
families.

## **Table of Contents**

[About the Author](#)

[Acknowledgments](#)

[Preface: What is Psychoanalysis?](#)

1. [Psychotherapeutic Interaction](#)
2. [Postmodern Psychoanalysis or Wild Analysis?](#)
3. [What Brings About Change in Psychoanalytic Treatment?](#)
4. [The Two-Woman Phenomenon Revisited](#)
5. [Psychoanalytic Treatment of Adult Eating Disorders](#)
6. [Psychoanalytic Treatment of Ulcerative Colitis](#)
7. [Externalization and Existential Anguish in the Borderline Patient](#)
8. [Psychoanalytic Treatment of the Borderline Patient](#)
9. [Malignant Eroticized Countertransference](#)
10. [In the Clutches of the Devil](#)
11. [Nothingness, Meaninglessness, Chaos, and the 'Black Hole'](#)
12. [A Failure in Psychoanalytic Psychotherapy of a Schizophrenic Patient](#)

13. [Impasse and Failure in Psychoanalytic Treatment](#)
14. [OCD, OCPD: Acronyms Do Not Make A Disease](#)
15. [Contingency and the Unformulated  
Countertransference](#)
16. [Self-Analysis: A Fool for a Patient?](#)

[Epilogue: Archaic Sadism](#)

[References](#)

## ABOUT THE AUTHOR

Richard D. Chessick, MD, PhD, is Professor of Psychiatry and Behavioral Sciences at Northwestern University, Training and Supervising analyst at the Center for Psychoanalytic Study, Chicago, and Senior Attending Psychiatrist at Evanston Hospital. Dr. Chessick is the 1989 recipient of the American Society of Psychoanalytic Physicians' Sigmund Freud Award for outstanding contributions to psychiatry and psychoanalysis, and he was elected president of that organization in 1996-97. He is a Fellow of the American Academy of Psychoanalysis (where he serves as vice-chair of their committee on human rights and social issues and as a member of the study group on psychoanalysis and women, among other

assignments), a Life Fellow of the American Psychiatric Association and the American Orthopsychiatric Association, a Fellow of the Academy of Psychosomatic Medicine and the American Society for Adolescent Psychiatry, a corresponding member of the German Psychoanalytic Society, and a member of eighteen other professional societies. His PhD is in philosophy and he taught as Adjunct Professor of Philosophy at Loyola University Chicago for several years. Northwestern University residents in psychiatry have repeatedly awarded him their 'teacher of the year' certificate over his forty years of donated teaching at that university.

Dr. Chessick is on the editorial board of four major journals [*Journal of the American Academy of Psychoanalysis*, *American Journal of Psychoanalysis*, *Psychoanalysis and Psychotherapy*, and the *American Journal of Psychotherapy*], he



also serves the latter as Associate Editor in charge of the International Editorial Board), and has published more than 200 papers since 1953 in the fields of neurology, psychiatry, philosophy, and psychoanalysis. An international lecturer, he is the author of fifteen books (see list at the beginning of the present book). Dr. Chessick is in the private practice of psychiatry and psychoanalysis in Evanston, Illinois.

## ACKNOWLEDGMENTS

I thank all the wonderful national and international colleagues who have supported my work, patiently listened to my presentations, and offered helpful suggestions and criticisms over many years.

This book could not have been written without the dedicated help of Ms. Elizabeth Grudzien, my administrative assistant for many years, who not only typed the manuscript but helped with the many references, library and other errands, and a multiplicity of details that were inevitably required to produce the manuscript. Thank you very much, Betty.

It also could not have been written without the compassion, empathy, and patience of Marcia, my

wife of forty-five years, who put up with the intense concentration this book demanded of me, in addition to the burdens of my psychoanalytic practice. To her I owe all my happiness and no words can sufficiently express my gratitude and love.

We have to accept perforce the beautiful complexity of the analytic situation and that we can never be sure of anything; we must remain receptive to the material, always attentive to the changes that can occur. The analytic process is very subtle, and we are not going to simplify it with a position taken at the outset.

(R. Horatio Etchegoyen 1999: 436)

## **Preface: What is Psychoanalysis?**

This is a summing up of my forty-five years of clinical and teaching experience. I believe psychoanalysis can have a scientific foundation, even if it is a procedure in which the investigator has an indissoluble influence on what is being investigated, and the possibility of replication is deeply compromised by the uniqueness of the relationship. Psychoanalytic notions do not readily lend themselves to empirical validation. Yet it has been increasingly recognized in contemporary philosophy of science that these problems are general to all scientific inquiry and they represent the limitations of all science. The fact that it is very difficult to validate psychoanalytic hypotheses is not restricted only to psychoanalysis as a science;

witness the plethora of theories and arguments in such traditional sciences as physics and astrophysics about quantum theory, about the so-called 'cosmological constant' and whether it is necessary to postulate an inflationary phase in the origin of the universe, and the curious difficulty of locating proton decay, determining the mass of neutrinos, and finding gravitational waves predicted by the various theories but so far not possible to demonstrate convincingly empirically. The whole conception of science in the twentieth century has shifted, but it does not follow from this that the data of psychoanalysis, any more than the data of any other field, are nothing but the current product of an interaction or a dialogue between patient and analyst. This is true in spite of the current intersubjective fashion as illustrated, for example, by the popularity of Bakhtin's (Emerson 1997) postmodern concepts

of dialogue, polyphony, and unfinalizability. This so-called postmodern stance may or may not be valid but it is far from generally accepted and the whole current fashion of postmodernism and hermeneutics remains very poorly defined and highly polemical.

I do not think psychoanalytic theories are idolized today as they once were, because we now know that all theories tend to filter awareness and promote countertransference. On the other hand we need theories, for in any science, as Kuhn (1962) in his famous work explained it, there has to be a 'stable paradigmatic corpus of notions', a group of core defining ideas. Progress in science involves departures from the prevailing paradigm, but just as science is dead without innovations, so it is lost without its traditions and fundamental body of acquired knowledge. For us this has been provided by the work of Freud and the

psychoanalytic pioneers as summarized in Fenichel's (1945) classic textbook. Much of the recent psychoanalytic literature has attempted not to modify and correct Freud's paradigm as should be done on the basis of new clinical and other research findings, but to replace it entirely in the name of either making psychoanalysis more of a traditional science or of making it a relationship therapy or a hermeneutic exercise. I think this is a major mistake and, contrary to current fashion, I think we should retain Freud's basic ideas as our central paradigm and starting point. I strongly disagree with the claim that we are now close to solving the so-called 'hard problem' challenge of the mind-brain problem, the problem of how to get from neuronal firings to the qualia of consciousness. This is exactly what stymied Freud, causing him to abandon his 'Project for a Scientific Psychology' and develop his metapsychology, and



we are still stymied by it today.

The only way I know of to establish scientific knowledge is by consensual validation from a series of investigators. Indeed, there has been a serious effort by prominent psychoanalysts, especially in last twenty years, to establish some areas of confluence. For example, Gabbard (1995a) published an important paper delineating the gradual migration in our field away from extreme positions and toward some generally accepted principles, and Wallerstein's (1988) seminal paper 'One psychoanalysis or many?' was a central topic of discussion at the 1989 International Psychoanalytical Congress. It is easy to criticize psychoanalytic institutions and bureaucracies and many authors (e.g. Gedo 1997) have done so; nobody would disagree that such organizations should fear dogma more than freedom of inquiry, but it is very difficult, human

narcissism and group psychology being what it is, to keep such organizations from becoming a conservative force. At the same time there is a wealth of clinical knowledge and useful theoretical ideas to be found in Freud's pellucid writings that are of foundational value even today. When Kohut was asked who to read after one reads Freud he replied, 'Read Freud again.' I agree.

Psychoanalysis, although containing a significant hermeneutic aspect, is primarily a clinical science. Also, as originally pointed out by the philosopher Paul Ricoeur (1970), it is a new form of investigation, one that combines both hermeneutics and empirical study. Furthermore, it is increasingly a medical science, for we are in the era of great advances in psychopharmacology and so it is no longer unusual these days during a psychoanalytic treatment that psychopharmacological medications need to be

prescribed. Both the psychic effect of such prescriptions as well as the physiological effects, including the effects of combining psychopharmacologic agents with other particular medications the patient may be taking, have to be considered and evaluated by the analyst. Prescribing necessary medication is not so different from Freud's feeding of the 'Rat Man' or collecting money for the 'Wolf Man', and it carries the same complications for the transference and potential for countertransference enactment. But it is certainly a countertransference enactment to withhold necessary medication from a patient, entailing needless suffering. Also, a variety of physical symptoms and problems arise during the course of a long psychoanalysis, in addition to the already ongoing medical problems of those patients who enter psychoanalysis with a psychosomatic disorder.

As a brief rather dramatic clinical example, a middle-aged very successful business woman who was extremely suspicious of doctors and all authorities due to her childhood experiences of abuse from her father, sought psychoanalysis with me because of a variety of serious problems, among which she listed a 'neurotic sleep disturbance' over the past few years, manifested by frequent awakenings at night. When I took her initial psychiatric history I discovered she was on atenolol for those years, prescribed by her internist for her elevated blood pressure. Clinical experience had taught me that occasionally this drug causes exactly that problem, and I suggested she ask her internist to change the drug. His response was that my suggestion proved psychoanalysts were not 'real' doctors, and he suggested she seek cognitive therapy from a psychologist he recommended. However, she

persisted, and with much grumbling he switched her to a calcium channel blocker for her high blood pressure. The 'neurotic sleep disturbance' immediately disappeared. This facilitated, for this suspicious lady, the establishment of what Freud called the 'unobjectionable positive transference', and she was subsequently able to enter into the psychoanalytic process.

About two years later this lady, who was clearly a psychosomatic responder, was under a great deal of realistic stress for business and personal reasons not of her making and not under her control. She developed nausea, vomiting, and stomach cramps that were reaching such intensity that she could hardly function or take care of her young child. At my suggestion she called her internist, a different one by now, and after listening to her he said brusquely, 'What do you expect, you are under a lot of stress. Reduce the

stress.' He would not prescribe for her, considering her a neurotic, since a recent gastrointestinal work-up had revealed no organic disease. The symptoms got worse and worse and I became genuinely alarmed that this patient would physically and psychologically collapse from the constant cramps and retching; the situation was rapidly becoming an emergency. Again, drawing on my clinical experience, I prescribed Compazine suppositories for her, and in a day or two she was a different person, more comfortable and able to function again. These experiences had profound transferential effects, as one might expect, and led to considerable exploration of her mother's angry and rejecting reaction when she was ill as a child, and the internalization of this destructive attitude toward herself. We were able then to explore the unconscious determinants behind her choice of internists. Psychoanalysis for her was ultimately

quite successful even though she was a very difficult patient, and these medical issues provided unexpected important turning points in achieving the success.

## Hermeneutics

Ricoeur, in his famous seminal work, *Freud and Philosophy* (1970), said there are two kinds of hermeneutics. The first of these he labeled the 'hermeneutics of suspicion', represented by the work of Freud, Marx, and Nietzsche, to some extent Feuerbach, and, I would add, Foucault. Their task is demystification and a reduction of 'illusions'. A crisis of the philosophy of the subject is involved here; these authors point to the lie of consciousness and to consciousness as a lie. For Freud consciousness expresses the unconscious and sexuality; for Marx the conscious is formed by economics. In 1888, Nietzsche's last good year,

Freud was 32 years old and deeply immersed in psychoanalytic work on hysteria; he had not yet undertaken his self-analysis. In that year Nietzsche wrote, 'All philosophy is "interpretation", a tearing off of masks' (Chessick 1983a).

Freud built a one-person or solipsistic metapsychological model, his 'mental apparatus', out of a two-person dialogue that was dyadic and nonsolipsistic. Ricoeur's discussion of Freud's work places great emphasis on dreams as the key to the psychoanalytic focus on the relationship of desire to language. The text of a dream is the manifest dream; owing to repression it is a coded message. The latent dream Ricoeur calls the 'primitive speech of desire'. Freud used hermeneutics to get from the text of the dream to the primitive speech of desire and the same process is used for decoding neurotic symptoms.



Viewed in this fashion, Freud's crucial question is, 'How does desire achieve speech?' This is found as early as in Freud's theory of aphasia. Freud's explanation of aphasia denies the standard brain location theory (Broca's area, for example) and instead conceives of aphasia as a nonlocalized neurological situation in which speech is cut off from the concepts signified by the words. This leads to Freud's (1914) later use of the connection or lack of connection of 'thing- presentations' with 'word-presentations' in his theories of neurosis and psychosis. But in Freud there is a contradiction, for in Freud's metapsychology the human remains a 'thing', a 'psychic apparatus', and this metapsychology is an attempt at a 'scientific' set of quasi-neurological explanations.

The oscillation between a humanistic and a mechanistic view of humans is a well-known hidden tension in Freud's thought (Holt 1973).

Even Freud's wish to decode symptoms and dreams implies a value system in its dedicated pursuit of meaning, coherence, and clarity. Freud begins with a simple natural-sciences hydraulic model and ends with a mythology, the 'battle of the giants' (Freud 1930, p. 122), Eros and the death instinct.<sup>1</sup> But when Freud, under the influence of the philosopher Feuerbach during his formative years (Boehlich 1990), emphasizes only the dismal, neurotic, regressive, and projective aspects of art and religion he is actually projecting his own pessimism, his own blinders that allow him to see only the negative aspects. Even psychoanalytic code-breaking, even deciphering, even hermeneutics are permeated by one's own fundamental life attitudes. There is no such thing as the study of truth that does not involve the person doing the study. One's own life attitudes are hidden premises in whatever study one makes.

Freud's original idea of psychoanalysis contains two aspects. The first of these involves explanations through the use of forces, or energetics. These are the so-called economic explanations that are made, involving dynamic forces playing against each other. The second presents an exegesis of the apparent or manifest through the latent, the classical hermeneutic approach. But psychoanalysis always has to incorporate energetics into hermeneutics in order to make a psychoanalytic interpretation. This is because the distortions that take place when one goes from the latent to the manifest occur for a reason; there is a force at work that must be understood to explain why these particular sets of transformations take place. Because of this 'force', explanations must involve energetics, dynamics, and so on. The earliest conceptions of psychoanalysis, as in *The Interpretation of Dreams*

(Freud 1900), contain explanations using energetics and explanations using hermeneutics.

The methodological incorporation of hermeneutics and energetics was Freud's crucial epistemological discovery. It represents a new form of investigation, an alternative to investigating the data of clinical psychiatry and the narratives constituting psychoanalysis and psychoanalytic psychotherapy by either standard natural-sciences empirical statistical study or by speculative subjective intuitions. The argument that hermeneutics combined with energetics begins a relevant and autonomous intellectual discipline with its own methodology offers an important message for any mental health professional who feels there has to be an alternative in our work to either the inhumane mechanism of hard empirical science on the one hand or a purely speculative philosophy on the

other.

But the problem with hermeneutics is that it does not provide any body of convincingly testable propositions. This runs the risk of it being an arcane source of wisdom that generates little evidence that we may proceed to verify. Recognizing this objection, Ricoeur (1977) tried to answer it with his concept that the analytic experience is equivalent to what the epistemology of logical empiricism calls observable measurable data. For Ricoeur, in psychoanalysis there are not facts, there are only narrative reports. But his view ignores the important communications in the patient's nonverbal behavior, the central role of the transference, and the possibility that psychoanalysts, like any group of trained scientists, could check and criticize each other's work. One should not overlook the empirical implications of the phenomena of transference

and the observable and predictable unfolding of the psychoanalytic process as conducted by a properly trained psychoanalyst. Through the transference there is a link between Freudian conceptions and natural science so that one cannot (as Ricoeur does) conceive of psychoanalysis solely as hermeneutics and energetics. There are also important natural-science phenomena involved in psychoanalysis which show themselves in the observable behavior of the patient and, above all, in the crucial phenomena of transference. On that point Ricoeur's exegesis has been the most severely criticized by psychoanalysts (Friedman 1976, Holt 1981, Modell 1978, Spence 1982).

### **Intersubjectivity**

Intersubjectivity, an assortment of views involving interpersonal psychiatry,

constructivism, perspectivism, relativism, and more specific types of intersubjectivity such as that of Stolorow and Atwood (1992), challenges the concept of objectivity as an analytic ideal but, as Blum (1998) points out, 'Acknowledging the relativity and limitation of objectivity does not diminish its analytic importance' (p. 190). The problem with the entire group of theories based on the intersubjective approach is that the external object relationship is emphasized at the expense of what, in my clinical experience, turns out to be far more important, the intrapsychic self and object representations, the pair of intrapsychic glasses developed in childhood through which all current adult object relations and objects are viewed, represented, experienced, and responded to. The declaration that the transference is primarily shaped in the present ignores the fact that the transference is basically a

revival of unconscious infantile conflicts and more or less traumatic experiences and pre-cognitive memories which have been worked over during infancy into archaic core fantasies (see Arlow 1969a, Chessick 1996a).The patient in a sense evolves certain fantasies in infancy that include crucial intrapsychic self and object representations, that will then emerge in the transference. Therefore, in my opinion, the transference primarily represents the regressive repetition and revival of the past through the displacement of and/or projection of the unconscious fantasy objects and relationships of infancy and childhood onto the psychoanalyst.

In previous publications I (1995, 1996b) have pointed out how intersubjectivity tends to slide over into nihilism. It even challenges all theory construction, for if there is no objective and consensual observation of clinical facts possible,



one cannot build any theories and test them against clinical data. The point I am trying to make is that regardless of the idiosyncrasies of various analysts, and assuming that the analysts we are paying attention to have received a thorough personal psychoanalysis of their own and therefore are bringing only sliver patient vectors into the treatment, it is possible to accumulate a body of analytic findings which can be checked 'against findings with different patients, with different analysts, and in analytic observations and studies outside the analytic situation' (Blum 1998, pp. 194-5). Furthermore, emphasis on the intersubjective, on the here-and-now aspects of the therapy, while certainly having value, can easily represent a flight from the emergence of both the patient's and the therapist's unconscious conflicts and core fantasies.

Although enactments inevitably occur and are

sources of understanding countertransference, a powerful debate continues as to whether these enactments and the analyst's unintentional emotional involvement are the most important curative aspects in psychoanalysis. Whitaker and Malone (1953) pointed out that all psychotherapy involves a therapist and a patient who have what they call both therapist and patient vectors in them that work on the level of the apparent as well as the unconscious relationship between patient and therapist. Therapist vectors are responses to the needs of the immature child part of the other person. Most often the responses of the therapist are therapist vector responses to the patient. At times, however, the patient responds with therapist vector responses to the (we hope) relatively small residual child part of the therapist. Patient vectors are archaic demands for a feeling response from the other person, much as a young

child urgently demands that his or her parents serve as archaic selfobjects.

Clearly patients will get well only if the patient vectors of the therapist do not make excessive demands on the patient's therapist vectors, but Whitaker and Malone then make a rather startling point. They insist it is vital for successful psychotherapy that the therapist bring in his or her patient vectors along with his or her therapist vectors. This they call a total participation with the patient, a concept also emphasized by Little (1957), as necessary before the analyst's interpretations can be meaningfully heard. Both the analyst and the patient have characterological defenses against such participation, because it is one which carries great vulnerability, that must be worked through before effective explorations of the past can begin. The therapist thus expands the frontiers of his or her own emotional growth

during the therapy.

If the therapist refuses to participate totally in this fashion, it is experienced by the patient as a severe rejection, or, in self psychology terms, a massive empathic failure of the selfobject, and the therapy is not successful. In a more extreme view Boesky (1990) states, 'If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis would not proceed to a successful conclusion' (p. 573). It is clear that this becomes an extremely important issue if we agree that for a psychoanalysis to be successful, some sort of unplanned and spontaneous participation on the part of the analyst is necessary and unavoidable, perhaps arising from unformulated countertransference (Chessick 1999a), or perhaps from a sort of 'preconscious attunement' (Kantrowitz 1999), but always requiring 'the analyst's self-discipline to

preserve the analytic role and keep the treatment safe for both participants' (p. 65).

McLaughlin (1987) describes how 'The incessant play of nonverbal activity between patient and analyst actualizes and amplifies the primary verbal data of the psychoanalytic dialogue' (p. 557). Rcnik (1993a) presents the most extreme view of this, claiming that 'an analyst's activity including how an analyst listens and all the various moment-to-moment technical decisions an analyst makes is constantly determined by his or her individual psychology in ways of which the analyst can become aware only after the fact' (p. 559). In that sense he agrees with Boasky and points out that '*unconscious* personal motivations expressed in action by the analyst are not only unavoidable, but *necessary to the analytic process*' (p. 564).

But it is quite possible that these factors can also impede or defeat an analytic process! For I define the analytic process as occurring in a situation in which the analyst, attempting to be as objective and neutral as he or she possibly can be, and listening and interpreting on multiple channels that shift as the patient's material indicates (Chessick 1992a), facilitates the emergence of transference phenomena that illuminate the patient's infantile core conflicts and fantasies. So Blum (1998) writes, 'In the classical tradition, the relatively objective and neutral analyst permits clarification of the patient's fantasy distortions within a grounded rather definitive reality.' But, he adds, 'If countertransference is intense and intrusive, if the analyst validates or fulfills the patient's fantasies, or if the analyst behaves like the patient's childhood objects ... then analysis of transference

can be impaired' (p. 197). One of the reasons it becomes impaired is that the patient cannot contemplate the transference if it is being enacted in some major fashion through the analyst's countertransference, instead of being identified and interpreted.

Although it is true that patients will hang the transference on various peculiarities of the analyst, I believe the primary source of the transference comes from infantile core fantasies and unconscious archaic psychic structures. The emergence of these in the transference needs to be continuously studied by both the patient and the analyst. The archaic remains a vital and often disruptive or self-defeating force, an active past at any level of development. The exceptional emphasis by intersubjectivists on the co-creation of both analytic data and the transference loses sight of this central proposition of Freud's

psychoanalysis since, as Blum (1998) explains, 'The current object relationship of the coparticipants takes center stage, and infantile conflicts recede into relative obscurity or unimportance' (p. 199).

I regard psychoanalysis as retaining a scientific core, based on the observation of emergent transference phenomena. As an ideal, it is important for the analyst to maintain what might be called good-enough objectivity and good-enough neutrality in order to allow transference manifestations to emerge, especially the archaic transference manifestations which often have only a small connection to the idiosyncrasies of the properly analyzed analyst's personality, for example, such archaic fantasies of the analyst as a serene Buddha, the analyst as a god, as possessing magical powers, as omniscient, and so forth.



The matter is actually more complicated than I have expressed it here so far. The phenomena of transference cannot be understood merely by empirical observation, although this is the obvious natural- sciences starting point. There is more to it, however, because in order to achieve a firm and continuing grasp of the transference, the analyst must be able to have and to be motivated to exercise a self-reflective receptive capacity, characterized by a willingness to maintain a state of reverie akin to that advocated by Bion, until certain unformulated or inarticulate conceptions begin to float across his or her consciousness. These are countertransference manifestations stirred up or placed in the analyst by the patient's transference, for example through projective identification and the patient's need to re-create certain crucial childhood relationships, sometimes playing the role of the parent and sometimes of

the child. So the analyst must always, besides exercising the psychological self-receptive process, also be silently asking himself or herself what role is being pressed upon the analyst and how the patient is attempting to use the analyst, what is expected, what is anticipated, and what is experienced through the glasses of the patient's childhood representations.

Bollas (1987) compares this to the mother's capacity to grasp the inarticulate sensations and feelings of the child and transform them into verbal representations that can be mutually considered and negotiated. The capacity to do this by the analyst also provides the patient with a new and more mature object for internalization, and hopefully the very process of self-reflection will be internalized. This capacity is one of the hardest functions to teach candidates. A certain innate talent is required and also a certain psychological-

mindfulness and comfort with uncertainty, dreams, fantasies, and desires. Freud (1926a) correctly complained that medical training tends to marginalize this function in order to stress external observation in the study of physical illness, a long and time-honored tradition in medicine. Anyone who has tried to help new residents in psychiatry grasp these concepts will attest to the truth of Freud's complaint, and I think it explains why contemporary psychiatry clings so tenaciously to a shallow Kraepelinian orientation, a kind of pseudo-internal medicine.

Even more unfortunately, there is a trend among analysts today away from this procedure. As Yorke (1995) complains:

They do not relax and give themselves up to free-floating attention. They do not, for example, find that appropriate associations attuned to those of the patient come readily to mind, that one of the patient's remarks

recalls another that gives it fresh meaning, or that a fleeting thought touches something in their own unconscious that points to a deeper or more primitive context than the one which the patient consciously presents, or that a patient's immediate fantasy spontaneously recalls in the analyst's mind something said in a session days or weeks ago. Rather ... they give the impression of sitting on the edge of their seats as they try to make sense of what the patient tells them. They try to fit it into a theoretical framework and feel vindicated when the 'fit' is a good one. (p. 25)

Even Renik (1998), who has been one of the most outspoken advocates of subjectivity in the analytic situation, still regards psychoanalysis as a science. This is because he believes we can, although imperfectly, evaluate our interpretations on the basis of their predictive capacity. He writes:

When I suggest to a patient that he is burdened by irrational guilt feelings, I can see whether his mood improves; or when a patient and I conclude that she no longer

needs to be afraid of being more sexually potent than her mother, we can see whether she will begin to be able to have orgasms during intercourse. The circumstances under which psychoanalysts can make predictions can be poorly controlled, and definitive empirical evidence for a psychoanalytic proposition may be very difficult to obtain, but hypotheses-testing via prediction is possible in psychoanalysis. Therefore psychoanalysis is a science, (pp. 492-3)

So in spite of the emphasis on intersubjectivity, it does not follow that objectivity is impossible to achieve in clinical psychoanalysis. The fact that there is a predictive value to the meanings that are interpreted in the psychoanalytic process also distinguishes psychoanalysis from pure hermeneutics, where the criteria of valid meaning do not include subsequent empirical experiences.

Gabbard (1997) reminds us that there are a whole variety of differing approaches grouped under the loose heading of 'intersubjectivity'. The

danger of intersubjectivity, he points out, is the privileging of the patient's subjectivity. He stresses the importance of the analyst's perspective being different from that of the patient's internal experience and the developmental value of that difference, just as in infant development the subjective object is transformed into an objective object, 'one that is partly created by the infant and partly the by-product of the infant's increasing attunement to the *actual* characteristics of the mother as an external object with her own subjectivity' (p. 18).

The heart of the matter, as I (1996a, 1996b) have elsewhere pointed out, goes back to Freud's (1912a) description of how the patient's template is repeated again and again in the transference. As Gabbard (1997) explains:

Although the analyst's subjectivity influences that template to some degree, there are

nevertheless transference patterns that are characteristic of individuals. The patient's intrapsychic conflicts and internal object relations were forged long before entering analysis and will find a way to make themselves known, regardless of the analyst's contribution, (p. 22)

The crucial point is that the object representations and characteristic processes of object relations that are internalized in the patient's psyche will appear in the analytic process in one sequence or another depending on the subjectivity of the analyst, but they will appear, and will appear in a reanalysis with a different analyst, assuming the psychoanalysts are competent.

### **The Analyst as a New Object**

Psychoanalytic technique involves free association, frequency, regularity, recumbency, the analyst's special way of listening, relative neutrality, abstinence, and interventions primarily

involving interpretation and analysis of transference. Starting from the current surface of the material and working in increasing depth, we hope for reconstruction of pathogenic experiences or deficits from the past and uncovering the core fantasies and other compromises that were evolved to deal with them. We recognize the powerful effect of the real person of the analyst and the intensity of his or her emotional involvement with the patient over many years, but whereas in psychotherapy this is deliberately utilized along with the transference, in psychoanalysis the transference is hopefully identified and interpreted along with its genetic roots.

The role of a new object experience as constituting the silent power of psychoanalysis, and the relationship as integral to therapeutic change especially with sicker patients has been



increasingly recognized. These so-called sicker patients are characterized by unreliability of object constancy, 'failure to tame drives or to develop stable defenses, deficiencies in self-esteem, in frustration tolerance, in affect modulation' (Pine 1992, p. 252), and at times a blurring of reality testing and self and object boundaries. In psychotherapy supportive elements are moved to the foreground of the interaction, whereas in psychoanalysis the holding environment forms the background. A shifting back and forth may be necessary, depending on the vicissitudes of the patient's state (Chessick 1996a).

After-education is very important in the analytic process, as is the analyst functioning as a new object providing a corrective reparative experience (Loewald 1960) or transformative experience (Bollas 1987). I do not see how this can

be avoided, or even that it should be, but it is a genetic fallacy to think that the interchange between the analyst and the patient has the same direct affective impact as the interchange between a caretaker and an infant. Adult affects and object relations are not isomorphic with their infantile precursors because the former are experienced entirely through the schemata of intrapsychic representations and fantasies established during infancy and childhood. Furthermore, the benefits to the patient from experiencing the analyst as calm, collected, tactful, tolerant, and dedicated are clearly not the same as those benefits arising from 'the crucial addition of technical neutrality and relatively objective analytic interpretation of unconscious conflict and trauma' (Blum 1998, p. 201), as this material is regressively revived and even relived in the psychoanalytic process.

Shane et al. (1997) base their entire theoretical

approach to psychoanalysis on the premise that the salutary effects on development of the mother-child interaction can be also produced by the analyst-patient interaction. Recognizing the uncertainty of this premise, they ask: 'Can such a significant and far-reaching development take place in an adult or a child through the analytic experience itself, based on understanding, insight, and a living- through relationship with the analyst? We believe it can' (p. 99). But they require of the analyst, if this is to happen, 'Availability, concern, positive responsiveness, positive regard, a commitment to the patient's well-being, and an encouraging attitude in regard to all the patient's struggles and conflicts, as well as wishes and desires' (p. 99). This is very nice, but how does it distinguish psychoanalysis from any other form of physician-patient relationship? Sometimes understanding and insight are actually

blocked or defended against by various physician-patient enactments, and sometimes the analyst's attempt to be so empathic and actively produce and even report such loving and caring attitudes to the patient can hide countertransference phenomena. The kind of self-revelation recommended by these authors can easily be used in an unconscious collusion to gratify narcissistic and exhibitionistic needs of the analyst, of the patient, or both. For example, in an admittedly extreme view, they recommend that in certain instances, if a patient says 'I love you', and you love the patient you should tell the patient so, forming a 'nonsexual attachment' in this manner. Freud, of course, would scoff at even the possibility of such an attachment, and he might sarcastically ask how to respond when a patient says 'I love you' and you do not particularly love the patient. Do you say 'I do not love you'? What

do you say in the latter situation that is not either a lie or a humiliation for the patient, if you have already conditioned the patient to expect self-revelatory responses? All this is a re-run of the well known admonitions Freud gave to Ferenczi when the latter tried physical interaction with his patients; how easily one thing leads to another in boundary crossings! Psychoanalysis of this sort can dangerously disintegrate into a kind of hand-holding and love therapy, which is often what patients want and which unanalyzed therapists will sometimes provide in order to avoid having to face the patient's or the therapist's rage and negative transferences or countertransferences.

### **The 'Data' of Psychoanalysis**

There is a dangerous fallacy in the extreme intersubjective and the hermeneutic viewpoints that assume the centrality of continual co-creation

of the data of psychoanalysis. The notion of 'co-creation' shifts our attention away from the patient's ownership of unconscious conflict and archaic fantasy, and moves our focus away from pathogenesis and toward iatrogenesis. Patients enter analysis with character pathology that has developed as a set of compromise formations and defenses against the drives and experiences that produced early infantile conflicts and archaic fantasies. They present these at the onset of analysis, sometimes even from the very first telephone call in making an appointment; these are not created or co-created in analysis. The centerpiece of psychoanalysis is to uncover and understand the persisting influence of earlier developmental phases and the conflicts and archaic fantasies these have produced, through the regressive revival of them in the analytic process. In so doing we have to assume that the good

enough psychoanalyst has at least an adequate capacity to retain objectivity toward the patient and toward his or her own countertransference. It is this assumption that forms the basis of my contention that psychoanalysis is primarily a science, that reliable data can be collected over the years by many well trained analysts working with a variety of patients, and that on the basis of these data reliable theories may be formulated that can then be extrapolated to the treatment of other patients.

In spite of a number of papers by a variety of prominent psychoanalysts attempting to replace Freud's drive theory, I think it remains an extremely valuable heuristic notion to help us in thinking about our patients and about our unfortunate species in general (Chessick 1996c). It is reassuring that such well known psychoanalysts as Andre Green and Leo Rangell agree with me

about this (see Raymond and Rosbrow-Reich 1997). I agree with Ritvo and Solnit (1995), who write:

Nowhere is the concept of instinctual drive more useful than in the psychoanalytic situation itself, where it is indispensable to an understanding of transference and where the relationship between the drives, ever pressing for representation and discharge, and resistance and defense provide a reliable guide to the psychoanalyst in her or her interventions and interpretations, (p. 332)

Yorke (1995) points out that Freud's metapsychological concepts:

... although capable of modification in the light of fresh clinical and theoretical findings are, in their fundamentals, indispensable. ... Critics of metapsychology seem to lose sight of the purpose of metapsychological concepts. They are explanatory concepts, means to an end and not ends in themselves, (pp. 3, 23)

Perhaps it would be important here to clarify



Kant's notion of 'heuristic principles', as he used them in his (1790) *Critique of Judgement*. This notion was also taken up by Einstein, who called them 'heuristic viewpoints', serving the purpose of allowing us to make assertions from which familiar facts could then be deduced. Heuristic viewpoints, for example, drive theory, cannot be directly falsified or proven; their value is in their usefulness in explaining familiar facts, such as the overwhelming human preoccupation with lust and aggression that makes up what Hegel (1840) called the 'slaughter bench' of history, 'upon which the happiness of nations, the wisdom of states, and the virtues of individuals were sacrificed' (p. 24). Our greatest novelists are our greatest psychologists. Consider this statement by Captain Ahab (Melville 1850):

What is it, what nameless, inscrutable, unearthly thing is it; what cozening, hidden lord and master, and cruel, remorseless

emperor commands me; then against all natural lovings and longings, I so keep pushing and crowding, and jamming myself on all the time; recklessly making me ready to do what in my own proper, natural heart, I durst not so much as dare? (pp. 444-5)

From my point of view, that of the post-Freudian psychoanalyst in what Wallerstein (1995) calls the post-ego-psychological age, the psychoanalyst does indeed regard everything in the mind and even one's character patterns as compromise formations between drives and repressing forces, but he or she is extremely judicious as to which compromise formations require analysis. This is the way deconstructionist and constructionist aspects are combined in any psychoanalytic therapy. The art of therapy is to know what to analyze and what to leave alone, and to develop the proper timing and phrasing of interpretations and other interventions so that the whole experience does not appear to the patient to be

coming from a torture chamber and constitute a perpetual humiliation and destruction of self-esteem.

What is currently missing is a genealogical study of why in certain cultures certain types of psychoanalytic theories tend to predominate. For example, in South America, Kleinian theories, peppered with the ideas of Lacan, are the current fashion. Lacan's version of Freud swept like a tidal wave over France a few years ago. In the immediate post World War II United States, ego psychology was the fashion. In our current cultural milieu, one of affluence, rampant global capitalism, and extravagant consumerism, a hedonistic and pleasure-oriented culture that emphasizes fast-fast-fast relief and the relativity of all moral and ethical principles, a plurality of theories and schools and various forms of intersubjectivity have come to be the fashionable

basis of psychoanalytic theory formation.

There is also an important financial explanation for this, since the more one views psychoanalysis as a form of hermeneutics, the less one needs to view it as a scientific medical discipline, opening the door, as happened in France with the advent of Lacanianism, for everyone to feel free to practice what they call 'psychoanalysis'. What this has led to is not a flourishing of psychoanalysis but a marginalizing of it in our society, a loss of respect for it, and the provision of an opening for insurance companies to deny payments for analytic treatment. The net result of this has been a disaster for many troubled individuals who need prolonged psychoanalytic therapy and with the advent of so-called managed care no longer have the means to provide it. This situation also entails a loss of reliable and detailed information from the deep

analysis of many psychoanalytic cases by highly qualified psychoanalysts.

The philosopher Adorno (1973) outlined three forms of what he called negative dialectical thinking, which may help us in untangling the difficult problems involved in trying to derive 'truth' from the data of psychoanalysis. One of these forms is what he calls the internal critique. Adorno and the other members of the so-called Frankfurt School argued that the Enlightenment was predicated upon an epistemological error, namely the idea that our knowledge can fully capture reality, and understanding can be determinate. They believed this error leads to an impoverishment of rationality and finally to its collapse. It is the kind of error, for example, involved in trying interminably to specify exactly what is psychoanalysis and what is not psychoanalysis. Adorno maintains that our

representations of reality always entail some level of indeterminacy. We know that conceptual thought is limited, and we also know there is a discrepancy between any concept of something and the object itself, a discrepancy we can understand through the use of what Adorno calls nonidentity. Nonidentity refers to that part of the concept which does not fit the object and is therefore misguided and superfluous, but it also negates the concept. Conceptual systems such as Freud's drive theory or his tripartite model of the psyche, then, are valuable and indispensable to give us direction and motivation, and they are a part of the dialectical process of understanding. They contain what I have called a heuristic value and we cannot do without them. The contradictions that occur between our clinical experience and our conceptual systems are the way in which we get closer to understanding, but

we cannot focus as we should on these contradictions if we assume that our conceptual systems are congruent with the whole truth. This is the first form of negative dialectics; it is the contradictions that take us closer to understanding.

Adorno's second form of negative dialectics he calls constellation, in which one attempts to get to a deeper discernment of the object, or the patient in our instance, by emphasizing the shortcomings of a whole variety of differing conceptual systems that are employed by various individuals or schools of thought in their study of the object or patient. This is the epistemological basis of my [1992a] five channel theory of psychoanalytic listening, in which I propose that we need to listen to patients (and ourselves) on several channels at a time, each of which are based on differing and conflicting conceptual systems, in order to have a

better understanding of the patient since no one of them can give a complete picture.

The third form of negative dialectics, close to Kohut's notion of empathy, consists of what Adorno calls mimesis. This is a form of cognition distinct from conceptualization, an attempt to identify with the object, that is, one's self identifying with the 'other' by becoming in imagination like the 'other'. Elsewhere I (1998) have discussed the whole special and controversial issue of empathy as a form of psychoanalytic investigation. There are no clear or set rules for mimesis but rather an indefinite number of imaginative responses. Mimetic identification is neither precise and exhaustive nor fully comprehensible; it is open to continuous interpretation and its meaning is inexhaustible.

I believe our approach to the patient should



employ all of these techniques, and when we are able to do so we have a more balanced and appropriate view of the individual who is coming to us because he or she is suffering; who is, as I see it, enslaved to an infantile fantasy life and poor maladaptive childhood compromise formations as well as manifesting what Gedo (1988) calls 'apraxias', a lack of certain basic skills in human adaptation. These 'apraxias' may be viewed as manifesting themselves in another form of the transference, the interpersonal situation the patient creates with the analyst. Here again, the main contribution comes from the patient, as what Fonagy (1999) calls 'procedural memories' are attempted to be re-enacted in the relationship with the analyst, sequences of actions and pressures brought upon the analyst, who needs to recognize and interpret these to the patient. But although the personality and theories of the

analyst have a role in the appearance of these memories and the way in which they appear, in my opinion it is an error to ignore what the patient is attempting to tell us about the past, which the patient would tell in one form or another regardless of the specific analyst, if given a chance to do so.

It is our task as psychoanalysts to deal with all of this and to not get caught up in two of the cardinal errors that Adorno talks about. These are hypostasis, which occurs because once a theoretical system is developed it is believed that system has fully captured everything about the patient and no further thought is needed or evoked; and rigidity, in which a system tends to become fixed. Not long after that, schools are set up, schisms develop, leaders and apostles appear, and we have the psychoanalytic civil wars.

Reporting on a discussion of the topic 'One Psychoanalysis or Many?', Hanly (1997) summarized Rangell's central proposal as being that, 'psychoanalysis as a body of knowledge is ... an evolving, unitary, coherent, composite theory, whereas contemporary psychoanalytic culture makes it out to be a collection of alternative, inconsistent, but equally viable theories' (p. 485). Theoretical plurality in our field, Rangell is reported to have said, is more a matter of political and bureaucratic matters and is not based on any established scientific validity. A study of these political and bureaucratic matters surely ought to be the subject of a thorough investigation by future scholars in our field.

Hanly asks:

Why is psychoanalysis so vulnerable to charisma and group identifications? Psychoanalysts, rather like philosophers, seem to adopt theoretical positions for

reasons other than the strictly rational ones of fact, logic, and explanation.... Is this a consequence of failure to analyze the idealizing transference, so that analysts are exposed to basing their theoretical views on a personal affiliation rather than on clinical observation? (p. 486)

He continues:

I take Freud's theory to be the core of a unitary psychoanalytic theory .... I continue to consider Freud's durable theories to be the best empirical hypotheses available for this purpose and, therefore, consider them like any empirical hypotheses to be subject to continuing clinical testing and logical evaluation. The formulation of new explanatory hypotheses in the form of alternative theories is an essential part of this endeavor to improve and develop psychoanalysis. It is the preference for the easy, exhilarating transformation of new and old theories into charismatic ideologies that causes a failure or refusal to engage in this difficult, painstaking work, (p. 488)

I do not think the Enlightenment project is

bankrupt. It is in need of some revision, but future human emancipation and freedom still have the best chance of developing through the exercise of reason. It is incorrect to say psychoanalysis in the contemporary world is generally dismissed as a relic of a bygone age. This is somewhat true in the United States where the huge pharmaceutical corporations, insurance companies, and managed care tyrannies have been able to dominate United States psychiatry, but it is not true in South America, it is not true in continental Europe, and psychoanalysis is currently enjoying exploding interest in Russia and Japan. There has been remarkable growth especially in France, Germany, Italy, Argentina, and Brazil. There are today a number of critics of Freud who are notorious in their hatred of psychoanalysis, but Freud has always been viciously attacked by prominent critics ever since his first publications.

Psychoanalysis is a threat in a commercialized society in which a quick-fix mentality reigns and a greater premium is placed on conspicuous consumption than on self-examination. More generally, as Chasseguet-Smirgel (Raymond and Rosbrow-Reich 1997) puts it, 'there exists a struggle against psychoanalysis which is one with the struggle against thought itself. A denial of the unconscious is in keeping with the dehumanized world in which we live' (p. 462).

Certain authors set up a straw man, the so-called orthodox psychoanalyst who dogmatically believes that his work is pure nineteenth-century science, who does not accept the fact that conflicting theories in our field are legitimate because he considers his own theory to be the only 'truth', and who does not make any effort to think about his own contributions to the therapeutic material and to reflect on the unsolved problems

of psychoanalysis. These authors have missed the general shift in even the most traditional psychoanalytic literature over the past twenty years, in which even the most prominent analysts are wrestling with these problems (see Wallerstein 1995). A number of authors (e.g. Chessick 1992a; Pine 1985) have suggested that multiple theories are necessary in psychoanalysis although these theories are epistemologically conflicting. The harsh critics of psychoanalysis have only addressed selected aspects of it and have neglected the contributions of post-classical analysts. But we are all post-classical analysts these days and there are few if any dogmatic Freudians left.

Only the most poorly trained and inadequate psychoanalysts attempt to fit analysands into a Procrustean bed of authoritarian rigidly established psychoanalytic concepts and

procedures, fostering compliance. Kohut (1977) would consider this a massive failure of empathy, and he (1984) stated in his posthumously published work that actually the particular theoretical orientation of the analyst is not as important in psychoanalytic healing as is the analyst's capacity to be empathic with what is hurting or narcissistically wounding the patient at any given time, regardless of the language the analyst uses to communicate that empathic understanding to the patient.

## Conclusions

The fact that some of the phenomena generated in the analytic process cannot be traditionally scientifically replicated does not demonstrate that psychoanalysis is not a science; it simply demonstrates that, like all sciences, psychoanalysis can only provide a limited picture



and is subject to the continual process over the years of alteration and modification of Freud's theories as our empirical knowledge grows out of our clinical work. It is very dangerous to the future of psychoanalysis to divorce it from its biological or even quasi-biological roots such as drive theory, to ignore its scientific foundations, and instead to try to characterize psychoanalysis as some sort of purely hermeneutic or intersubjective discipline in which 'the focus of therapeutic action goes from an authoritative therapist interpreting the patient's unconscious roots, to a therapist engaging the patient in a kind of corrective emotional experience, involving a mutual resolution and discovery of unconscious interferences in both therapist and patient' (Feinsilver 1999, p. 281). This postmodern approach runs the serious risk of encouraging a total relativism, subjectivism, cultism, mysticism,

and hopelessness about the progress of the field as well as an increasing derogation of it in the mind of the public and a subsequent marginalization of it in our society.

Psychoanalysis is evolving and changing as every science should, while psychotherapy today is riding off madly in all directions in an attempt to bend itself to fit the cruel demands of managed care and so to stay in business. There are hundreds of forms of psychotherapy, most of them practiced by poorly trained individuals who have only a foggy idea of what they are doing. I believe this is what can be expected of psychotherapy in the future since there are no criteria agreed upon and no certification examinations that one needs to pass in order to call oneself a psychotherapist. Psychoanalysis, however, is and should be much more strict and is continuously making a serious attempt to define itself.

One of my most influential teachers, Franz Alexander, argued that psychoanalysis and psychoanalytically oriented psychotherapy were procedures that gave operational meaning to the motto of the Renaissance humanists: respect for the dignity of the individual. In his (1964) last and posthumous publication, he wrote:

[Psychoanalytic] Psychotherapy aims not only at enabling a person to adjust himself to existing conditions, but also to realize his unique potentials. Never was this aim more difficult and at the same time more essential. Psychoanalysis and psychotherapy in general are among the few still existing remedies against the relentlessly progressing levelization of industrial societies which tend to reduce the individual person to becoming an indistinguishable member of the faceless masses, (p. 243)

Psychoanalysis is no longer a lucrative discipline; most psychoanalysts confess that much of their practice is now taken up by the practice of

psychotherapy. Only a small percentage of well trained psychoanalysts are dedicated enough to confine their treatment to full-scale three or four times weekly psychoanalysis, which often requires them to treat patients at very reduced fees since insurance help for such treatment is now almost completely unavailable. It is to this dedicated group of psychoanalysts that we must look for the future development of the discipline as a science, as a legitimate means for the scientific exploration of the human psyche that was the guiding vision of Sigmund Freud.

### *Notes*

Originally published in the *Journal of the American Academy of Psychoanalysis* (in press). Reprinted by permission.

- <sup>1</sup> Plato in *Sophist* also speaks of *gigantomachia peri tes ousias* (the battle of the giants concerning Being). See Hamilton and Cairns (1973, p. 990).

## Psychotherapeutic Interaction

The basic trend in psychodynamic psychotherapy since the time of Freud has been increasingly to emphasize and understand the therapeutic aspects of the relationship between the psychotherapist and the patient. Already with the case of Dora (Freud 1905)—one of the most magnificent writings in the whole literature of psychiatry—Freud humbly recognized that there was more to psychotherapy than simply (or not so simply) the uncovering of unconscious material.

In the relationship between the patient and the therapist, especially with the many borderline patients we see today, the psychic field and the deep inner attitude of the psychotherapist are

absolutely crucial. The psychotherapist must have inborn talent, good supervision, and thorough knowledge of psychodynamics and the therapeutic technique.

In individual therapy it is clear that an optimal field must be presented to the patient by the therapist. Nacht (1962) writes:

It seems to me that what is most important ... is not so much what the analyst says as what he is. It is precisely what he is in the depths of himself—his real availability, his receptivity, and his authentic acceptance of what the other is—which gives value, pungency, and effectiveness to what he says.

It is usually assumed that psychotherapy is in part an art merely because of our ignorance about the field. This assumption implies that as we gain more knowledge—or more precisely scientific understanding—of psychology and psychotherapy, the practice of psychotherapy will

become more and more scientific, thereby approaching the ideal doctor-patient model in medicine.

I maintain that this generally held fundamental assumption is completely wrong and that it accounts for much of the confusion and acrimony within our field, as well as for unfair invidious comparisons with other 'more scientific' branches of medicine. For this assumption is based on a misconception about the nature of knowledge—a misconception that has prevailed for centuries as a squabble between the proponents of science and the proponents of the humanities—the two cultures.

The language of science stresses true and false propositions, error, causality, law, prediction, fact, and equilibrium of systems. The language of the humanistic imagination focuses upon destiny and

human purpose, fate and fortune, tragedy, and illusion.

It is certainly possible to argue that depending on which critical faculty of the mind—imagination or understanding—is being employed, a different map of what appears to be reality will emerge. One map would be sober and factual, claiming to be the custodian of literal truth, mechanistic and objective. The second would be mythical, teleological, dramatic, and dealing more with concepts like creativity, destiny, and human purpose.

The need to construct objective, factual, mechanistic chains of causal explanations as well as the need to construct heuristic, often dramatic and anthropomorphic, explanatory fictions are *both* fundamental human cognitive needs, based on different nuclear operations of human mental



functioning, as first delineated by Kant (1785). The great physicist Bohr similarly distinguished—according to Heisenberg (1971, p. 89)—among the languages of religion, science, and art, and suggested that 'We ought to look upon these different forms as complementary descriptions which, though they exclude one another, are needed to convey the rich possibilities flowing from man's relationship with the central order.' Thus the language of the imagination and the language of the understanding represent different ways of looking at the same sensory manifold, although this is no longer being presented in Kantian terminology.

Since there are these two different nuclear operations of the mind which may be used in organizing the sensory manifold, it becomes more understandable how differences and arguments arise among observers of the sensory manifold.

The special theory of psychotherapeutic interaction presented in *Why Psychotherapists Fail* (Chessick 1983b) takes this into account and thus provides four roots of psychotherapeutic interaction instead of the usual two. This is because maps of the psychic field interacting between the therapist and the patient must be provided in bilingual fashion and the languages must not be confused with each other. Each language selects a center for the psychic field of the therapist and another for that of the patient.

Just as the special theory of relativity holds only for certain special situations (observers in uniform relative motion), I use the phrase 'special theory', maintaining the analogy to physics, because my theory also holds for certain special situations—individual psychotherapy, using the definitions, settings, and techniques generally accepted as constituting psychoanalytically

oriented psychotherapy. A second analogy to the special theory of relativity is that my theory can be reduced to Freudian psychodynamics for everyday practical use, if certain limitations are observed (similarly the special theory of relativity can be reduced to Newtonian physics for practical terrestrial use).

In the language of scientific understanding, the therapist may be described in terms of his ego operations, countertransference structure, therapist and patient vectors, and training in therapeutic technique. In this language the patient may be described in terms of his ego operations, a genetic-dynamic formulation, the structural theory of Freud, transference, and patient and therapist vectors. Thus a scientific understanding of the process of psychotherapy would have to examine the steady mutual influencing throughout psychotherapy—on both conscious and

unconscious levels—of the psychic fields of the therapist and the patient, using the descriptive terminology outlined above.

In the language of the humanistic imagination which is much more dramatic, emotional, and oriented to human purposes, the two psychic fields would be described quite differently. Here we find terminologies such as the I-Thou relationship, self-actualization, the authentic life, the encounter, basic anxiety, the will to power, caring, presence, the capacity for trust, lifestyle, career-line, and even Freud's famous statement that psychotherapy is a labor of love.

This is a concept of considerable importance to psychotherapists. The quarrel between some so-called opposing schools of psychotherapy really lies in the contrast that naturally emerges when the method of science or the method of the

humanistic imagination is applied to the sense data. For these are grounded respectively on the entirely different faculties of cognitive understanding and the reproductive or creative imagination. The two maps of reality and descriptions of what is going on are not fundamentally opposed and may be used successfully to complement each other, provided the therapist is carefully aware of when and why he is using each competing map. If this is possible, then a greater understanding of patient material and patient problems can be achieved and we have great depth to our conception of how to present the most effective psychic field to the patient.

An education strictly confined to technique and practice of scientific psychotherapy tends toward a sterility and withdrawal from participation with the patient at a truly human level. On the other

hand, an education too heavily weighted in the humanities and without the firm anchor of both scientific methodology and dedication to the medical or physicianly vocation, causes a profound loss of the scientific grounding and the objective observation aspects of psychotherapy, with a consequent serious tendency to misunderstand, and even to go off into the deep end and engage in bizarre and unjustifiable procedures with patients. Neither of these extremes is fair to the patient; both of them are exploitation and they represent a serious and inexcusable defect in the psychic field of the therapist.

Furthermore, it is clear that psychotherapists would be more inclined to fail when all aspects of the psychotherapeutic interaction are not taken into account or not understood. The best insurance against failure from such causes would be the ability of the therapist to describe the

interaction in both languages and to visualize maps of both psychic fields. Because of the limits of our knowledge or our capacities we can sometimes explain success or failure in psychotherapy in one language but not in the other. Thus a failure that seems inexplicable from the point of view of scientific understanding can sometimes be explained in the language of humanistic imagination and vice versa.

Some reviewers of *Why Psychotherapists Fail* missed this main point—the goal of a humanistic curriculum is not to produce a Renaissance man out of service to some philosophical aesthetic ideal. A humanistic education for the psychotherapist is not a luxury, but a logical extension of the fundamental theoretical notions behind the special theory of psychotherapeutic interaction which argues that a complete understanding of the patient and of

psychotherapeutic interaction cannot *ever* be achieved by a purely technical scientific education in dynamic psychiatry, no matter how thorough. If my basic theoretical orientation is correct, a corresponding education in the language of the humanistic imagination will *have to* be provided for the psychotherapist. I shall now proceed to outline in greater detail the special theory of therapeutic interaction in order to support my contention that a basic humanistic education will *have to* constitute a necessary part of the training of anyone who wishes to do intensive individual psychotherapy. It must be made absolutely clear first that *no* curriculum and *no* training program can take the place of or even compare in importance to the thorough personal psychotherapy of the psychotherapist.

From the fourfold roots of psychotherapeutic interaction it is now possible to characterize



psychotherapeutic interaction more deeply. Beginning with *the language of scientific investigation*: Freud (1923) originally presented the concept of the ego as being a precipitate of abandoned object cathexes and containing the history of these object choices. Thus ego formation is based on introjection, a process especially important in the early phases of development.

There is not much agreement on the exact method by which introjects are formed and how they function in specific stages of ego development to either enhance or impair the adaptative functioning of the ego. It is generally agreed that at least in the borderline patient, because of the destructive introjects, there is a profound lack of a sense of self-love, beloved self, or inner sustainment, without which even the best technical interpretations will fail. This has generally been described by the borderline patient

as his sense of alienation, or identity diffusion, or feeling dead while being alive, and I have discussed these feelings as a function of the lack of good-enough holding in infancy elsewhere (Chessick 1977a, 1977b).

The importance of all this in terms of the special theory of psychotherapeutic interaction is that destructive introjects in the patient present a *limiting factor*, determining to what extent the patient can actually experience the benign psychic field offered by the therapist. Thus regardless of how well trained and well prepared the therapist is, and regardless of how healing his psychic field may be, the presence of certain types of destructive introjects and even the lack of a firm grasp of his own sense of identity may make it impossible for the patient to actually experience a therapeutic interaction.

The problem of unfreezing the destructive introjects, as first introduced by Winnicott (1958), thus becomes the key for any successful psychotherapeutic interaction to occur. It is through the providing of a setting or an atmosphere or ambience in the psychotherapy that this unfreezing takes place. The limitations on the unfreezing of destructive introjects usually delineates the limitations of the patient's capacity to respond to psychotherapy even in the presence of a therapist with a healthy and mature psychic field to offer.

Since this unfreezing applies to aspects of early ego formation, it is clear that it can only occur if a controlled regression is permitted to take place as a natural consequence of a sense of security in the therapeutic alliance that is allowed to form between a relatively healthy therapist in alliance with whatever mature aspects are available in the

observing ego of the patient. If the therapist 'behaves himself' as Winnicott calls it, and behaves without too much cost simply because of being a relatively mature person, and the therapist neither exploits the patient nor retaliates against the patient, an invitation to a controlled regression tacitly occurs. If this is consistently offered there is a chance at least for an unfreezing to take place, although we must face it squarely that at least in the borderline patient, this may take many years.

The crucial unfreezing contains with it two major constructive and therapeutic events: the loss of destructive introjects and the introjection of the psychic field offered by the therapist in exchange. However, the regression contains a major destructive event, for such a regression stirs up omnipotent expectations on the part of the patient. A yearning appears for the therapist magically to restore to the patient all the missing

experiences from his infancy and make good for the patient all the negative experiences of his infancy. The typical consequence of this stirred up yearning for magical relief arc: acting out, in which the patient quits the treatment or finds a third person to meet his infantile cravings; the need for revenge, in which the patient may stalemate the treatment through passive aggression or allowing his life to fail; projection of destructive introjects onto the therapist with fear and hatred of him as a result, and autistic retreat into sadistic or sexual phantasies, or even hallucinations and delusions.

Psychotherapeutic interaction can successfully occur if the omnipotent demands that appear from the patient when regression begins are not too overwhelming and immediate, if the patient does not immediately quit or set out to destroy the therapy because there is no magic to be provided, if the destructive introjects which have made up

the early ego formation of the patient are not so horrible and malevolent that they cannot be unfrozen, and if the psychic field of the therapist is mature enough.

To keep the psychic field of the therapist mature enough there is certain specific work that the therapist must do with every patient, and in every psychotherapy. Each regressive step in the patient confronts the therapist with a new set of feelings, demands, and reactions to which there will be a countertransference reaction. Each intercurrent realistic or narcissistic blow in the life of the psychotherapist over the long period of psychotherapy—in which both the therapist and patient are experiencing numerous events in their actual living—will also present the therapist with a series of countertransference stimulations. The very length of time of the therapy also represents a time frustration to the secret omnipotent hopes

of the psychotherapist (Wile 1972).

All these factors operate to provoke the tendency to exploit or retaliate, or both, even in minor ways such as the tone of one's voice, letting the patient out early, and so on. Thus a constant self-analysis of the countertransference structure must be going on within the therapist in order to keep the psychic field up to a maximum of maturity. This continues simultaneously with efforts to understand the patient and interpret this understanding of the patient back to him.

Switching now to *the language of the humanistic imagination*, it is clear that the patient must continuously experience the presence of the therapist; each therapy session must count. Each session must represent an encounter between the psychic field of the therapist which in its maturity extends trust, confidence, and hope, and the need-

fear dilemma of the patient with a tendency to fall away from an authentic self and from being with another person.

It is most important to understand that the encounter or the I-Thou relationship that we try to present to the patient represent *epiphenomena* of a successful working through by the psychotherapist of the various phases of his countertransference structure as called forth by the various phases of the patient's psychotherapy. They also represent epiphenomena of the removal of destructive introjects that then permit the patient to go on to develop the capacity to experience the therapist's psychic field. The reverse is *not* true and here is where unfortunately an increasingly common amateur error takes place. One cannot force presence or encounter down a patient's throat. Hugging and kissing and going through all kinds of gestures of a



physical nature with a patient will not fool the patient; they mask serious countertransference problems in the therapist and will not affect the patient because of the presence of destructive introjects. Only the natural and inevitable unfolding of a human encounter in the forward progress of psychotherapy, as both the patient and therapist work through their respective tasks, can produce a genuine growth experience for both.

The task within the patient is to lose the destructive introjects and replace them with the more benevolent psychic field of the therapist. The task within the therapist is continuous scrutiny of the countertransference structure for the purpose of keeping the psychic field as optimal as possible, as well as a most careful and dedicated attention to the patient's material for the purpose of understanding and interpretation. There are no short cuts to this. The encounter experience would

be an epiphenomenon of the net progress of field interaction and this underscores the error of trying to mysteriously force a 'presence' on the patient by various dramatic maneuvers.

This theoretical conception also makes it clear why innumerable courses and seminars of any sort are no substitution for the intensive psychotherapy of the psychotherapist. No amount of knowledge can substitute for the massive countertransference founderingings that invariably take place when the therapist is not in possession of self-knowledge. The importance of continual analysis of the countertransference structure in maintaining the optimal psychic field is theoretically clear. Of course this is based primarily on the intensive psychotherapy of the therapist, without which it would be impossible to avoid the development of a malevolent countertransference situation that would preclude

any effect of the psychic field in a therapeutic fashion, regardless of the patient's readiness for it.

I am alarmingly aware of the lack of regard of this fact among psychotherapists—for the most part nonmedical—who attempt to provide care, love, and various physical gratifications for patients along a variety of theoretical lines in and out of swimming pools, and so forth, without provision for the countertransference aspects of what they are doing. If the special theory of psychotherapeutic interaction is correct, it is clear that the beneficial effects of an I-Thou type of relationship between the therapist and the patient can only occur if the countertransference aspects in the therapist are thoroughly worked through and the hostile introjects in the patient have become exchanged for the benevolent introjects from the therapist in an atmosphere of therapy that permits a regression in the service of the ego.

No amount of dramatic jumping on the patient can cause this to happen one bit faster and the time frustration in doing intensive psychotherapy is a fact of life that has to be faced by anyone in our field. Although there are two maps on which one can describe a therapeutic interaction that is going on at any time in the psychotherapy, these maps do not imply chronological equivalence. This is the profound weakness of sticking only to the language of the humanistic imagination when describing the psychotherapy process and it also explains why in our day-to-day therapeutic work we tend to reduce our theoretical conceptions down to the scientific language of Freud. The appearance of a beneficial interaction best described in the language of the humanistic imagination is a reward for the patient working through of the patient's material, although it often appears as something dramatic and teleological

leading, when the groundwork has been provided and it is ready to appear, to a dramatic acceleration in the psychotherapy.

## Summary

There are two competing languages that may be used for the description of psychotherapist interaction. These languages are grounded on different nuclear operations of the mind and the therapist must be thoroughly familiar with both of them and able to shift back and forth from one to the other both for the purpose of understanding and the purpose of interpretation to the patient in the most effective fashion.

The great danger arising from the existence of these two complementary languages comes from making the mistake of assuming the processes described by both of them necessarily occur chronologically at the same time or with any kind

of equivalence in psychotherapy. A common amateur error is to think that teleological purposes such as presence or I-Thou relationship can somehow be forced on a patient if the therapist is only good enough or cares enough or loves enough. For the patient to really experience such phenomena, a long period of controlled regression in the service of the ego will first be necessary in order to remove destructive introjects that interfere with communication and growth.

### *Note*

Originally published in the *American Journal of Psychotherapy* 28: 243-52, 1974. Reprinted by permission.

## **Addendum**

Over the twenty-five years since this paper appeared, the ideas in it evolved into my book (Chessick 1992a) advocating a 'five channel'

approach to psychoanalytic listening to maximize our understanding of a patient. For those not familiar with this approach, which I used in the treatment of the patients described in the chapters of the present book, I will now briefly review these five standpoints or channels (models, perspectives, frameworks) from which we can tune in to the transmission from the patient. Each of them, as is well known, is based on premises that are currently conflicting and irreconcilable. The *first* channel was presented by Freud and focuses on the Oedipus complex and the emergence in a properly conducted psychoanalysis of the need for drive satisfaction in the transference. This enables us to study the patient's conflict in terms of defenses against the instinctual drives and the resulting compromise formations produced by the ego in dealing with its three harsh masters: the superego, the id, and

external reality. Freud's structural theory, placing the Oedipus complex at the focus, was developed for this purpose. At the core of it are the patient's childhood or infantile fantasies which repeat themselves over and over again in the patient's mental life and behavior (Arlow 1985). We carefully listen for the derivatives of these fantasies and look for them to be re-enacted in the transference. I believe this to be the primary model, the starting point for all psychoanalytic listening.

The *second* channel utilizes the perspective of object-relations theory for its model. The work of Klein and her analysand Bion focuses on the earliest projective and introjective fantasies of the patient as they appear in the object relatedness manifest in the transference and in the process of projective identification as it occurs in the analytic process. Bion (1963, 1967) emphasized the 'toilet



function' of the analyst, in which the analyst must receive, metabolize, and give back in acceptable form the unacceptable fantasies and affects and expressions of these coming from the patient. Klein (1975a) developed the concept of projective identification (defined differently by every author), in which the patient is allowed to place into the analyst whatever representations he or she wishes to place there, with more therapeutic focus on preoedipal fantasies and processes. For Klein, projective identification was also an interactional event in which great pressure is put on the therapist to behave in a manner that corroborates the projection. For Kernberg (1975), aware of Klein's confusion of the intrapsychic and the interactional under one process, it is a very primitive mental event that represents an incomplete projection. A study of projective identification operating in the therapeutic process

reveals the patient's earliest internalized object relations and yields data about how the patient as an infant organized these relations into self and object representations and then projected and reintprojected various aspects of these images. Understanding of these processes clarifies the patient's relationships in the present because all such relationships are perceived and reacted to through the spectacles of these early organized self and object representations. Kernberg (1975, 1976, 1980) presented the most thorough theoretical elaboration of this material (reviewed by Chessick 1977a, 1985a).

A *third* channel, focusing on the patient's being-in-the-world, is the phenomenological point of view. Here an attempt is made to grasp the facts of the patient's life phenomenologically, without other theoretical preconceptions to organize the data. This approach was elaborated in philosophy

by Husserl and then differently by Heidegger, and taken up especially by the pioneer psychoanalysts such as Boss (1963), especially in their effort to understand seriously disturbed and psychotic patients. A corollary of this approach began with Feuerbach and Marx, and was elaborated by thinkers like Fromm, Sartre, and—most recently—Lacan (reviewed by Chessick 1992b): society shapes the individual and we can only understand the individual if we understand the society or culture or world in which he or she must continuously live and interact. So, to understand an individual, we must understand that lived state of being-in-the-world which is unique for the situation of each person.

The *fourth* approach is from self psychology (Kohut 1971, 1977, 1984; reviewed by Chessick 1985a), which focuses on the state of the patient's sense of self as it is empathically grasped by the

analyst. Important predecessors of this approach were Fairbairn and Winnicott. The latter introduced the notion of the true and the false self that was taken up in detail by R.D. Laing (1960) in his brilliant exposition of schizoid and schizophrenic conditions. Kohut brought the focus on the self into a systematic and elaborate theory; significant alterations in this theory have recently been offered by Gedo (1979), whose work does not receive the attention it deserves. Although Gedo rejected many of Kohut's premises, often on the basis of careful arguments, his establishment of hierarchies of self-organization represents a further elaboration and movement away from traditional psychoanalytic metapsychology.

The *final* approach to organizing the transmission from the patient might be loosely termed the interactive, focusing on the countertransference of the therapist or, more

generally, on the here-and-now factors in the treatment and emphasizing the analyst's participation. An example is Kohut's insistence on the primary role of the analyst's empathic grasp of how the patient experiences the analyst as constituting the methodology that distinguishes psychoanalysis from the other sciences.

Many of the numerous and conflicting points of view under this rubric have been developed as a response to our increasing understanding, especially in preoedipally damaged patients, of the patient's need for an experience and not just an explanation in the treatment. Modell (1976) offered the notion of the psychoanalytic process in the early phase of the treatment of narcissistic or schizoid patients as providing a 'cocoon', a holding of the patient until the patient is ready for self-exploration. Langs (1979) emphasized the presence of delineated interactive fields in which

the data coming from the patient is loaded with allusions to the therapist's participation and even the therapist's mental state. In this extreme (Chessick 1982a) but carefully worked out view, the patient's unconscious is given the capacity for perception of the therapist's personal difficulties and having a motive to cure the therapist so the therapist may in turn cure the patient.

Gill (1982) emphasized the importance of the therapist's participation in the particular transference manifestations that develop in a given treatment and also focused his interpretation on the here- and-now interaction between patient and therapist. Gill's view is close to Sullivan's (1953) more extreme interpersonal theory of psychiatry which, however, eschews Freud's crucial concept of psychic reality and attempts to study a scientifically delineated interaction in the treatment, one in which the

therapist both participates in and observes the interaction at the same time. Sullivan's approach suffered from a metapsychological shallowness because of its emphasis on the interactional without sufficient study of the filtering mechanism through which the patient inevitably experiences this interaction. Sullivan's concept of parataxic distortion attempts to make up for this, but has not received widespread acceptance.

Wolf (1985), from a self psychological channel, pointed out in his notion of 'regressive listening' the impact of the therapy situation itself on the analyst and his capacity to listen. This important concept belongs at the margin of the self psychological and the interactive channels, and I hope it will receive greater attention and explication in the future.

Nietzsche, postulating the metaphysical notion

of the will to power underneath all human behavior and mentation (reviewed by Chessick 1983a), profoundly influenced the psychoanalytic approach of Adler. Breaking with Freud, Adler attempted to evaluate all the data of psychoanalysis from this principle, but his approach suffered from an intrinsic oversimplification of all explanations. I will not employ the concepts of Adler or of the mystical Jung in this book.

Loewald (1980) was a pioneer in developing the traditional psychoanalytic approach but he also insisted that the patient's experience of the analyst was a major factor in the curative process. How does this experience affect the process of psychoanalytic listening? For example, sometimes the patient's experience in the analytic situation is only communicated at the end of the treatment session. As the patient leaves the room there may



occur a 'separate' type of dialogue or interaction, in which material that has been left out of awareness during the period of free association is given direct exposition by the patient. This is also an especially valuable time to study countertransference manifestations. Freud, as mentioned above, was aware of this phenomenon, at least as a clue to the transference.

Gedo (1977) sharpened our focus on the archaic transferences, in which the patient forces a response out of the analyst and contaminates the evenly hovering attention stance advocated by Freud. The management of such archaic transferences and how they affect psychoanalytic listening is one of the most important and central issues in modern psychoanalytic therapy because so many patients present with preoedipal damage and rapidly develop such transferences. Gunther (1976) emphasized the converse of the archaic

transference, namely, the narcissistic aspects of the countertransference. He pointed out that countertransference manifestations appear often after the therapist's narcissistic equilibrium has been upset; they represent an attempt to restore the therapist's equilibrium and he urged us to look for these situations in psychoanalytic listening.

The most complete traditional exposition of the interaction between patient and analyst was offered in a series of papers by Lipton (1977a, 1979, 1983), who went back even to a restudy of Freud's cases in order to demonstrate how significant aspects of the real interaction between the patient and the analyst profoundly affected the data that were presented for psychoanalytic understanding. Freud in his actual practice (often quite sensibly) violated some of his own admonitions published in his papers on technique. Stone (1981) systematized this real interaction

under the rubric of the 'physicianly vocation' of the analyst and demonstrated compellingly the profound impact of it on the material produced and the process of the treatment itself.

It is likely that Freud's papers on technique were basically aimed at preventing massive acting out by incompletely analyzed or even unanalyzed therapists with their patients, as was common in the early days of psychoanalysis and remains all too common with less justification today. But Freud's admonitions tended in the middle of the twentieth century in the United States to become codified into a rigid set of rules that sometimes produced iatrogenic narcissistic manifestations in patients and led to either an impasse in the treatment or a surrender of autonomy by the patient, accompanied by a massive identification with the 'aggressor' analyst; obviously these are unsatisfactory outcomes for a lengthy and

expensive treatment.

The authors described above were all addressing these problems in their own way, but the conflicting premises behind their approaches again highlight the difference between viewing the patient as suffering from a psychic deficit with emphasis on experiential repair, and viewing the patient as suffering from psychic conflict that requires explication. My view differs significantly from that of Gedo and Golberg (1973) in that their principle of 'theoretical complementarity' (p. 4) assumed the different frames of reference or models of the mind may operate only as long as no internal contradictions arose among the various parts of the theory. They believed even Freud did not intend to dispense with his older conceptions as he went forward to propose new ones, and the changeover from one set of Freud's concepts to another did not have to indicate that one

superseded the other. These authors claimed that Freud 'correctly assumed that a given set of data might be understood most clearly by utilizing one particular frame of reference or model of the mind, whereas another set of data demanded a different set of concepts for its clarification' (p. 4).

But in my approach, theoretical orientations or models are being utilized that *directly conflict with each other* and cannot be thought of as complementary because the basic premises that underlie them, both their epistemological foundations (Chessick 1980) as well as their basic assumptions about human nature and its motivations (Chessick 1977b), directly collide. This forces a *radical discontinuity* as we shift from channel to channel in our receiving instrument, rather than, as we would all prefer to do, sliding back and forth between theoretically consistent positions, or at least complementary positions that

are consistent with each other.

The worst mistake a beginner can make at this point in the development of psychoanalytic theory is to assume that in some fashion these five various standpoints can be blended or melded into some supraordinate theory that can generate all of them. Careful examination of the premises of these standpoints reveals that this is simply impossible in our current state of knowledge and we are forced, if we use this shifting of systems, to accept the radical discontinuities. The problem in the human sciences is profound, and some thinkers have claimed that *in principle* no agreement can ever be reached on a single theoretical model for scientific understanding of all human mentation and behavior.

It may seem to some readers that certain other theoretical approaches or models should be added

to these channels; what I am offering here is what has proved in my forty-five years of clinical experience to be of the most value, to be the least speculative (experience-distant), and to generate the least number of arbitrary inferences. The most important requirement of a model is that it be suggested by the very data the patient produces rather than superimposed on the data by experience-distant or arbitrary prior conceptions in the mind of the therapist. This is a relative concept because no theory is truly experience-near, since it is impossible to approach data without some prior conceptions. Our only hope is that our conceptions be not too abstract, generalized, and divorced from the specific material, and that they are capable of being validated by a study of how the patient responds to interventions based on them. Even this is fraught with difficulty, as it is all-too-human to

hear what we wish to hear or, infer what we wish to infer.

The hardest part of using this approach is to be willing to keep discontinuous and conflicting models in one's mind, which offends the natural and very dangerous human tendency for a neat, consistent, and holistic theoretical explanation of all material, even if it is wrong. Kant (1781) called this tendency the regulative principle of reasoning, and Freud would have based it on the powerful synthesizing function of the ego.

My approach requires tolerance and flexibility on the part of the therapist as well as a certain maturity, for it is sometimes the unfortunate result of a personal psychoanalysis that the individual becomes a strong and rigid adherent of the particular theoretical orientation or style of their analyst. Kohut (1984) suggested that the



reasons for this are inherent in a psychoanalysis that has incorrectly and prematurely interpreted certain transference manifestations. Since no data available at present convincingly and decisively prove any of these theoretical orientations to be the one and only best orientation, uncritical adherence to any one of them would have to be a leftover of a misunderstood or unanalyzed transference, just as emerging from one's psychoanalysis with a sense of nihilism about all analytic theories would be a similar indication for further analytic work. In the present book I will not discuss these various theoretical orientations (channels, models, standpoints, frameworks, perspectives) in any further detail, as I have done so elsewhere (Chessick 1992a), along with clinical illustrations.

## Postmodern Psychoanalysis or Wild Analysis?

There are a number of unchanging ideas—none of them particularly stylish—worth fighting for; that honor is immitigable; that so, too, is dignity, despite the almost inherent ridiculousness of human beings; that one's life is a work of art, however badly botched, which can be restored and touched up here and there but not fundamentally changed; that, in connection with this, integrity includes coherence of personality; that elegance, where possible, is very nice, but there are many things more important than style, loyalty and decency among them; that a cello is a finer instrument than an electric guitar; and that a man ought to start the day with a clean handkerchief. ('Aristides' 1994)

Natoli and Hutcheon (1993) point out that

'very few critical terms in recent memory have been used and abused as "postmodernism"' (p. 1). The modernist project, as Habermas calls it, assumes that it is possible to determine objectively a foundation for a progressive grasp of 'truth', so that knowledge accrued may be at least to some extent culture-neutral and value free. Hopefully even history itself and any shifts in our ways of seeing ourselves within it can be understood in terms of objective studies. Postmodernism may be thought of as negating this basic foundationalist proposition and can be criticized, as Norris (1990) does, for effacing 'all sense of the difference between truth and falsehood, reality and illusion, serious and nonserious discourse' (p. 2)

Postmodern paradox, ambiguity, irony, indeterminacy, and contingency are claimed to replace the closure, unity, order, and the rational

of modernism. Modernism saw uncertainty as temporary but postmodernism sees no way out of uncertainty because the growth of knowledge inevitably expands the field of ignorance. This is the Hegelian concept that thought expands until it meets its negation. Postmodernism is characterized by radical ontological and epistemological doubt, and by the claim that the self is not a core entity, the 'decentering' of the self. This has immediate and obvious implications for the practice of psychoanalysis, and indeed Holland (1983) has discussed 'postmodern psychoanalysis' from this point of view. So in the postmodern psychoanalytic process we do not deal with a discovery of meaning or with a patient that has a fixed personal identity. Instead 'meaning' arises from the interaction, it is created in the interactional process and even the self or identity of both the patient and the psychoanalyst

is created from that interaction: 'The most personal thing I have, my identity, is not in me but in your interaction with me or in a divided me' (p. 304). This postmodern view makes the ego unstable, decenters it, and renders identity as uncertain as everything else. So Heller (1993) can write, 'Postmodernism as a cultural movement ... has a simple enough message: anything goes' (p. 503).

Poststructuralism leans heavily on Nietzsche's claim that there are no facts, just interpretations. The poststructuralist aspect of postmodernism declares all attempts to turn any language into an instrument of positive knowledge to be utterly futile (Bertens 1993). A radical indeterminacy is built in to this point of view, which may lead to magic, mysticism, transcendentalism, and even dehumanization, breaking down traditional barriers in western culture and emphasizing that

no intellectual or moral system, no way of perceiving reality, can ultimately be legitimized. So poststructuralist deconstructionism can abandon all attempts at acquiring what might be termed 'positive' knowledge, and students in 'politically correct' colleges may study Shakespeare or the comic strips without moral or literary criteria determining the worth of one over the other. Poststructuralists insist, allegedly following Nietzsche, that the self is really an empty place, no longer a coherent entity that has the power to impose order on its environment; it has become decentered. The radical indeterminacy of postmodernism has similarly characterized the individual ego, rendering stability and identity as uncertain as everything else.

Huyssen (1993) attempts to distinguish between poststructuralism and postmodernism in the sense that poststructuralism is a form of

literary criticism that is closer to modernism, but this seems to me an artificial distinction that I will not use in this chapter. Perhaps the best example of this aspect of poststructuralism may be found in the views of Barthes (1968): he opposes Sartre's claim that literature has a responsibility to communicate and argues that literature simply must abolish itself, opening the door to writers like Joyce, Stein, and Beckett, and that literature has nothing to say because there is nothing worth saying any longer about the human condition. Huyssen would prefer to see poststructuralism as offering 'a theory of modernism characterized by *Nachträglichkeit*, both in the psychoanalytic and the historical senses' (p. 137), but I think this simply is an attempt to render poststructuralism as somewhat less radical than postmodernism and I doubt if many contemporary thinkers would accept his distinction.

There is an ambivalence in poststructuralist criticism that is reflected in its emphasis on the ambiguous writings of Nietzsche, whose works are also subsequently deconstructed by Derrida (1979). Elsewhere I (Chessick 1983a) have outlined the paradoxical nature of Nietzsche's thought, which lends itself to ambivalence, ambiguity, and to the use of Nietzsche's philosophy—if one would call it that—for a variety of conflicting purposes. In this chapter I will use the terms 'postmodernism' and 'poststructuralism' interchangeably, viewing poststructuralism as an offshoot or a symptom of postmodernism. I will also attempt to avoid the polemical and the political aspects of this debate in which, for example, critics of postmodernism are labeled as neoconservative or reactionaries, whereas advocates of it are claimed to be liberated feminists or politically correct. I wish to



concentrate on only those aspects of postmodernism and poststructuralism that are relevant to the practice of psychoanalysis.

The great physicist Hawking (1993) reminds us (*contra* Kohut) that aggression in our species is built into our DNA (deoxyribonucleic acid). He points out that academic philosophy of science has little understanding of how science really works. Theory is developed first and scientists are very reluctant to give it up. When observations don't fit the theory, the observations are questioned and, if necessary, ad hoc hypotheses are entered in. Hawking maintains that what we regard as reality is conditioned by our theories and that we do not know what reality is independent of our theories.

This is another way of saying that the analyst's theory is an important aspect of his or her countertransference (Myerson 1993). There is

simply no agreement among analysts about whether to stress the interactional aspects of what goes on in the treatment or to re-emphasize Freud's original view of the process as located primarily in the patient and only facilitated by the analyst. This debate has been reviewed by Boesky (1990), who writes:

The superficial view that we can simply assume that the 'actual' behavior of the analyst is correctly perceived by the patient is misleading, whether or not the intervention of the analyst is an 'accurate' interpretation introduced in an empathic and timely manner, or an inadvertent error. We can only infer what any behavior or intervention by the analyst means to the patient through a disciplined study of the patient's behavior, associations, dreams, and actions outside the sessions, (p. 568)

Everyone agrees that the psychoanalytic treatment situation is vastly more complex than was realized by the early generations of

psychoanalysts. Efforts by philosophers of science like Grünbaum (1984, 1993) to reduce it to propositional forms such as the 'tally argument' he attacks are both simplistic and already obsolete.

Gedo (1991) tells us regretfully, 'There can be no doubt about the conclusion that the psychoanalytic world I aspired to join over 40 years ago is entirely dead' (p. 168). He laments the situation in the psychoanalytic community, which he claims no longer contains scholars, scientists, humanists, or even educated persons, and no readers of serious literature; earning as much money as possible and self-promotion have taken priority. As more and more types of patients are accepted for analysis, Gedo explains that we have run into disorders that are based on what he calls apraxias, which he defines as defects in psychological ability to modulate ordinary emotional responses to the vicissitudes of

everyday life. In such patients expectable life circumstances trigger extreme affect states.

If Gedo is correct, it is not possible to argue that patients with these kinds of preoedipal disorders are simply expressing a reaction to the intersubjective nature of the particular encounter with a particular analyst. The patient brings to the analysis a certain set of maladaptive internalized practices that either represent identification with significant parents or compromise formations formed by the early ego in dealing with its three harsh masters. The patient presents these mechanisms from the very first moment of contact with the analyst, even on the telephone making the first appointment. So, it is sometimes possible on the telephone even while setting the initial appointment to recognize patients who are paranoid, anxious, obsessive-compulsive, depressed, and so on. This is hardly totally

attributable to the vicissitudes of the psychoanalyst's input, although such input may have a triggering effect from time to time.

In a properly conducted psychoanalysis certain major transference paradigms will appear—either oedipal, preoedipal, or archaic, or selfobject transferences, depending on the terminology we wish to use—with the order depending somewhat on the input from the analyst. But in a properly conducted psychoanalysis all of this set of transferences should appear and be worked through sooner or later. So Gedo claims that the problems of Kohut's (1977) 'guilty man' and 'tragic man', 'are generally to be found in almost every analysis' (1991, p. 87). Gedo emphasizes certain primitive behaviors that are repeated in the analytic situation, which are not either part of an infantile neurosis or an archaic transference. They are 'automatisms that do not necessarily

involve any object relationship and certainly cannot be understood in terms of the reality or the pleasure principle. These behaviors stem from the persistence of areas of primitive mentation that have never been encoded in symbolic terms' (1991, p. 87).

Our theories and our personalities always have distorting consequences on subsequent events constituting whatever appears in the analytic situation, as Gedo recognizes, and this is what produces the exceedingly difficult paradox that all great theorists in our field have found clinical material in their patients that they believe validates their theories even when the theories conflict with each other. At the same time there are certain essential patterns that are built into the fabric of the self or, looking at it from a different theoretical viewpoint, that constitute primary ego mechanisms or defense

transferences, that will be revealed sooner or later in any well-conducted analysis. There is no doubt, as Gedo points out, that patients gain an enormous amount of knowledge about us as time passes and that it is impossible to maintain strict neutrality. At the same time, I believe it is throwing out the baby with the bath water to claim that the whole of the material of any psychoanalytic procedure is intersubjective and that the patient's basic contribution to this material cannot be sorted out in order to stand by itself and give us at least a reliable adumbration of the patient's fundamental psychic structures.

For example, my own experience with many borderline patients over a number of years has been that a review of the whole sequence of treatments by psychiatrists and psychotherapists that such patients often go through before they come into analysis reveals certain common

fundamental patterns of reacting and experiencing that the patient expresses, regardless of the input from the psychotherapist or the therapist's gender, age, or other characteristics. It may take some time before these patterns appear, but they reliably do appear unless the therapist is incredibly disruptive or immersed in a pathological countertransference that he or she cannot control. Kohut (1977) in a way recognized this when he emphasized over and over again that what was important was how the patient experienced the analyst. In Kohut's terms, the patient's claim that the psychoanalyst has failed as a selfobject is far more important toward understanding the patient than winning an argument about whether the analyst actually 'in reality' failed the patient. To put it another way, it is the patient's experiencing of the input from the analyst that calls forth the various archaic patterns



(Gedo's 'apraxias') from the patient as the patient regresses in the transference phases. This 'experiencing' can be colored by repressed archaic narcissistic needs if one wishes to look at it from the point of view of self psychology, or by projective identification, if one wishes to use a more Kleinian approach.

There are patients, for example, who reach certain phases in treatment where every word that the analyst says irritates them and produces disagreement, no matter how careful the analyst may be to be empathic, or 'in tune', or to examine the intersubjective situation. There are patients who in certain phases are irritated with every aspect of the analyst's office—the temperature, the lighting, the decorations, the furniture, and so on. Occasionally I have found during a consultation that the therapist attempted to change around the decor of the office to please the

patient, leading only to an endless shifting and changing of furnishings, with the patient just as dissatisfied as before.

Reading through the subjective record of Little's (1990) three psychoanalyses, it is remarkable to note that she started each of her analyses with three entirely different therapists the same way—with crazy, destructive, bizarre behavior. She had a need to display what she calls in her terms, 'pockets' of 'madness':

These may extend over large or small areas of someone's personality, causing a greater or lesser degree of disturbance in his life, his work and leisure, and his relationships. Such things arise from anxieties earlier than those of psychoneurosis; they concern survival and identity ... and for those who suffer from them the *sound* of words spoken may be important, but not their *meaning*, so that verbal interpretation is of little use and other means of dealing with the anxiety need to found. (Little 1990, p. 86)

Little of course believes that only by regression to dependence can areas where psychotic anxieties are dominant be explored, 'early experiences uncovered, and underlying delusional ideas recognized and resolved, via the transference/countertransference partnership ... in both positive and negative phases' (p. 107).

Gedo (1991) is certainly correct when he argues that even the tone of voice in which we make interpretations communicates important information to the patient and shapes the patient's response to the interpretations. I do not disagree with any of this, but I only challenge the concept that the whole of the therapeutic interaction is represented by an intersubjective mutual dialogue that cannot reveal anything essential or structural in the patient. In this sense I am opposed to the postmodern or poststructuralist approach, which I think carries the danger of an ambience that

generates therapeutic nihilism, promotes 'wild analysis' where 'anything goes', and provides a rationalization for destructive countertransference acting out.

This is no debate with postmodern profound doubts about objectivity, truth, and the possibility of achieving stable knowledge. A certain amount of skepticism is always useful, as we all have a narcissistic investment in our beliefs. Robinson (1993) writes:

The self is implicated in its own destiny; it carries within itself secret desires and unknown capacities that profoundly affect its history. Above all, the modern self is a site of internal tension and conflict. This new conception made Freud the central figure in the emergence of the modernist sensibility in the early twentieth century, (p. 117)

My point is that this complex self, or ego if one wishes to use ego psychological terms, with all its internal inconsistencies and intrapsychic tensions,

is at the basis of every psychoanalytic encounter and, given the proper chance in the regressive process that takes place, it will display itself consistently in all its varying and paradoxical manifestations. It is our job as psychoanalysts to allow this to happen and to convey the knowledge that we gain when it does happen back to the patient in an appropriate fashion. Even if our contribution to the interpersonal situation affects the way in which the material does unfold, there is something basic in the patient that can be outlined, developed, and communicated back to the patient, given only the qualification that the psychoanalyst is competent. This competence is often manifest by the analyst knowing when to intervene and when to keep silent.

Kakar (1982), in his interesting study of the wholly different notion of the self as it is thought of in India, a study emphasizing the widely

different roles in cultures of healing traditions and the importance of cultural relativity, surprisingly finishes by reversing himself to conclude with a quotation from Lionel Trilling that echoes Sullivan's famous statement that everyone is much more simply human than otherwise. Trilling (1972) writes:

Generally our awareness of the differences between the moral assumptions of one culture and those of another is so developed and active that we find it hard to believe there is any such thing as an essential human nature; but we all know moments when these differences, as literature attests to them, seem to make no difference, seem scarcely to exist. We read the *Iliad* or the plays of Sophocles or Shakespeare and they come so close to our hearts and minds that they put to rout, or into abeyance, our instructed consciousness of moral life as it is conditioned by a particular culture—they persuade us that human nature never varies, that the moral life is unitary and its terms perennial, and that only a busy intruding

pedantry could have suggested otherwise,  
(pp. 1-2)

This debate is part of the wider philosophical debate that was probably precipitated by Rorty (1979). According to Wilson (1993), Rorty (1989) argues that there is no core self or inherently human qualities or essence. Horrible behavior is explained from such a point of view out of circumstances, a relativistic approach in which there is no allowance for any human nature that would render some actions to be labeled entirely inhuman. Wilson believes that we do have a core self although selfish desires and moral capacities may conflict with each other, and he tries to give evidence for this. He points out, just as I wish to point out in this chapter, that there are two crucial errors that can be committed in this argument between modernism and postmodernism. The first is to argue that language, or culture, or circumstances such as the analyst's input, is

everything and determines the entire psychoanalytic process. The second, which was committed in some of Freud's early papers, is to believe that culture, or the analyst's input, or the circumstances, have nothing whatever to do with the material that is generated. An example of this view today is that of Langs (1979), who argues that if the analyst is strictly neutral and offers nothing but interpretations, then the material produced by the patient will refer primarily to the patient's psychopathology. This of course is an extreme view and I (Chessick 1982a) have elsewhere questioned whether it is possible to carry it out in practice without creating such a depriving environment that the patient will react with the symptomatology of narcissistic wounding.

Lyotard (1984) has expressed the theme of postmodernism or poststructuralism as the



rejection of all metanarratives, or 'incredulity toward metanarratives' (p. xxiv), meaning by 'metanarrative' any theory about Reality that is supposed to be true for all time and from all points of view. This is similar to the arguments of Rorty (1979), who essentially reduces metaphysics to pragmatism and language games. Because all observation is theory-laden there can be no Reality that is objectively there for all knowers, argue the postmodernists or poststructuralists, and they reject even partial or contingent 'truth', arguing that 'truth' is 'hegemonic', 'logocentric', 'phallogocentric', and so forth (Himmelfarb 1994). It follows, as Kane (1993) points out, that, 'Any attempt to show that one point of view is objectively right and all others wrong would have to appeal to the presuppositions and standards of rationality of one among other points of view and could not therefore claim either certainty or

objective truth' (p. 414). Because all knowing and understanding involve interpretation in terms of some conceptual scheme or linguistic framework, some language games or forms of life local and particular to the knowers or inquirers are embedded in historical and cultural traditions that they cannot transcend in order to attain a neutral or objective point of view. Kane calls this, 'a pervasive image (perhaps *the* dominant image) of the modern intellectual landscape' (p. 414). He continues, 'The claim that human inquirers are embedded in historical traditions and cultural frameworks from which they cannot escape to a "neutral" or "absolute" perspective eventually threatens the ideal of objective explanation as well as that of objective worth' (p. 417).

Kane's answer to this dilemma is that we are not trapped between a Platonic realism and a postmodernist or poststructuralist nihilism or

pragmatism. He explains, 'For the way the world is may simply be all the different ways the world is, described in different vocabularies' (p. 418). So, for example, the history of a city could be simply the *summation* of what the weather man, the economist, the social historian, the geographer, and others correctly say—which means that to describe fully the way the world is would require broad learning and using many vocabularies. He continues, 'If some of these ways are incommensurable with, or irreducible to, others (if they can not be wholly translated into, or reduced to, some one level of description), so be it' (p. 419). This is also the point of view I (Chessick 1992a) have expressed in a recent book, in which I have suggested that we use five channels of listening in psychoanalytic treatment. These channels are not reducible to each other and the basic premises of them conflict, but the summation of our listening

on all five of these channels, I maintain, does give some approximation to the objective truth of what is going on with the patient.

Rescher (1973, 1991, 1992) has approached this problem in another way, attempting to avoid poststructuralist nihilism by his system of 'conceptual idealism'. Opposed to the postmodernists in his basic premise that there is an empirical reality 'out there', which can be approached by our study of it, Rescher (1992) defines his position of conceptual idealism or pragmatic idealism as maintaining that 'Any fully adequate descriptive characterization of the nature of physical ("material") reality must make reference to mental operations; some recourse to verbal characteristics or operations is required within the substantive content of an adequate account of what it is to be real' (p. 305). Rescher and I agree with the postmodern claim that the

activity of the knower permeates what we know, not only in the constituting but also in the constitution of what is known. But our point of view is a guarded version of scientific realism, which concedes that both constitutive and regulative principles are supplied by the mind. This represents a sort of halfway point of view between classical scientific naive empiricism as advocated by Freud, and the poststructuralist or postmodern approach. Rescher (1973) writes, 'Descriptive information about the empirical features of things is always in part a product of mental contrivance' (p. 9). What I wish to emphasize here is the phrase 'in part'. Even if our conceptual machinery is not innate and is a cultural artifact, socially formed and transmitted as Rescher points out, there is implied the possibility of a hermeneutical study to tease out these artifacts and supply us with an

approximation of a residue that may be called objective reality about the patient.

Focusing this on the psychoanalytic process, of course both the psychoanalyst and the patient approach each other with preconceived notions, linguistic usages, unconscious infantile fantasies, and other factors that importantly affect the way they experience each other in the relationship and the interaction between them. But let us give the psychoanalyst credit for the capacity to analyze countertransference and to be able through the use of hermeneutics and even phenomenology (one of the channels of psychoanalytic listening I have described in my book) to identify those aspects of himself or herself on which the assessment and evaluation of the patient are contingent, and on which the decision to intervene with an interpretation rests. A similar self-study is assumed from the well-trained psychoanalyst

when he or she evaluates the response to a given interpretation. Through this method we cannot obtain, as Freud and the empiricists of the nineteenth century thought, a single view of permanent objective 'reality', but we can, by a summation of the data gathered using at least five channels of psychoanalytic listening, attain a sort of approximation to an objective evaluation of what is going on in the intrapsychic life of the patient.

Much of this disagreement has been echoed at the level of philosophy in a recent work that consists of a battleground, although civil and productive, between Caputo, offering his 'postmodern' critique of the transcendental aspirations of the western philosophical tradition, and Marsh, espousing 'critical modernism' that attempts to retrieve and affirm the fundamental validity of that tradition. It is another and perhaps

more readable version of the battle between Derrida and Habermas; a third author, Westphal, is the mediator (Marsh et al. 1992). There is a core of epistemological agreement at the heart of this debate. All accept what might be called the postfoundationalist standpoint, that reason is inextricably rooted in history and there is no intuitive grasp of truth that would not be mediated by social and linguistic structures, bringing an essential element of ambiguity of undecidability to what we call truth. In agreement with Marsh, I do not take this as a defeat for reason but as a renewed call to a more critical and hermeneutic use of reason, attempting to thematize unthought presuppositions and critically assess their cogency. Caputo and Derrida, on the other hand, emphasize the impossibility of truth or 'the untruth of truth', which I believe leads to an extreme view and, if it permeates one's practice of



psychoanalysis, runs an inevitable danger of nihilism and wild psychoanalysis where anything goes as long as it is agreed on by both the patient and the analyst.

Psychoanalysis, in my view, when practiced from this latter postmodern vantage point, can become a kind of collusion and mutual myth-making, with so-called narrative 'truth' arising out of the dialogue between the analyst and the patient. The defensive aspects of such myth-making are ignored and the dangers of wild analysis and of this form of what we might call postmodern psychoanalysis are the same: the reinforcement of the patient's defensive structures by the use of inexact interpretations, as Glover (1931) pointed out in a classic paper long ago.

Ingram (1994, p. 184) in a learned and stimulating paper suggests:

I believe that what actually occurs in good therapy is unavailable for discussion and review because there is no legitimate discourse for reporting it. I warrant that experienced and successful therapists know precisely what I mean and will join me in acknowledging how much this is so, even if they scowl at other opinions expressed in this essay.

There is an echo of Wittgenstein's *Tractatus* in this statement. Wittgenstein's (1961) *Tractatus*, originally published in 1921, ends with a nihilistic and famous sentence, 'What we cannot speak about we must pass over in silence' (p. 151). Earlier in his paper Ingram refers to Wittgenstein's notion of 'language games', but this belongs to Wittgenstein's later philosophy, which some consider to be akin to the work of Heidegger, and others consider simply muddle-headed. Certainly it is a step in the postmodern direction.

Those like Spence (1982), who emphasize the

'narrative truth' in the psychoanalytic exchange, move the entire psychoanalytic process away from the natural sciences and into the area of relativism, hermeneutics, postmodernism, and nihilism that Bloom (1987) so cogently deplored in *The Closing of the American Mind*. The great danger of this emphasis that I wish to focus on as the central point of this chapter, is that it leads to the same problem in psychoanalytic work that is found in currently fashionable academic postmodern studies of philosophy and ethics: anything goes and anything is true if the two partners in the dialogue can agree on it and find it useful. There is no standard by which to measure the possibility of collusion to avoid the truth in such an approach. Nor is there any cognizance of the powerful role of projective identification and the gross distortions of the experience of the analyst that are produced by the neurotic patient's

early infantile fantasies, wishes, conflicts, and defenses, as pointed out over and over again in the work of Arlow (1969b):

When memory and perception offer material which is consonant with fantasy thinking, the data are selectively perceived and the memories are selectively recalled and used as material to serve as a vehicle for the unconscious fantasy ... . This is not the objective reality which can be observed by outsiders and validated consensually. (Such objective reality is] ... impossible to recollect because what the child experiences is at the very moment of experience a complex intermingling of perception and fantasy. This complex intermingling is what really happened as far as the individual is concerned, (p. 39)

I maintain that proper psychoanalytic listening along five or more channels, and correct self-analysis (Chessick 1990), as well as a feel for hermeneutics and phenomenology, will enable the analyst substantially to identify the contribution of

both countertransference and cultural background practices. It is possible to approximate some kind of object understanding of what is basic to the psychic structures of the patient, that is to say, the predominant compromise formations produced by the patient's ego in dealing with its three harsh masters (the superego, the id, and the external world) or, alternatively, an assessment of the state of the patient's self at any given time using Kohut's (1977) method of prolonged empathic immersion. The summation of listening along these various channels, I maintain, produces, given the properly thoroughly trained psychoanalyst, an approximation of something structurally consistent in the patient, even given the limitations of language and the fact that effective communication requires a choice of words and tone of voice that 'clicks' with the patient at the given time. The same is true in the subsequent

assessment of our interpretative interventions.

I have been increasingly concerned with the deconstructive trend beginning ambivalently in the philosophy of Nietzsche, running through the morally disreputable thought of Heidegger, and ending in the word play and nihilism of Derrida, and its effect on current psychoanalytic theorizing. The concept of postmodernism has come to mean too many things for the term to have any but a negating effect, and I suggest that a psychoanalytic treatment carried out in this ambience runs the danger of becoming what Freud called wild psychoanalysis. If I have to choose between Lyotard and Habermas, I prefer Habermas, even though to be postmodern has become quite *de rigueur* among literary and social analysts. So Nutall (1983) writes:

My own position, which is that the word *reality* can legitimately be used without

apologetic inverted commas and that literature may represent that same reality, is in itself scandalously simple; but to argue for this view in the 1980s is to be involved in complex 'in-fighting', (p. viii)

The result is that we no longer worry about falling into the naive realism of the nineteenth century, but now 'we are in danger of producing from our universities a generation of naive relativists' (p. 191). If I have to choose between Derrida and Freud, I prefer to return to Freud.

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 23: 47-62, 1995. Reprinted by permission.

## What Brings About Change in Psychoanalytic Treatment?

Two general points of view have developed regarding what brings about change in psychoanalytic treatment. One approach emphasizes interpretation, especially of the transference, and historical or narrative reconstruction. The other approach emphasizes the experiential and transactional aspects of a new and better human relationship. In this chapter I will briefly discuss various current conceptualizations that illustrate this difference in emphasis and suggest how both interpretive and interpersonal factors work together to produce change in psychoanalytic treatment. Then I wish



to concentrate on what I regard as the bedrock of the psychoanalytic process, the uncovering of the patient's unique, individualized core preoedipal fantasies that undergo subsequent elaboration and repression during the oedipal period, and the analysis of these fantasies as representing compromise formations arising out of early preoedipal and oedipal infantile conflicts.

I will not discuss in detail the current controversies about the exact nature and metapsychological status of these early fantasy formations, as this has been recently covered in a series of articles (Abend 1990, Dowling 1990, Inderbitziw and Levy 1990, Shane and Shane 1990, Shapiro 1990, Trosman 1990). Suffice it to say that behind the fixed and organized repressed unconscious fantasies is what Dowling (1990) calls 'the blurred, undifferentiated preconceptual thought of early oedipal and preoedipal life' that

perhaps includes 'sensorimotor or behavioral memories, which arise primarily from preverbal experience and remain influential throughout childhood and adult life' (p. 109). Indeed, sometimes the first clue to such fantasies appears in the patient's behavior rather than in his or her verbalization during the analytic process. These fantasies differ from other unconscious content in 'their enduring quality and their organized, story-like quality reflecting the distortions typical of the primary process' and form 'dynamically unconscious templates from the childhood past' that 'are relatively impervious to new experience' (Inderbitziw and Levy 1990, p. 113). I wish to emphasize the danger, even in a well-conducted analysis along the lines that combine both interpretation and a meliorative interpersonal ambience, of considering the psychoanalysis to be in a concluding stage when the patient forms an

'empathic matrix' (Kohut 1984), or seems to be more mature, successful, realistic, and less narcissistic and more loving in his or her interpersonal relations, if this core fantasy activity has not been reached and analyzed.

### **Curative Factors**

Freud's mature view was that the establishment and resolution of the transference neurosis by interpretations and working-through constituted the crucial curative factor in psychoanalytic work. But Glover argues at the 1936 Marienbad Symposium on curative factors that for interpretations to be efficacious, especially in the 'deeper pathological states, a prerequisite of the efficacy on interpretation is the attitude, the true unconscious attitude, of the analyst to his patient' (Glover 1937, p. 131). At that symposium, Sterba described the meliorative function of

introjection in a mutative interpretation as altering the ego rather than the superego (as proposed in Strachey's [ 1934] classic paper), since the patient could imitate the therapist's analytic attitude of objective observing and in consequence alter his or her ego to conform to this example (Osman and Tabachnick 1988). The concept of the therapeutic alliance was brought up, developed by Zetzel (1956), and later depicted by Greenson (1965) as the 'working alliance'. Loewald (1980) conceived of the new object relationship as useful in the resumption of development and the correction of reality distortion. The maturity of the analyst becomes crucial and represents a higher degree of integration for the patient just as the mother mediates this for the child. Stone (1961) stressed the affective bond or 'primordial transference' as crucial in facilitating understanding and

integration for the patient. He advised analysts to permit the patient to experience their physicianly vocation as 'an integrated reality-syntonic representation of parental functions' (p. 110).

At the Edinburgh symposium on the same topic in 1961, Gitelson and Nacht each emphasized the patient's emotional attachment to the analyst as a significant facilitator of the integrating or restructuring outcome of successful analytic work. Most of the participants in the conference, however (Osman and Tabachnick 1988), sided with the Kleinians such as Segal, who emphasized the acquisition of insight through interpretation and argued that emphasis on the positive affective aspect of the relationship made it impossible to analyze the patient's inherent sadism and aggression. In contrast, Nacht viewed the affective interaction of the analyst with the patient as the most crucial factor in effecting a cure. He often

claimed, 'It is what the analyst is rather than what he says that matters' (Nacht 1962, p. 207).

This controversy resurfaced again in the 1977 debate (Scharfman 1979) between the followers of Kernberg, who utilize a contemporary 'object relations' viewpoint that includes some aspects of Kleinian theory, and the self psychologists, who emphasize the archaic self/selfobject bond that forms between the patient and the analyst as the patient experiences the analyst's empathic capacity. But certain analysts who are not self psychologists also currently insist that crucial noninterpretive elements must be provided in the psychoanalytic process for change to take place. Stone (1981) believes that interpretation is the crucial factor for change in the psychoanalytic process, but he insists it is effective only in the proper ambience. He emphasizes the importance of clarification, properly timed questions, and the

interruptions of silence—all of which he considers 'preparatory or ancillary to mutative interpretation' (p. 96).

Noninterpretative elements in the situation contributing to the process are embedded in the analyst's attitude, providing it is reasonable and decent; for example, the tone and rhetorical quality of the analyst's verbal interventions, his or her facial expression at the beginning and end of the sessions, and the affectual tone in which realities such as hours, fees, absences, intercurrent life crises, and so forth, are handled. A certain kind of elasticity in the analyst's personality is also needed. For example, Lipton (1977a, 1979) reviewed the climate of Freud's analyses, which preserves a real adult object relationship, although restricted, and a natural friendly and appropriate interaction between the patient and the analyst. In another publication, I (1992a) have discussed the

details of Freud's (1909) treatment of 'Paul Lorenz', informed by Lipton's study.

Empathy is an extremely important factor in the psychoanalytic process although Stone, in contrast to Kohut, does not feel that it makes up for maternal deficits. The indestructibility of the analyst is another important factor, and Stone gives Winnicott (1969) the credit for bringing this to our attention. In his conclusion, Stone (1981) reminds us that the psychoanalytic process begins and ends between two adults. The patient has every right to ask the question, 'What sort of person is this to whom I am entrusting my entire mental and emotional being?' (p. 113). The entire argument of his paper is directed against 'the superfluous iatrogenic regressions attendant on superfluous deprivations, whether or not the patient is aware of suffering as such' (p. 113) He wishes to produce a natural interpersonal



ambience as a consequence of the analyst's natural attitude toward the patient, which he does not view as curative per se, but provides an optimum ambience for effective interpretative work.

The psychoanalytic process inevitably includes both conflict resolution via interpretation leading to insight and working-through, and a development-enhancing experience in a new object relationship. Shane and Shane (1989) describe the meliorative interrelationship and inter-digitation between these two aspects of the psychoanalytic process:

Resolution of unconscious conflict liberates an arrested or skewed developmental process in the patient. The structure-building consequences of this development enable the patient to face with greater courage and confidence dangerous dysphoric affects inherent in even more deeply buried conflict. And so on. The effect is an increasingly authentic engagement in

the analytic relationship. This, we believe, is the meliorative circular ascending spiral discoverable in any productive analytic relationship, (p. 337)

## **The Role of Countertransference**

If this is correct, the special characteristics of the analyst, as emphasized already by Winnicott, including consistent interest in the patient, benign neutrality, capacity to forego expected retaliations, ability to maintain integrity despite attacks or seductions from the patient, and his or her 'consistent and persistent curiosity about and attempt to interpret the meanings of the patient's neurotic behaviors, both outside the treatment and in the transference' (Cooper 1989, p. 12) lead directly to focus on the role of countertransference. Slakter (1987) reviews our evolving understanding of countertransference, which comprises a complex system of unconscious

cues, both given and received, and arises out of a dynamic interaction between the patient and the therapist. The whole issue of what constitutes countertransference remains unresolved and is beyond the scope of this chapter (see Chessick 1986); a shift toward a more inclusive conceptualization has been traced by Abend (1989). For Freud countertransference was simply a block to listening, representing certain blind spots in the analyst. Winnicott (1949) and the Kleinians Heimann (1950) and Little (1951) insisted that all the responses of the analyst to the patient be included under countertransference. Abend argues that the current widened definition of countertransference is a phenomenon of the general de-idealization of authority in the world. Abend (1989) correctly maintains that transforming countertransference into empathy and understanding is a crucial skill of the analyst,

'perhaps the ultimate test of the gifted analytic clinician' (p. 389).

Without reference to Moliere's play in 1666 describing *The Misanthrope*, Newman (1988) explains:

The tragedy of character is that it so often works to interfere with what the subject needs most—a usable object. This is most poignant with people who have suffered significant early traumata and therefore have reorganized their psychic structures with highly protective mechanisms. Frequently, the pathological character repetitively works to achieve the conviction of the unusability of the current objects through evoking complementary responses from the companion object .... Whether intentionally induced or not, whenever the external object enacts the complementary role to the patient's character, once more the patient gains conviction that distance must be maintained. Thus, the new object in the patient's mind becomes identified with and contaminated by the original object, and is thereby disqualified for use as a new object,

(p. 251)

For Newman, patients in this manner produce countertransference, which in turn tells us about their internal objects. The analyst typically experiences negative attitudes, painful affects, and a profound sense of being demeaned and considered useless. Out of the intense interaction, the patients can learn about their archaic objects if the analyst can manage his or her countertransference.

In pathological development, the child's disappointment and consequent rage and protest are not soothed. The parental object is viewed as unresponsive and unable to contain the results of unresponsiveness, so it is seen as doubly dangerous. The patient is fixed at the level of intense primary or archaic need states. The character structure that results from these early developmental failures wards off the internal pain

of needs and the attachment to 'an intrusive, critical, excessively narcissistic, unavailable object' (p. 257). The character so formed provides the illusion of connectedness to objects but controls the attachment to new objects by distancing either through compliance or control, a phenomenon known as the 'defense transference', which is immediately experienced at the beginning of psychoanalytic therapy as the patient uses the same characterologic maneuvers toward the therapist. The analyst's reactions to this allow the analyst to sample the faulty objects of the patient's childhood and, if the analyst can manage the countertransference, it will facilitate 'an authentic recognition of the patient's inner world and in effect [supply] a missing function' (p. 274). Therefore the proper mastery of countertransference facilitates the process of change in psychoanalytic therapy.

But Newman (1988) carries this further by insisting that in the treatment of some patients this enmeshment in the transference-countertransference experience is necessary, a drama that must be repeated with affective participation by both parties to the relationship in order for the patient to come to grips with the psychic reality of what happened in the past. Kligerman, in the discussion that follows Newman's article, points out, 'A decisive amount depends on the empathy, skill, and honesty of the analyst who ... is only too prone to feel bruised and narcissistically wounded himself, and, in subtle or not-so-subtle ways, tends to blame the patient' (p. 278). But this does not only involve reacting to the aggressive attacking and demeaning patient. Terman, in discussing Newman's article, reminds us it may also apply to the compliant patient. The greatest difficulty in such situations is in the

analyst's having to dislodge both parties 'from a position of comfort to one of greater tension and uncertainty' (p. 281).

Blatt and Behrends (1987) stress the 'gratifying involvement' that takes place between the patient and the therapist in the analytic process, which they see as the first step in the internalization process that allows the patient to change through the replacement of pathological introjects by the analytic introject. For them progress in treatment occurs through the same mechanisms as normal growth and therefore both the relationship and interpretation are essential components. At the same time as experiencing the therapy as a series of gratifying involvements, the analytic process is also experienced as a series of incompatibilities 'that facilitate internalization, whereby the patient recovers lost or disrupted regulatory, gratifying interactions with the



analyst, which are real or fantasied, by appropriating these interactions, transforming them into their own, enduring, self-generated functions and characteristics' (p. 293).

### **Current Traditional Positions**

Boesky (1988) regards the ego as a conceptual abstraction of great explanatory power, a group of functions. In the technical theory of Freud's structural model, the analyst interprets in order ultimately to help the patient achieve an alteration in his or her 'pathological compromise formations in the direction of less defensive rigidity, more realistic pleasure, less affective pain, and the best possible conditions for the adaptive and flexible functioning of the patient' (p. 307). Resistance from the modern structural point of view is 'a compromise formation between defenses, drive derivatives, painful affects, the need for

punishment, and considerations of reality' (p. 309). Boesky insists that it is not true that our sickest patients suffer from pathology that is outside of conflict. Our task as analysts is to interpret these conflicts and nature will build the psychic structure. What really 'propels the psychoanalytic process', writes Boesky, is 'examining, describing, and interpreting alterations in a variety of resistances' (p. 314).

For Rangell (1989) the unconscious ego makes choices, which he considers to be 'an ongoing core process of mental functioning' (p. 190). This exercise of unconscious choice by the ego is very important to understand the psychoanalytic process because active unconscious ego choices determine the selection of defenses and the nature of external behavior. This assumes secondary process functioning in the unconscious, an idea that is not generally accepted. Rangell argues that

there is a full range of secondary process unconscious activity, 'evaluating, planning and executing action' (p. 200). These functions are affected by interpretation in the analytic process, during which the ego continuously judges what repressed material may be allowed into expression. The analytic process provides a strengthening of the ego through interpretation. This allows it to decide to face further repressed material that, when interpreted, leads to further strengthening. Using the concept of unconscious choice, the method in which the ego is altered in the psychoanalytic process can be characterized in a specific fashion.

### **Focus on the Curative Fantasy**

Ornstein and Ornstein (1977), in a quite different emphasis from the traditional view, stress the 'curative fantasy' with which the patient

begins treatment, the wish to have the past undone and made up for. When this is activated in the treatment, there occurs an interaction or engagement with the therapist, and the therapist's responses to this are crucial. According to these authors, the therapist must help curative fantasies emerge and deal with the guilt over them, allowing them to transform and mature. What is curative are not primarily nonspecific 'physicianly vocation' elements in the treatment, but the increased unfolding of archaic curative fantasies, the wish to use the therapist as a selfobject (Kohut) and the hope for a 'new beginning' (Balint). The curative fantasy motivates the patient toward recovery out of the assumption that the treatment will compensate for everything by bringing power, skills, and success.

The interpretation of this fantasy depends on one's theoretical orientation. For example, some

would relate it to infantile instinctual aims seeking satisfaction in the transference, similar to Freud's discussion of cure by love. The Ornsteins, from the point of view of self psychology, focus on the patient's new hopes, which, due to the fear of disappointment, are defended against. This is experienced by the analyst as 'resistance'. Patients may need to set up rejecting situations, in spite of their wish to be accepted, as a defense against the possibility of disappointment. Attempting to get the patient to face his or her hostility when these fantasies are disappointed and when projection takes place, implies that the patient is unlovable and that something is fundamentally wrong with the patient. Such interpretations, according to the Ornsteins and other self psychologists, just retraumatize the patient. The rage must be accepted as appropriate to the patient's experienced reality, as a response to an

experienced injury due to the disappointed wish for unconditional success, acceptance, power, and skills. For self psychologists, empathic acceptance, followed by understanding, followed by interpretation remains the crucial set of factors in analytic cure (Chessick 1985a; Kohut 1984).

### **Correction of Expectations**

Weiss and Sampson (1986) believe that control is possible over one's unconscious mental life, that one regulates it with respect to beliefs and external reality on the principle of avoiding danger and maintaining safety. For them unconscious ego thinking is experimental action, like normal thought. We learn unconsciously from our early experiences, acquire beliefs, and on the basis of these develop long-term goals. Due to such unconscious beliefs we may suffer guilt, shame, or remorse, and this causes certain rigid constricted

maladaptive behavior.

For example, the authors view 'much of' (p. 67) adult psychopathology as due to a child's wish to maintain the ties with the parents out of the unconscious guilt over separation that the child believes will hurt the parents. There are two ways such beliefs arise. Either the child attempts to gratify its impulse or reach an important goal and discovers this threatens the tie to the parents, at which point parental behavior and response becomes crucial, or a traumatic event occurs, for which the child blames itself, believing it was caused by its wish to gratify an impulse or reach an important goal. The authors claim that patients who feel they do not deserve to be loved make rapid progress when they recognize this unconscious guilt. A deficit cannot be filled by subsequent good relationships in the ordinary course of life if the individual does not feel that he

or she deserves a good relationship. This is why adult patients have persistent 'deficits,' for otherwise they would correct these deficits much earlier through new relationships.

For these authors, in the psychoanalytic process the patient works with the analyst to disconfirm pathogenic beliefs by testing them with respect to the analyst and by understanding them via interpretations. The motive to do this is very strong because these unconscious expectations and beliefs are very constricting and produce painful guilt.

An important form of testing is by turning the passive into the active. The patient behaves to the analyst as his or her parent behaved to the patient. This is in contrast to the transference, where the patient behaves to the analyst as he or she behaved to a parent. The authors claim all patients



do both of these in order to keep traumatic memories repressed. Testing by turning passive into active is with the hope that the analyst will not react by getting upset but will maintain the analytic stance. If so, the patient can identify with the analyst's lesser vulnerability and question the childhood belief that the trauma was deserved. This may be observed in extra-analytic situations also, for it is not unusual that later in life the grown child may treat the parent the way the child felt treated by the parent when the child was young. The more traumatized the patient was, the more likely the patient will begin the treatment with the test involving change from passive to active, as this is safer than the ordinary transference.

The authors believe that with testing and utilizing interpretation the ego controls the transference and keeps the expression of it

appropriate and relatively safe. Thus after-education or new experiences with the analyst are the key to psychoanalytic treatment. In their emphasis on testing and new experiences, these authors, although they start with the same premise about the ego's capacity for unconscious judgment as does Rangell (1989), come up with quite a different conception of how psychoanalytic treatment works than the more traditional conception. Their work provides a fertile area for future research on the psychoanalytic process.

### **Core Fantasies**

Arlow (1985) stresses that after the age of 6 or 7 everyone has a unique typical repetitive fantasy activity and their adult conscious fantasy life reflects derivatives of this. Even our perception is determined by this crucial unconscious fantasy activity, which forms 'the mental set against which

the data of perception are perceived, registered, interpreted, remembered, and responded to' (p. 526). These fantasies go through convolutions as one develops, and some later editions may even provide defensive distortions of earlier fantasies. He writes:

In the course of treatment one can observe how the symptoms of the patient's illness, how his life history and his love relations, his character structure and his artistic creations may all represent in different ways derivative manifestations of the persistent unconscious fantasy activity, of the 'fantasied reality' that governs the individual's life. (p. 534)

Arlow views the analyst's behavior as a stimulus, as a day residue, but it is through the stimulation of the patient's unconscious fantasy life that the reaction we call transference occurs. Even in the transference at least at first we see only derivatives of the persistent unconscious fantasy

activity of childhood that governs the individual's life.

I agree with this out of my own clinical experience (Chessick 1992a, 1993a). At the core of every patient there resides a crucial fantasy activity, interwoven with early infantile experiences to a greater or lesser degree, depending on how traumatic these experiences have been. But, as Arlow explains, 'What constitutes trauma is not inherent in the actual, real event, but rather the individual's response to the disorganizing, disruptive combination of impulses and fears integrated into a set of unconscious fantasies' (p. 533). Certain object relations and self psychology theories, as well as the views of Weiss and Sampson (1986) discussed above, tend to minimize the role of this unconscious fantasy activity and emphasize the pathogenic effect of real events and interactions.

But the individual's experience, explains Arlow (1980), 'is usually organized in terms of a few, leading, unconscious phantasies which dominate an individual's perception of the world and create the mental set by which she or he perceives and interprets her/his experience' (p. 131). Transference is not a repetition of the patient's actual early interactions with present objects, but expresses derivatives of the patient's persistent unconscious childhood fantasies, the 'psychic reality' of these early interactions for the patient.

My position is that empathy with the patient and appropriate interpretations allowing selfobject transferences to arise constitute a vital way of beginning the treatment. Along with the physicianly vocation of the analyst, empathy sets up an ambience that is optimal for the integration of interpretations and for the development of a new object relationship. This object relationship,

as it arises out of the proper ambience of the treatment, continuously provides the motivation for the patient to develop, whether one wishes to view it with Freud as love for the analyst or with Loewald (1980) as a developmental reaching out toward higher levels of integration.

The setting of the analytic treatment with the patient on the couch and doing most of the talking promotes regression. The rule of abstinence, properly applied, promotes the resurgence of yearnings for old objects, the appearance of fantasy activity, and the subsequent development of the transference. If the patient is excessively gratified the transference does not appear, but if the patient is irrationally or sadistically ungratified in the treatment, the reaction will be one of iatrogenic narcissism and rage, which cannot properly be called transference. Everything depends on the maturation, skill, and clinical

judgment of the analyst.

The interpretation of the transference and of extratransference situations should ultimately aim at focusing on the central psychic core of the patient through the continuous analysis of derivatives of that core. The patient's observing ego must engage with the analyst and eventually take over the search for the crucial infantile fantasies and/or traumata in some combination of intensity woven into a unique special fantasy activity; in some patients the material will be almost purely fantasy and in others the most serious kind of abuse and exposure to real horror and death has taken place. Still, no matter how great the traumata, it is the basic unique fantasy activity woven around traumata that has the primary effect on all of the patient's subsequent behavior and capacity to relate to other people.

If this vital core can be reached, identified, and worked through with the patient, it allows the past to recede into the past and no longer pervade the present. The ghosts can become ancestors (Loewald 1980). This offers the ego new options and new choices and new compromises in dealing with its three harsh masters—the id, superego, and reality. Thus, although change can occur in psychoanalytic therapy through a new object relationship or an empathic experience with an understanding analyst, a basic structural change that does not simply consist of identification or internalization of a more benign object can only come about when there has been a thorough understanding of the early infantile fantasy activity that forms the background mental set of the patient's perceptual and motor system, the core of the patient's psychic reality. Derivatives of these fantasies can be found in every aspect of the



patient's choices, behavior, and relationships in later life, and they persist to an amazing degree even into old age.

It has also been my experience from the reanalysis of patients that some analyses are aborted as this core is approached; the treatment is covered over by a superficial and premature turn toward increased integration and maturation, giving the impression that the patient has made a recovery and suggesting termination. The uncovering of these fantasies is vigorously defended against, as they represent some kind of crucial compromise formation in an attempt to master profound infantile anxieties, traumata, and conflicts. To expose them renders the patient vulnerable to re-experiencing the intense dread of annihilation and overwhelming fragmentation the infant suffered at a time when it was as yet extremely incapable of dealing with such powerful

affects. This, in my judgment, forms the bedrock of analytic treatment; if the patient cannot bear to have this core exposed, the treatment will abort and remain a psychotherapy even though an apparently distinct but superficial improvement in the patient may take place. This leaves the patient vulnerable to continual pervasion of his or her behavior and choices by the core infantile fantasy activity, so that the improvement is only maintained as long as the internalization of the therapist continues.

A dramatic example is provided by Freud's (1918) case of the Wolf Man, who internalized the gratification of being Freud's famous patient and imagined himself under the protection of the apparently omnipotent Freud until the time he heard Freud had developed cancer. At this point the patient broke down, and his recovery took place when he was able cleverly to establish

himself not as the special patient of the omnipotent Freud, but as the sort of 'mascot' of the entire psychoanalytic movement, which protected him against the sickness or death of any individual psychoanalyst. This resulted in a lasting improvement in his condition (Gardiner 1971).

I do not wish to diminish the importance of empathic understanding of the patient and of the analysis of selfobject or archaic transferences, but this work is only preliminary to the basic analytic task of altering the ego; it must be carried through before a sufficient alliance can be formed with the patient to allow the observing ego of the patient to join in a search for the core fantasies. In Menninger's (1958) concept of the psychoanalytic process, written before Kohut's self psychology, there occurs after a suitable period of frustration of the patient's curative fantasy, a turning around that Menninger labels *kairos* from the Greek of

Hippocrates, a turning toward maturation that takes place at a suitable or proper point in the analytic regression. The question is whether this turning around does not represent an escape from the analysis of the patient's core and constitutes a reintegration motivated primarily by an attempt to avoid depth analysis. In that sense Menninger's process might be better labeled a psychotherapy because basic structural change does not occur.

I believe this accounts for the failure of many of the early psychoanalyses in which the patient's Oedipus complex was analyzed according to the then prevailing custom and the patient pronounced cured, after which some of these 'analyzed' early analysts went on to manifest serious psychopathology, even psychosis and suicide. There is no reason that, sooner or later after the influence of the analyst has passed, the early core fantasy activity should not regain its

pervasive motivating power if it has not been uncovered and worked through, leaving the ego open to new options and choices.

This approach stresses conflicts more than deficits, so that situations like 'alexithymia' and other alleged deficits such as the inability to experience hunger in the eating disorders (Chessick 1985b) that have been attributed to primary deficits in development, could be at least partly understood as existing on the basis of conflict. Such disorders would then have a better prognosis in that once the conflict over the repressed infantile fantasies was resolved, the so-called 'deficits', to whatever extent they are derivatives of the fantasy activity, could disappear. In the manner of Gedo (1979) we may also address and try to correct the 'deficits' directly, a form of after-education therapy that, although it may be very useful of the patient, does not really

constitute an investigation of the patient's unconscious by the method of psychoanalysis that Arlow (1985) says is 'fundamentally ... a psychology of conflict' (p. 525).

The disagreement between my views and self psychology is that I believe that after one has worked through the narcissistic transference and the oedipal material begins to appear, as in Kohut's case of Mr. M. (1977: Ch. 1 and p. 141), the treatment is not over. Rather, the stage has now been properly set for a traditional analysis. When the walls and the roof of a house are cracked because they are resting on a faulty foundation, one must obviously first repair the foundation. Self psychologists maintain that in humans, in contrast to a house, there is an inherent developmental force that will take over and repair the rest once the foundation is secure. But can this occur without further psychoanalytic treatment of

distortions due to the patient's pathological ego alterations in later childhood stages, with their characteristic conflicts, defenses, compromises, and fantasy activities?

The foundation must be repaired first if at all possible. Here the method of empathy and the study of archaic transferences become central, and it is only after these have been worked through and understood by the patient and the building of a reasonably firm tension-regulation system has been established, that the patient can then tolerate the development of more traditional transference and the frustrations and tensions that the rule of abstinence entails. In practice, these days most patients seem to need some degree of foundational repair, but in less serious cases this can go on *pari passu* with traditional interpretation. Some patients, however, need a very long period of restoration of the self first;

Modell's (1976) 'cocoon phase' may have to go on for years.

Bifurcation in physics (Davies 1989) is a phenomenon whereby the number of solutions of a certain type presented by a dynamic system changes abruptly as one of the parameters defining the dynamics crosses a critical value. This concept could be applied to Brenner's (1982) firm conceptualization of all symptoms and behavior as representing a compromise formed by the ego among the demands of the id, the superego, and reality. Change of symptoms, change of behavior, so-called structural improvement in psychoanalysis, then, would all represent a change in the compromise formations formed by the ego. It follows that a sudden and abrupt jump in the direction of improvement could take place if one of the parameters defining the dynamics that are at play on the ego when it has to form a



compromise suddenly shifts or crosses a critical value; the same would be true in the opposite direction. This explains the common phenomenon of there appearing to be a plateau or lack of progress in psychoanalysis for long periods of time and then an apparent sudden breakthrough where compromise formations sharply shift.

An abrupt negative shift may be most commonly observed if the patient develops some kind of organic disease. The bodily needs and requirements are massively increased, and the ego sometimes has to deal with them at the expense of more fortunate compromises; the onset of a bodily disease can even be heralded by the appearance of such negative shifts. For example, it is well known that pancreatic cancer is often preceded by a period of depression, and other authors have reported either depressive or hypomanic behavior heralding the onset of coronary artery disease

(Chessick 1985a).

Another such bifurcation occurs in severely damaged patients who experience disappointment in archaic selfobject expectations. Here the narcissistic rage can become so overwhelming that a critical value is crossed; previous compromise formations such as obsessional rituals or masochism are suddenly overshadowed by massive projection and projective identification. This is an emergency and can break up the treatment if the ego's capacity to respond to interpretations is lost.

This can also occur in psychoanalysis as the patient's core fantasy activity described above is approached. In those cases where the fear of revelation of this core is overwhelming, the patient may suddenly disrupt the analysis by projection in which the analyst is perceived as an

intrusive malevolent monster. Although this perception itself is a derivative of the core fantasy activity, if there is insufficient tension-regulation and capacity for insight, the patient cannot continue the treatment. At this point the patient may insist on sitting up or even leaving therapy on the basis of overwhelming fear of the process or of the analyst. Characteristically they go on to some other form of group or supportive therapy that does not address the core fantasy activity.

## **Psychoanalysis and Psychotherapy**

The primordial meaning of the psychoanalytic situation lies in the reverberations of it for the preoedipal child in the patient. A strong argument can be made that this was even true for the treatments described in Freud's famous case histories (Buckley 1989). There seems to be a general agreement (Rothstein 1988) that the more

disturbed the patient the less the treatment may be called psychoanalysis and the more it involves influencing, suggestion, correction of expectations, stabilization, superego modification, and model provision for identification or introjection, as well as holding and support, with a focus on solving specific problems. Healthier patients seem to require only a reasonable modicum of these factors and can concentrate more on reliving in the transference and reconstruction through interpretation. What is paramount in any given therapy is a function of what aspect of the patient's development is being repeated with the therapist at any given time, since, as Holinger (1989) points out, that developmental stage is what determines the meaning of a given intervention. Thus the context and not just the content of any intervention must be considered in judging the appropriateness of the intervention.

It is our task as therapist to be able in each case to identify the predominant transference and predominant mode of relationship that the patient is using at any given time, and to tune the emphasis in the therapy to those factors that are appropriate to that developmental phase, while at the same time minimizing or de-emphasizing those factors that are inappropriate. For example, a fragmented, psychotic, or 'borderline' severely disturbed chaotic patient is manifesting preoedipal pathology in which defective coping operations and interpersonal invariants have determined the developmental course and were needed for adaptation. After language has been acquired, the so-called 'defenses' that we experience from the patient are secondary reworkings of this (Stern 1985). The original problem of severely preoedipal disturbed patients is coping with reality; the core fantasies in such

patients reflect the sensorimotor memories and the fear of a recurrent preverbal holocaust.

Gedo (1979, 1986) emphasizes the failure of such patients to develop normal skills. This is 'beyond interpretation' and the psychotherapist must deliberately demonstrate these adaptative skills to the patient. If the therapist refuses to educate the patient, claims Gedo, then there has simply been another parental failure. These preverbal patterns are the hardest to modify because they are crucial in tension relief. There is no correlation of self and object representations with the patient-analyst exchange, claims Gedo, in direct contrast to the views of Kernberg (1976). The transference depends on the therapist's personality, specific issues that are brought in by the personal qualities of the therapist, and the technical choices dictated by the therapist's psychoanalytic convictions.

In the management of archaic transferences, the therapist is often 'forced to do something', a reluctant compliance without which the patient develops an unmanageable rage that threatens to fragment the patient and break up the treatment. The skill of the therapist is to do just enough so the patient has some sense of the therapist's recognition that words alone will not suffice, but not to afford so much gratification that the patient has no motivation to change, which would engender an artificial need for more and more gratification. Later in the treatment words alone do suffice, and the patient should be able to tolerate the psychoanalytic process involving interpretations, the pain of reliving early childhood experiences, and the analysis of core fantasies. Gratifying behavior on the part of the analyst at this point is inappropriate and represents seduction and countertransference

acting out; if it takes place the result is an interminable treatment. The presence of this latter situation can be spotted by a sufficiently trained analyst through the recognition that no depth is being achieved in the development of various transference phases; the material becomes increasingly boring and repetitive. This represents analyst failure not patient failure.

Spira (1988) explains that our very choice of a specific psychoanalytic theory and rejection of others has a defensive function. Similarly, our choice of which factors we consider paramount in the psychoanalytic process also represents a compromise formation made by our ego in an attempt to balance the demands of our id, our superego, and our reality. The rigidity with which one clings to a given theoretical system is a measure of how important that choice has become as a means of reducing the therapist's anxiety; the



greater the therapist's personal self-knowledge and the greater the maturation of the therapist, the more open the therapist can be to the experience of data that might lead to a gradual shift in theoretical position or a bifurcation jump. Such changes in theoretical position, then, could be either mature if based on the accumulation of experience and interchange of ideas enabling the ego to make better judgments because it has better information, or neurotic and primarily dominated by the therapist's need to avoid signal anxiety. In another publication (Chessick 1990) I tried to illustrate how the therapist's continuing self-analysis leads to a better understanding of his or her shifts in theoretical orientation over many years of practice.

## Summary

The development of two general points of view

regarding what brings about change in psychoanalytic treatment is traced in this chapter. One set of conceptions emphasizes interpretation, especially of the transference, and historical or narrative reconstruction. The other set emphasizes the experiential and transactional aspects of a new and better human relationship. Various current versions of this difference in emphasis are discussed.

Future investigation is needed to distinguish (a) the role of correction of expectations generated out of actual infantile experiences through the new relationship to the analyst, from (b) the role of interpretation of early fantasy activity and reconstruction of how this was generated and congealed in the patient's childhood. The danger of avoiding the analysis of core infantile fantasy activity and its effect on the patient's current perception, thinking, and

behavior, by a premature termination of the treatment when the relationships of the patient seem to be more successful, mature, and realistic, is stressed.

One must be careful not to utilize self psychology or object relations theory beyond foundational repair in psychoanalytic therapy without considering the consequences. One must ask oneself always if one is utilizing such theories and practices and the interpretations based on them defensively, in a collusion to avoid facing the patient's core unique childhood oedipal and preoedipal fantasy activity and the reverberations of it in the analyst's core fantasy activity. Continuing self-analysis is required in each and every treatment process, which is why the analyst also learns and matures from every case. The openness of the analyst permits insight through interpretation, meliorative noninterpretative

aspects of the new object relationship or experience, regression due to the analyst's reliability which gives the opportunity to undo developmental arrests through the analysis of core fantasies, a symbolic holding environment, and the collaborative creation of a narrative, all of which are known to have therapeutic effects and work together to produce change in psychoanalytic treatment.

#### *Note*

Originally published in the *Psychoanalytic Review*, 8: 279-300, 1994. Reprinted by permission.

## The Two-Woman Phenomenon Revisited

In 1987 Stanley Weiss published an important clinical paper describing what he named 'the two-woman phenomenon'. Men who show this syndrome retain their commitment to their wife but are also passionately in love with another woman. They appear in the clinician's office only when a conflict occurs because one or the other woman must be given up due to the vicissitudes of life. Such men usually got married early in life to a woman from a background similar to their own. Weiss writes:

They remain monogamous and devoted, but following an initial period of sexual passion and love, they become emotionally distant

from their wives; at a later time they fall passionately in love with another woman. While they are in love with the new woman their feelings of responsibility and commitment to wife and marriage remain intact and ongoing.

The intense pleasure and passion that is awakened by and invested in the new love object spreads to all the functioning and activities of these men. They describe life as taking on a special glow and excitement that they had once felt with the wife but then had lost. They emphasize that the new woman admires and affirms them; she finds their work, interests, and ideas exciting. She appears to enhance creative functioning, (p. 273)

The new woman is usually from a different background and her age is not of obvious significance. Furthermore, these men are not the same as the group of men who divorce their wives in mid-life and begin over with a younger woman, but rather they are devoted and conscientious husbands. Reciprocally, the wife is depicted as a

devoted and conscientious woman who takes good care of the home and children. Unfortunately, she does not stimulate passion or excitement in the man and he indulges in sex with his wife infrequently and more out of duty. In fact, it is often reported that sexual relations occur mainly because the man does not wish his wife to become suspicious that he has another woman. The man believes, often correctly (in my clinical experience), that his wife is not interested in his work, except possibly for the money and prestige that it brings to her.

Weiss adds that these men are not promiscuous and they set high standards of functioning for themselves and others. When the man considers having to give up the other woman he speaks sadly of life 'returning, once again, to the colorless, dull, daily routine, devoid of any pleasure' (p. 274), usually accompanied by a

profound fear that his creative functioning will also be lost (see also Chessick 1999b).

These relationships involving two women can go on for a long time. The crisis occurs when a decision must be made, in which the individual must choose between his terrible guilt involved in deserting a devoted, conscientious wife of long standing on the one hand, and the terrible despair involved in losing a woman who has enhanced his creative functioning and brought excitement and happiness into his life, on the other. An additional factor in coercing the man to give up the other woman, if he is forced to decide, is the fear of this usually successful individual that he will otherwise be shunned by his colleagues and his career will be ruined.

As Mr. B, the 49-year-old 'highly intelligent, sensitive and successful executive' whose case is



cited by Weiss as an example, put it:

I cannot believe I am in this position. It is so confusing. It has an unreal quality. I'm not the type of man to have an affair. Yet, we have been together for five years. I feel strong and alive, and my life has been wonderful since we met. J is so intuitive and bright. She loves and admires me. I feel I will lose everything good if I have to give her up. (1987, p. 275)

Such an individual often views or imagines his wife as powerful and destructive and believes that the new woman is devoted to enhancing his masculinity, autonomy, pleasure, and creativity.

## Dynamics

Weiss points out that often a series of psychosomatic symptoms occur before the two-woman phenomenon is triggered, during which time these men experience a heightened awareness of loss, sickness, and impending death.

They feel unappreciated for what they have accomplished. All of these feelings are accompanied by an upsurge of aggression, as pointed out by Jacques (1980). For example, Mr. B's falling in love with J was preceded by cardiac-like symptoms and similar concerns, and characteristically in addition, 'much unhappiness and regret about not having followed a more idealized career path' (p. 283).

A cardinal psychodynamic agent in these cases is a primitive superego which wants to extinguish all sexual pleasure, aggression, and autonomy, and demands a central emphasis on self-sacrifice and hard work for never-ending success. This leads to an intense unconscious conflict between powerful id wishes for instinctual gratification and prohibition by the superego with its never-ending demands for more and more performance. Weiss explains the two-woman phenomenon as a

compromise formation. At home the man remains true to his superego requirements but with a smoldering anger towards his wife; outside the home he experiences success and pleasure but at the same time a fear of devastating punishment if he commits himself to the new woman.

Patients who present this two-woman phenomenon do not fall into any one diagnostic category. A considerable degree of psychodynamic variation was manifest in the cases that Weiss investigated, from those with significant preoedipal pathology and an archaic superego to others in which the two-woman phenomenon is an analyzable defensive style. There is such a complicated mixture of preoedipal pathology often present in these patients, Weiss explains, that they present difficulties in evaluating analyzability and treatment strategy.

## Commentary

Several remarks are in order about the case of Mr. B and the interpretation of it Weiss offers. Mr. B, according to Weiss, in the first evaluation sessions already had a 'fantasy' that Weiss 'wished him to give up J and return to wife, home, and church' (p. 277). He never told Weiss of this at the time of the evaluation, but it turns out to be correct as a prophesy because that is exactly how the case ends up. This raises the interesting question of whether Mr. B was reacting to a genuine bias on the part of his analyst or whether he was projecting his own solution onto the analyst from the beginning. There is not enough detail given in the case presentation to make a decision.

More questionable and important is the psychodynamic formulation Weiss provides to explain the two-woman phenomenon. He says the

patient in childhood splits the maternal object into object representations, one all bad and one all good: 'This helped him to minimize conflict, modulate aggression, and maintain a pleasurable libidinal tie to the actual mother' (p. 283). Weiss carefully defines splitting here, but his definition is confusing: 'A defense mechanism that split the maternal object in childhood into two objects, which allowed the patient to maintain his psychic equilibrium' (p. 283). Surely Weiss here means object representations and does not imply that the patient actually chopped his mother in two. The explanation that follows from this assumption is that the two-woman phenomenon represents a return of the repressed, with the 'all bad' representation projected onto the wife and the 'all good' representation projected onto the other woman, J.

But I think that the clinical material does not

really support this simple formulation. In my clinical experience the patient does not separate the women into an 'all bad' wife and an 'all good' other woman. Actually both women are loved ambivalently; what is different is that the 'other woman' is loved with a passion whereas the wife is loved with a diluted or tepid devotion. What is the reason for this? Why does life take on a special glow and excitement when the other woman enters the mid-life picture, accompanied by an intense pleasure and passion invested in the other woman, enhancing all aspects of the aging man's functioning? Remember, this was once the case in the man's relationship with his wife, but it has now faded out. Clinically a 'splitting' has not occurred, only a slow cooling of once passionate feelings for the wife over years of time, and then suddenly an outburst of passion for another woman.

There is value in presenting alternative conceptualizations of a clinical pattern, in that what is misunderstood from one point of view may be understood from an alternative stance. Actually, there are several stances from which to view the two-woman phenomenon but in contrast to Weiss, who uses the object relations stance, I suggest that the approach emphasizing self psychology rather than 'splitting' would be more useful since we are dealing primarily with a narcissistic personality disorder.

What has occurred is a gradual accumulation of anger, which tends to peak in middle age as the needs of such men are sharply enhanced by the self-depletion problems of middle age, so often described in the literature of self psychology (see Chessick 1985a). The wife is not hated and not regarded as all bad. She is appreciated and loved, in a way. She does not stimulate passion any more

because of the man's accumulating anger that she cannot and will not function as a nursing mother, an archaic selfobject—which he regressively needs more and more as he grows older and more depleted. The perception of her as powerful or destructive is a projection of the man's own anger and vulnerability in needing her, not a projection of an 'all bad' archaic maternal representation. When the man returns to his wife he does not return to a hated object but to an empty colorless, dull daily routine, a reflection of his empty depleted self. He feels regressively weak and passive in her presence and, in Weiss's report, even—as fragmentation impends—thinks of suicide or death as the way out. This is the picture of a disappointed, deeply humiliated, narcissistic person who has a dim awareness of his increasing neediness and his increasing desire for support, mirroring, and empathy as he ages.



Weiss's notion that the maternal image is split into a good and bad image as a defense against the Oedipus complex does not seem to fit the actual development of the two-woman phenomenon as I have observed it clinically. I think it is an escape from the superego and from a depression which intensifies as narcissistic goals are not reached in middle age and the individual rages at himself for his failures and suffers from an empty depletion. The two-woman phenomenon represents a reaching out again, a regressive re-idealization of an external figure to make amends for the depletion in failing to attain unreachable ego ideals, and then a reassuring erotic fusion with this idealized person, which restores narcissistic equilibrium.

The clinically observable 'split' is not from the projection of 'all good' and 'all bad' maternal object representations, but into an idealized

woman on the one hand and a sought for wife-mother on the other, a wife-mother with power and who perhaps is feared—but who is still viewed as good. Escape from the rigid superego and its threats of punishment and unbearable humiliation for failing in middle age to live up to youthful and romantic narcissistic ideals, in my clinical experience, is the central issue. Suicide is another such escape.

In mid-life, as the awareness of illness and death increases, as financial worries pile up, as children grow up and leave, as aged parents become a burden, aggression increases enormously in those individuals who have not developed a secure empathic matrix. This often becomes turned into self-hatred, manifested in a resurgent primitive sadistic superego which denies all pleasure as undeserved, and generates self-denunciation and deep mortification, even

though the individual is reasonably successful. A war between the superego and the id takes place and the two-woman phenomenon does indeed represent a compromise formation. In this formation the wife is assigned the role of the emotionally nourishing mother and anger is always present at her as the man's nursing and mirroring needs increase, and as her inevitable failures as an empathic archaic selfobject become manifest. Because of this archaic selfobject functioning failure, there is a de-idealization of the wife and this idealization is also now transferred to the new woman.

With the new woman there is the incredible pleasure of uncomplicated orgasm and ejaculation with which nothing can compare because it is unambivalent as far as the idealization is concerned; there is no smoldering anger to interfere with libidinal arousal. For his wife there

is a sense of duty and a felt requirement to deliver an orgasm to her, which dilutes the man's sexual pleasure by increasing his rage, since this duty is not consistent with his unconscious demand that she function as an archaic selfobject—always giving and always present, with no needs of her own. The other woman wishes to please the man and gives narcissistic gratification, whereas the wife sets adult requirements, has demands, and makes often realistic criticism.

The man is healthy enough not to commit himself completely to the other woman because he knows at some level that if he did, eventually the idealization of her will suffer the same fate that his idealization of his wife has suffered, and he will not end up in a better situation than he is already in. The bilateral arrangement, while it is stable, functions well as a compromise. It allows the man to receive the mirroring that he needs and to enjoy

the illusion of archaic selfobject functioning from the other woman, while at the same time obtaining the needed maternal devotion of a conscientious wife who makes him a reasonable home. That is why such patients only come into treatment when they have to choose between one or the other woman. They desperately need both. The French, of course, had a phrase for it 'cinq-à-sept', the woman one visits from 5 to 7 p.m. before going home to dinner with wife and family.

### **The Narcissistic Two-Woman Spectrum**

It is well known that the two-woman phenomenon frequently involves fairly successful and relatively rich men with considerable power and prestige and who are not faced with failure of material or professional goals. I believe that it is possible to arrange ruined marriages of middle-aged narcissistic men along a spectrum, the main

markers of which have already appeared in the literature. At one end of the spectrum we have the marriage of the 'collapsible' man of prominence (Bird et al. 1983). The 'collapsible' husband is a VIP, 'prominent, affluent, highly visible in professional, political and social circles, and committed to the discharge of community responsibilities' (p. 290). Bird et al. describe characteristics of such a person as similar to the famous Type A personality which in other publications I (Chessick 1985a, 1987) have related in detail to the narcissistic personality disorder.

These 'collapsible' individuals were affluent men who appeared with a depressive reaction and in a somewhat regressed state. The reaction in each was preceded 'by attenuation of his bond with his wife and a deep fear of losing her' (p. 291). In describing the psychodynamics of this condition Bird et al. note that the man showed a

narcissistic identification with a powerful controlling mother and as a result of this showed the typical characteristics of a narcissistic personality disorder, while at the same time using the wife as a selfobject. Early in the marriage the wife was submissive and mothering. When she 'got fed up' with the husband's reliance on her, the man's psychological balance was severely threatened. These men did not engage in strenuous extramarital sexual activity but tended rather to become depressed and disorganized when the wife, for various reasons, was unable to continue a nurturing selfobject function. These marriages did not as a rule disintegrate and were amenable to marital therapy combined with individual psychotherapy. The goal of the treatment was to make the man stronger and less collapsible and to 'unfasten the neurotic marital interlock' (p. 294), allowing for separation and

individuation in each mate.

In the center of the spectrum we encounter the two-woman phenomenon appearing in various forms. In this situation the man remains with his wife but finds a second woman to serve certain alternative functions that his wife can or will no longer perform for him. This relatively stable situation has been described above in detail.

At the other end of the spectrum we find a group of men in middle age who more or less abruptly abandon their wives and seek another woman—who they seldom find. These men, who usually cannot explain the motivation for their search, have been studied by Prosen et al. (1972). The authors describe this problem as follows: a relatively happily married man reaches middle age. His premarital dating record shows very little in the way of heavy experience with a variety of



women and his wife was often his first love. At this point, however, he expresses dissatisfaction with his wife in terms of her aging appearance or in a complaint that she is inadequate in responding to his sexual needs. He may begin having difficulty in sexual performance with his wife. The net result is the search for another woman which disrupts the marriage, often permanently.

The authors note that the man continues to retain a 'young' body image and does not see himself aging in the same way as his wife. The narcissistic aspects of all this are clear, but the authors choose an alternative explanation, stressing the resurgence of the Oedipus complex in middle years. They contend that as the wife gradually ages and becomes an older woman she seems to the husband physically much more like the remembered mother. By the time a man reaches his teens, his mother is older and his

predominant memory is that of an older woman. The authors oppose this to the childhood vague fantasy memory of a 'young, beautiful and erotically stimulating woman' (p. 792). They believe that in the search for a younger and more attractive woman than his wife the man is searching for this fantasized erotic mother of childhood, and that this search begins at the time the wife reaches the age where she becomes more like the remembered mother and less like the fantasized young and beautiful mother. This inevitable aging of his wife compels the man to resume the search.

The authors stress the typical narcissistic denial of the changing self and the attempt on the part of the aging man to retain a sense of youth and vigor: 'In the finding of a narcissistically gratifying younger woman the man gains attention and re-affirmation of his ability to attain a love

object' (p. 793). This chase for the new woman also attempts to complete an unfinished task of adolescence, for these narcissistic men feel that they have not accomplished the conquests they should have performed as an adolescent. This compulsion to 'conquest', as in *Don Juan*, is a derivative of the Oedipus complex and contains with it both an idealization and a hostility to women. The aging man's wife becomes the target of the hostility and the new woman becomes the recipient of the idealization.

In explaining this phenomenon the authors lean on two alternative conceptualizations, neither of which they develop in any great detail. They suggest that the resurgence of the Oedipus complex in middle age could be involved in the etiology, which would be utilizing what Greenberg and Mitchell (1983) call the 'drive/structure' model. From that model of etiology the authors

shift to Greenberg and Mitchell's 'relational/structure model', an alternative perspective, in which there is postulated in the husband a 'splitting' of the representation of the wife 'accompanied by a splitting of his self-representation' (p. 792). Thus the man splits his wife's representation, and experiences only the aging and negative aspects of her as belonging to her. Also he splits his own self-representation so as to deny and hide the aging negative aspects of himself and consciously experience only youth and vigor. The fantasized mother aspect of the representation of the wife, the idealized woman, is projected out onto other women and becomes the object of the search, whereas the real wife is experienced as a degraded ugly object.

It should be pointed out, however, that the purpose of all this, as in the situation with the rest of the men on the spectrum, is to preserve the man

from narcissistic collapse and depression; the bottom line is for the man to preserve his narcissistic self-image of healthy youth and sexual potency, and for that he is willing to sacrifice his marriage. In my clinical experience I have seen such men, otherwise upright and respected members of the community, abandon not only their wives but the small children that they have engendered by her and go off in a fruitless search for the other woman who they never find, although they have a series of affairs which irreversibly destroy the marriage.

All of the phenomena on this spectrum in my judgment can be best explained by the same self psychological explanation I have employed above to elucidate the case presented by Weiss and the two-woman phenomenon in general. The man in the two-woman phenomenon is probably the healthiest of the husbands on the spectrum; the

collapsible man of prominence represents a depressive or autoplasic solution to the problem of narcissistic wounding at one end, and the man who abruptly abandons his wife to search for the fantasized mother represents the alloplastic or acting out solution at the other.

Weiss's depiction of the two-woman phenomenon is a real contribution to the clinical literature, but I feel that his attempt to explain it using Kernberg's formulations is not congruent with the actual clinical development of this condition, nor is it sufficient to explain the whole spectrum of these narcissistic disorders. I have attempted to add some formulations of my own gathered from my own clinical experience with several cases of this same phenomena. Like Weiss, I believe there are numerous variations of this clinical syndrome. I have seen cases where the man actually lived with his mother, who took the

position of the devoted conscientious wife, while he frequently visited the other woman whom he idealized. But he could never actually leave his mother and commit himself fully to the other woman. In another oscillating variation, the man married several times, at first idealizing the other woman, but in a few years divorcing her and each time returning to live with his mother. It is only when the mother died that the individual collapsed with a depression and came into treatment.

There are many variations along this spectrum and I suggest that our understanding of these phenomena will be much enhanced if we try to approach them from a variety of theoretical stances rather than to try to fit them all into one explanatory system. For example, Claman (1987) has described the sexually abusing unhappily married therapist who has 'a pattern consistent

with a narcissistic disturbance of the self, where hypothesized unfulfilled needs to be mirrored are met lavishly by a captive mirroring selfobject' (p. 37). This kind of sexually abusing therapist is described by Claman, as might be expected from the discussion above, in terms of the aging process in which unsatisfying and broken relationships with previously meaningful others leads the therapist predisposed to a narcissistic disturbance to turn toward his or her patients for gratification. This results in yet another version of the two-woman phenomenon in which the married therapist 'finds the veritable answer to his dreams: a young, lonely, "other-directed" female patient who holds her therapist in transferential awe' (p. 38).

In my clinical experience this has also happened between female therapists and their male patients, and may be explained utilizing



similar psychodynamics to the two-woman phenomenon described above. Goldberger (1988) labels this 'the two-man phenomenon' in women, and explains it on the basis of the woman's unresolved conflicted longing for intimacy with her mother. The pleasure she achieved with the later man, she says, is derived from the feminine identification in these men. Goldberger claims this is a quality in all the men she has seen who are lovers of the two-men women, but she adds that the women also gained an important affirmation in their sense of self from the second relationship. In another variation I have seen, a stable but aging homosexual couple was disrupted when one of the men began an affair 'on the side' with a younger man. The patient entered treatment when he felt forced to give up one or the other of the homosexual partners.

## Summary

The clinical syndrome of the 'two-woman phenomenon' as described by Weiss in a previous publication is reviewed. The problem of the role of the bias of the analyst in the treatment of such cases is raised, and the formulation used by Weiss to explain the phenomenon, employing the assumption of early splitting of maternal representations, is challenged. Viewing the two-woman syndrome as a manifestation of narcissistic pathology in middle age is suggested as a better explanation, one which more cogently fits the commonly observed clinical facts. A spectrum of pathological solutions to narcissistic wounding can be delineated in the patient's marital situation. These range from an empty depleted collapse on the one hand, to suddenly abandoning a wife of many years and engaging in a fruitless search for a fantasized woman on the other. The two-woman phenomenon stands in

between these extremes as an attempt at compromise formation.

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 17: 293-304, 1989. Reprinted by permission.

## Psychoanalytic Treatment of Adult Eating Disorders

No vital function in early life plays such a central role in the emotional household of the organism as does eating. The child experiences the first relief from physical discomfort during nursing; thus the satisfaction of hunger becomes deeply associated with the feeling of well-being and security. ... Another emotional attitude of fundamental importance, which becomes linked early in infancy with eating and hunger is possessiveness, with all its implications, such as greed, jealousy, and envy. ... Knowledge of these fundamental psychological facts is necessary for the understanding of the emotional background of neurotic eating disorders. (Alexander 1950, pp. 86-7)

The adult eating disorders as they present in

clinical practice can be placed on a spectrum ranging from severe anorexia on one end to super-obesity on the other, with all sorts of oscillations and variations in between. This chapter will discuss the psychological aspects of eating disorders as presented by medically otherwise healthy adult patients in the clinical practice of intensive psychotherapy and psychoanalysis, towards the purpose of better understanding and treatment of such patients.

## **Understanding**

Weiss and English (1957) remind us that some families are quite 'oral' in their orientation to life. A treat for such a family will be a good meal rather than creative work or play. They talk incessantly about food and the various ways it should be cooked, and other interests in life suffer proportionately. Everything about the offering and

receiving of food is endowed with a high emotional value. Kolb and Brodie (1982) and Shainess (1979) point out that the development of obesity often occurs in a family setting in which the parents compensate for their own life frustrations and disappointments through the child; the mother is the dominant family member and holds the obese child by anxious overprotection, including pushing food. The mother frequently has high expectations for the child's achievement to compensate for the failures of the parents. The obese child is one who has passively accepted the indulged role without rebellion, and has been taught to substitute food for love and satisfaction.

Hamburger (1951) described four different types of hyperphagia. One group of his patients over-ate in response to nonspecific emotional tensions such as loneliness, anxiety, or boredom.

Another group over-ate in chronic states of tension and frustration, using food as substitute gratification in unpleasant life situations over long periods. In a third group, over-eating represented a symptom of underlying psychopathology—most frequently depression. The final group, in which over-eating took on the proportions of an addiction, was characterized by a compulsive food craving unrelated to external events. Clearly, any generalizations about the psychological problems in eating disorders must be cautious indeed, because we are dealing with a group or variety of conditions, even within subgroups such as what *DSM-III* (3rd edition, p. 67) calls 'simple obesity'.

Numerous reports on emotional disturbances among the obese have flooded the literature. The better the study, the less the evidence for distinctive psychological features. For example Stunkard (1980) studied the negative body image

in obese persons, who characteristically complain in psychotherapy that their bodies are grotesque and loathsome and that others view them with hostility and contempt. He writes that although 'it seems reasonable' to suppose that all obese persons have derogatory feelings about their bodies, emotionally healthy obese persons have no such body image disturbances and only a minority of obese persons in treatment for other conditions such as neuroses show this. This important clinical observation is also made by Powers (1980).

The obesity of persons who were obese in childhood—so called 'hyperplastic obesity', 'juvenile-onset obesity', or 'developmental obesity'—differs from that of persons who became obese as adults ('hypertrophic obesity') in that the juvenile type tends to be more severe, more resistant to treatment, and more likely to be associated with emotional disturbances. However,



Stunkard (1975) and others disagree with the common notion that 'middle-age obesity' develops slowly and gradually; actually it occurs in a series of weight spurts, as each stressful period in middle age is accompanied in predisposed persons by excess eating. Although many obese persons report that they over-eat and gain weight when they are emotionally upset, Stunkard (1975) explains that it has 'proved singularly difficult to proceed from this provocative observation to an understanding of the precise relationship between emotional factors and obesity' (p. 777). Obesity at a later stage can become a rationalization for failure and the overweight person's attitude towards himself is further complicated by the current profound western cultural distaste for obesity, especially in women (Wooley and Wooley 1980).

Numerous authors have reported that the

obese child becomes filled with grandiose day dreams as he suffers daily defeats in his major aspirations. These fantasies are usually conscious or disavowed and they differ from the psychotic because the obese person is to some extent aware that they are unreasonable. In the psychotherapy of adult obese patients Ingram (1976) reports how these expansive and narcissistic features emerge coincident with weight reduction. Overeating appears protective, in some cases, against an incipient psychosis; such patients may develop a full-blown psychosis when they undertake to lose weight by vigorous dieting.

Stunkard (1975, 1980) describes about 10 per cent of obese persons, most commonly women, as manifesting a 'night-eating syndrome', characterized by morning anorexia and evening hyperphagia with insomnia. This syndrome, once precipitated by stressful life circumstances, tends

to occur daily until the stress is alleviated. A 'binge-eating syndrome' he says is found in about 5 per cent of obese persons, characterized by sudden compulsive ingestion of very large amounts of food in a very short time, usually with great subsequent agitation and self-condemnation. In these two syndromes, a mere 15 per cent of obese cases, it is easier to outline psychodynamics involving orality and ambivalence. Yet Bruch (1973) claims that in her experience such night-eaters are rare and binge-eaters are much more common.

This leaves a large majority of obese persons in whom the disorder seems to be subtle and all-pervasive. It is this large group that is more characteristically described as food addicts who have built in the use of food as a substitute for defects in psychic structure. Over-eating has become an indispensable part of their life pattern

and vigorous weight reduction exposes such patients to unbearable tensions—which is why vigorous treatment aimed at weight reduction alone seldom is successful and even if successful is seldom maintained for very long. Frosch (1977) places these patients among the 'character impulse disorders', emphasizing their intolerance of tension or frustration, based on developmental interference with their capacity for 'anticipation' and confidence. Similarly, Garfinkel et al. (1980) and Casper et al. (1980) demonstrated a high incidence of impulsive behaviors in the bulimic subgroup of anorexia nervosa patients.

Psychoanalytic recognition of food addiction goes back to Rado (1920), who also coined the important concept of 'alimentary orgasm'; the arguments for obesity as representing an addiction to food are updated and reviewed by Leon (1982). Today Rado's conceptions have

fallen into eclipse, but common observations and reports of obese patients about eating show that Rado's notion of the relatively slower and longer lasting 'alimentary orgasm', a diffuse feeling of well-being that extends throughout the organism, complete with a sense of repose and a far-away look in the eyes, can indeed serve in such patients as a short circuit avoiding more complex sexual and adult interpersonal intimacies. Clinical experience also confirms his contention that 'a long series of foods and delicacies can be worked out, forming a regular gradation from ordinary foods up to pure intoxicants', for this is frequently spontaneously reported by patients. I have investigated the drug end of this gradation and the 'pharmacogenic orgasm' in a previous publication (Chessick 1960), and Woolcott (1981) presents an excellent recent discussion of this, emphasizing the 'basic fault' in such patients which leads to a

'fusion-individuation conflict', in some ways similar to the pathology of the borderline patient.

In discussing the addict Kohut (1971) writes:

His psyche remains fixated on an archaic selfobject, and the personality will throughout life be dependent on certain objects in what seems to be an intense form of object hunger. The intensity of the search for and of the dependency on these objects is due to the fact that they are striven for as a substitute for the missing segments of the psychic structure, (p. 45)

He goes on to explain that in the personalities of addicts:

The trauma which they suffered is most frequently the severe disappointment in a mother who, because of her defective empathy with the child's needs ... did not appropriately fulfill the functions (as a stimulus barrier; as an optimal provider of needed stimuli; as a supplier of tension-relieving gratification, etc.) which the mature psychic apparatus should later be able to perform (or initiate), predominantly on its

own. Traumatic disappointments suffered during these archaic stages of the development of the idealized selfobject deprive the child of the gradual internalization of early experiences of being optimally soothed, or being aided in going to sleep, (p. 46n)

Bruch (1973) described 'reactive obesity', in which over-eating serves as a defense against a deeper depression in the patient, and a variety of authors such as Cantwell et al. (1977), have linked the eating disorders to depression, generating some hopeful reports (such as Pope et al. 1983) on the treatment of these disorders with antidepressant medication. Over-eating in these patients represents a self-soothing effort to prevent disintegration to more profound archaic experiences that are repressed, and are associated with the current depressive affectual situation. In Krystal's (1982) report these archaic experiences were often actual infantile disasters such as 'colic,

eczema, feeding, or sleeping difficulties' which are 'covered over by a conspiracy of silence, related to the shared wish to undo the common misfortune'. Thus over-eating protects the patient against basic massive affect states of a primitive archaic nature which threaten to develop if the current stress situation continues unabated, or—following Kohut—against fragmentation of the sense of self.

The psychological link underlying the whole spectrum of the eating disorders from super-obesity to anorexia is stressed by Wooley and Wooley (1980) and many other authors. Shainess (1979) vividly describes that link in psychoanalytic terms:

I feel convinced that the unconscious fantasies connected with food are that it is poison. The patient is trapped between the need to eat and to sustain life, and the paranoid projection in relation to food ... the anorexic feels full after a few bites, while the



obese always has room for more, no matter how much has been eaten, (pp. 230-1)

The efforts not to eat are seen as a phobic avoidance of poison while over-eating represents the need to retain food-as-mother, says Shainess. One obese patient of mine regularly referred to binge eating of bags of cookies as eating 'bags of garbage', and clearly distinguished this from her ordinary and normal eating pattern. In all the cases, the whole eating pattern is disorganized, and the relationship of child to mother is acted out over food.

Ritvo (1976) stresses the aggressive aspects of this relationship, with roots in the 'repressed oral sadomasochistic conflicts with the mother'. Thus anorexia characteristically breaks out upon going away from home and 'It is the introjected mother whom the adolescent is starving for and trying to control and punish' (p. 132). He adds the

important clinical point that the first turnings to men of such patients may be 'primarily an effort to replace the loss of the mother' (p. 133).

The syndrome of so-called bulimarexia, a binge-purge cycle, has become popular now (Casper 1983), with patients mostly in the teens and twenties, and about 5 per cent male, but which can appear at any adult age. During the binge there is a sense of loss of control and guilt; during the purge, a restitution, catharsis, and reinforcement of the sense of control. Underneath all of these various eating disorders, whether anorexia, bulimia, or the binge-purge cycle, there lies—as Kohut might say—a nameless preverbal depression, apathy, a sense of deadness, and diffuse rage. In my clinical experience the massive rage appears as either paranoid fears or self-hatred with a distorted self-image, or migraine, or temper tantrums, or any combination of these,

similar to the borderline patient. It may also appear as a curious compulsive ritual, devoid of pleasure, in which the patient eats up everything in sight. In all those patients, Bruch (1973, p. 100) points out, the fatness is only an externalization of the conviction of ugliness, on the inside. As one of my patients said:

I eat to feel, to get some sensation as opposed to no sensation. When you have done you are uncomfortable, but that is a feeling. I make myself fat, I think, to mirror how I feel inside about myself—it broadcasts a message that says, 'Love this ugly person as I am.' It fits with my lack of trust in people and says, 'I'll make it hard for you if you want to be nice to me.'

The dramatic eating disorder, whether through 'alimentary orgasms', masochistic infliction of self-starvation or unpleasant compulsive stuffing, or the binge-purge guilt and restitution circle, drains off the rage and paranoia (more or less) and

focuses the patient's attention away from the empty depleted self and onto preoccupation with gastro-intestinal tract sensations. In this manner some sort of being alive is maintained. So on top of the depleted and fragmented nuclear core, the patient has built various protective rituals and soothing activities which, in the case of the eating disorders, sometimes permit the patient to function in society.

But at the same time the patient must deal with the massive narcissistic rage or unconscious sadism. For example, Offenkrantz and Tobin (1974) discuss these patients as 'depressive characters' and emphasize the great unconscious rage at important objects who are not providing the patient with what he unconsciously feels he needs—a rage that often gets turned on the therapist. Under this lies an 'anaclitic depression' characterized by depletion and a hopelessness

that sufficient gratification will ever be possible.

Glover (1956) also placed less emphasis on fixation in the oral stage and viewed addiction as a transition state between psychotic and neurotic phases, serving the function of controlling sadism and preventing a regression to psychosis, or fragmentation. He writes:

The necessary formula appears to be that the individual's own hate impulses, together with identifications with objects towards whom he is ambivalent, constitute a dangerous psychic state ... symbolized as an internal concrete substance. The drug is then ... an external counter-substance which cures by destruction. In this sense drug-addiction might be considered an improvement on paranoia: the paranoid element is limited to the drug-substance which is then used as a therapeutic agent to deal with intrapsychic conflict of a melancholic pattern, (p. 208)

In this form of '*localizing* paranoid anxiety', adaptation is enabled to proceed, and the

differences in choice of substance from the more benign, like food, to dangerous chemicals is postulated by Glover to be simply related to the degree of archaic sadism.

There is no reason for this additional postulate, since food can certainly be conceived of by the patient as a destructive noxious substance. This is best summarized and illustrated in a recent play by Innaurato (1977), *The Transfiguration of Benno Blimpie*, a nightmarish account of a grotesquely fat and lonely 25-year-old man, who relives the humiliating events of his life while preparing to end it by eating himself to death. Benno, who spent his childhood eating, daydreaming, and drawing, says, 'Paintings, you see, aren't enough. When loneliness and emptiness and longing congeal, like a jelly, nothing assuages the ache. Nothing, nothing, nothing.' As the narcissistic rage erupts in the drama he depersonalizes and plans,

'When I become so fat I cannot get into his clothes, and can barely move, I will nail the door shut. I will put his eyes out with a long nail and I will bite at himself until he dies' (pp. 16-17).

As the drama reaches a climax he concludes:

I couldn't cry: Benno couldn't scream. He lay there; and in that instant, time stopped. And feeling, it stopped too, and seemed to merge with time, and with space. My sense of identity seeped out of me into the cracks in the concrete, (p. 26)

At this point, which Benno calls his 'transfiguration' and Kohut would call an irreversible fragmentation of the self, Benno prepares to mutilate his body with a meat cleaver.

Patients suffering from anorexia have been separated by Dally (1969) into three subgroups, and various authors (Wilson 1983) have stressed the heterogeneity of this syndrome as a 'final common pathway' for many disorders. Thus

anorexia, like obesity, can appear in clinical practice in a large variety of ways. For instance one group purges and induces vomiting; another group shows impulsive selfdestructive behavior including suicide attempts, self-mutilation, and alcoholism; and yet another group achieves the desired end of thinness solely by dieting. Halmi (Zales 1982) also reports this substantial diagnostic heterogeneity within the anorexic syndrome.

The psychodynamics of anorexia in young women have long been known to include the impairment of development arising from an early unsuccessful mother-daughter relationship. The adolescent girl, faced with feminine individuation and threatened by the loss of dependency on the family, responds to the conflict in these cases by regression to an infantile maternal relationship with unconscious craving for blissful eating



experiences. This is denied in the drama which is carried out by an oscillation between eating and severe dieting; the pursuit of thinness usually represents an act of hostile and defiant compliance by the patient against the mother.

Bruch (1975) has repeatedly stated that anorexia nervosa is more akin to schizophrenic development or borderline states than to neuroses. She admits that depressive features deserve special evaluation and may indicate a true depression as a primary illness, but she feels that the disorder expresses 'the underlying despair of a schizophrenic reaction' (p. 802), and she argues that recognition of the underlying potentially schizophrenic core is essential for effective treatment. In my clinical experience one of the important differentiating features between classical anorexia nervosa appearing rather suddenly in early adolescence and the usually less

lethal anorexia developing in adult patients, is that in the latter the core is depressive rather than schizophrenic and points to Kohut's descriptions of the empty depleted self and narcissistic rage and also Kernberg's conceptions of 'all-bad' self and object representations heavily invested with powerful negative and self-destructive affects.

Most psychodynamic formulations concerning the cause of anorexia have centered around the phobic response to food resulting from the sexual and social tensions generated by the physical changes associated with early puberty. But even Fenichel (1945) was aware that anorexias developing in adult life 'may have a very different dynamic significance'. He explains that anorexia may represent a simple hysterical conversion symptom expressing the fear of an orally perceived pregnancy, or of unconscious sadistic wishes. It may be a part of an ascetic reaction

formation in a compulsion neurosis. It may be an affect-equivalent in a depression, in which the symptom of refusal of food makes its appearance before other signs of the depression are developed. It may be a sign of the refusal of any contact with the objective world as an incipient schizophrenia.

Thus Fenichel comes a long way from any simplistic formulation of anorexia, at least in adults. He mentions a case reported by Eissler which illustrates that anorexia in an orally fixated person, even from the point of view of classical psychoanalysis, is thought of as 'only one symptom of a general disturbance of all object relationships'. In a paragraph remarkably similar to the language of Kohut, but which was written about twenty-five years earlier, Fenichel writes that Eissler's patient:

...had not gone beyond an extremely archaic

stage of ego development. The mother 'remained the most important part of the patient's ego.' The refusal of food represented the longing for the primary, still undifferentiated gratification by the mother and its sadistic distortion after frustration, (p. 177)

In trying to understand the eating disorders it is important to remember that there are two general kinds of functional disturbances. One of them consists of unwanted physiological changes caused by the inappropriate use of the function in question, which Fenichel labels an organ neurosis. The other kind of disturbance has a specific unconscious meaning, is an expression of a fantasy in 'body language', and is directly accessible to psychoanalysis in the same way as a dream; for this category the term conversion neurosis is usually reserved. A certain percentage of what are called organ neuroses actually are affect-equivalents; that is to say they represent the

specific physical expression of any given affect without the corresponding conscious mental experience. For example, anorexia in some cases is an affect-equivalent of depression, as recent studies (Cantwell et al. 1977, Casper and Davis 1977) increasingly demonstrate.

In most cases of adult eating disorders a pathological discomfort rooted in unconscious problems generates a certain behavior, which in turn causes somatic changes in the tissues. The person's behavior which initiated these changes was intended to relieve internal pressure; the somatic symptom forming the consequence of this attitude was not sought by the person either consciously or unconsciously. For example, Fenichel (1945) mentions a paper by Wulff, written in 1932 and to my knowledge never translated. Wulff described a 'psychoneurosis' seen more in women and related 'to hysteria,

cyclothymia and addiction'. This 'neurosis' is characterized by a fight against pregenital sexuality. Sexual satisfaction is conceived of as a 'dirty meal'. Periods of depression in which the patients stuff themselves and feel 'fat, bloated, dirty, untidy, or pregnant' alternate with 'good' periods in which they behave ascetically, feel slim, and conduct themselves either normally or with some elation. The alternating feelings of ugliness and beauty and the oscillation in the body feelings seem to be similar to the feelings before and after menstrual periods, and to also have an exhibitionistic component.

Fenichel, like many authors after him, vacillates in his description of food addictions between conflict interpretation using classical psychodynamics, and his intuitive clinical knowledge that such interpretation is not sufficient to explain the compulsively addictive

aspects of these cases. Following Rado, he recognizes 'an oral-erotic excitement' involved in eating, and that the food addictions are unsuccessful attempts to master guilt, depression, or anxiety by activity—but no real explanation is given as to how this works. Thus eating disorders for Fenichel become what he calls 'character defenses against anxiety', in which certain basic infantile conflicts are mastered by working them out over and over again in the realm of food or denial of food. Current psychoanalytic textbooks such as Bernstein and Warner (1981) add little to these formulations.

Bruch (1973, 1974, 1975, 1979, 1982) developed her own therapeutic approach to eating disorders, but her concepts have the same sense of generalization about them as the old classical psychoanalytic formulations. She recognizes a problem involving self-esteem, narcissistic rage,

depletion, and depression in these patients as well as a narcissistic power struggle with the parents—but she depends on interpersonal theory, using more or less a Sullivanian approach. This is criticized by various authors in the Psychosomatic Study Group of the Psychoanalytic Association of New York (Wilson 1983), who present in-depth case material from the formal psychoanalysis of anorexic patients, utilizing an object-relations orientation, differing from both Bruch and Kohut.

It is only in the study of each individual case that we can know what is most important for that patient. Bruch recognizes that food refusal is a defense against the original fear of eating too much; she correctly recognizes that the behavior of the anorexic is an extreme caricature of what the normal person has to do in order to lose weight. She does not always emphasize the tremendous self-hatred in the anorexic, and the



powerful rage and depressive affect that is expressed by the eating disorders, and she stresses the schizophrenic-like aspects.

Bruch (1979) candidly admits, 'Relatively little is known how this changeover takes place, from what looks like ordinary dieting to this inflexible self-destructive but hotly defended fixation on weight and food' (p. 76). Yet Kohut (1971) described stages of fragmentation of the self in severe borderline and schizophrenic patients where there is a reconstitution of the self but with certain parts of the body deattached and viewed as useless; such patients may indeed even cut off part of the body at this point. It is not hard to see how a fragmentation of the self in adolescents and adults can lead to a similar reconstitution where the useless part of the body self is the body fat; indeed Bruch (1979) points out from her vast clinical experience how many anorexics spend

time looking in the mirror over and over again 'taking pride in every pound they lose and every bone that shows. The more pride they take in it, the stronger the assertion that they look just fine' (p. 82).

Thus severe anorexia can be thought of as a pathological reconstitution of the fragmented self where—as sometimes occurs in schizophrenic and borderline patient—a part of the self becomes split off and utterly divested of libido in order to permit a shallow reconstitution of the rest; this decathected part is represented by the body fat which is then viewed as useless, unwanted, and in need of being cut off. Indeed, maintaining reconstitution of the self may require a continuing and dangerous cutting, off of this useless body fat representing the unwanted part of the self, which would explain the persistence with which these patients starve themselves, as well as their rigid

negativism towards treatment to the point where if they are force-fed they may commit suicide.

Severe pathological anorexia represents, as Bruch says, a grotesque mirror image of obesity. She maintains also that both are related to faulty hunger awareness. This leads to Bruch's claim that the lack of awareness of living one's own life is of fundamental significance for the development of severe eating disturbances; in my clinical experience also, this curious sense of being ineffective or being a child in an adult world is characteristic of patients with eating disorders.

Another clinical feature I have here emphasized as in the 'case' of Benno Blimpie, is not given so much prominence by Bruch—the deep inner emptiness, rage, and paranoid proclivities in such patients. For example, Bruch (1973) reports a case of a fat student nurse who

was hospitalized for an acute schizophrenic episode and was observed to eat ravenously whenever she had an argument or felt threatened. Her explanation was that she was afraid that the hostility of others and their angry words would rattle around inside her and keep on wounding her. 'By stuffing herself with food she would cover her sore inside, like with a poultice, and she would not feel the hurt so much' (p. 92). The deep intrapsychic dynamics involving cycles of introjection and projection or alternatively Kohut's concept of the depleted nuclear self and its disintegration products are omitted in Bruch's formulations.

It is clear from clinical experience that the eating disorders protect the patient from unbearable affects which then do appear if the eating disorder is stopped. It is the extremely negative self image and self hatred—or in Kohut's

terms the depleted self with the disintegration product of narcissistic rage—that precedes the development of obesity, as emphasized by Stunkard and Burt (1967), and by Powers (1980) and many others. This intrapsychic psychopathology forms the foundation for the various adult eating disorders, which then develop when the tension becomes unbearable, the faulty preoedipal self-soothing system becomes overwhelmed, and the self threatens to fragment or actually does so, as in *The Transfiguration of Benno Blimpie*.

## Treatment

It is generally agreed that obese patients are more difficult to treat than non-obese patients. In one study for example, 'More obese patients than nonobese patients terminated treatment prematurely, and those who remained in

treatment showed less improvement in psychological functioning' (Kaplan et al. 1980, p. 1880). Most authors are gloomy with respect to the efficacy of psychoanalysis and psychoanalytic psychotherapy for the treatment of eating disorders, but some recent studies (Rand 1981, Rand and Stunkard 1983, Zales 1982) are more hopeful, and the New York Group (Wilson 1983) considers psychoanalysis often to be the treatment of choice for anorexia, which they view as masking an oedipal neurosis.

Stunkard (1975) claims there is no value in uncovering unconscious causes of over-eating explained as neurotic conflict resolution according to the classical psychoanalytic model for the production of neurotic symptoms. The majority of cases of obesity represent a characterologic pattern at the basis of which is a profound failure in the early selfobject relationship, in which food

is used as a substitute for missing segments of the psychic structure. It is this structural defect which must be slowly and patiently repaired in psychoanalytic psychotherapy. As a clinical illustration, we may take Bruch's (1973) description of 'thin fat people', borrowed from Heckel—who warned us already in 1911 that the loss of weight by a fat person does not represent a cure by itself. Indeed, the patient may show much more serious psychopathology when the weight is lost, and the battle may shift from an attempt to reduce to an attempt to keep from gaining weight by an obsessive preoccupation with maintaining a semi-starved appearance that is so popular among fashion models in our slimness- culture. These unhappy dissatisfied people are still representatives of an eating disorder. Their compulsion to stay slim is a common clinical sequel in cases of obesity treated with various

forms of behavior modification or other symptom-focused therapies, which have in essence converted a miserable fat person into an even more miserable thin person—and in both cases a person who is preoccupied with eating. Clinically these adult patients do not progress to a malignant state of anorexia nervosa, but reach a certain miserable stability in their thinness.

The narcissistic aspects of adult compulsive eaters or dieters are especially striking, along with their very low sense of self-esteem, conviction of inadequacy, and compensatory fantasies and daydreams of 'astounding grandiosity' (Bruch 1973). Furthermore there is a curious 'all or nothing' attitude, so that when confronted with the fact that their unlimited aspirations are not obtainable, they are apt to give up, lay around at home, and simply eat and grow fatter! In clinical work with such patients it is dangerous to allow



the patient to assume that if psychotherapy is successful and they achieve thinness, this will somehow lead to the realization of their grandiose expectations—an attitude much reinforced by advertising in our culture. Actually the inability to follow a diet in such patients acts as a safeguard against putting their narcissistic fantasies to the test of reality. Thus as long as they are fat, they feel that they have it in their power now or in the future to set everything right by losing weight. The basic psychological problems do not come into full awareness until after effective reducing, so that remaining fat is an important defense against having to face their own narcissistic or borderline psychopathology. Reducing, when rigidly pursued or outwardly enforced, may precipitate a psychotic reaction or profound depression. Even Federn (1947) during the psychoanalytic treatment of schizophrenics observed that the

psychosis was sometimes initiated and precipitated by intentional weight reduction.

In my clinical experience not one patient has substantially reduced weight and maintained weight reduction without experiencing an extremely difficult and painful process. The inhibition of activity in obese persons is a more fundamental aspect of the disorder than the over-eating because it expresses a disturbance in the total approach to life and manifests, as Bruch (1973) puts it, 'a real lack of enjoyment in using one's body, or a deep-seated-mistrust of one's ability of mastery' (pp. 314-15); in Kohut's terms it is a representation of the empty depleted nuclear self. Thus the known value of exercise in weight reduction has to do with the reversal of a lifelong pattern of passivity, emptiness, daydreaming, and inactivity.

That group of fat people who are compulsive eaters represent, as Hamburger (1951) pointed out, an important subgroup of eating disorders. These patients seem unable to leave food in the refrigerator, or an unfinished piece of cake or box of candy with its cellophane wrapper broken, alone; they must compulsively finish everything. Although I am aware of no specific publications on this subject, it has been my clinical experience that such patients are acting out a ritual of pleasing somebody else which hides a deep narcissistic rage. Thus it is either the disturbed anxious overcontrolling mother who has made it clear that food is precious and every bit must be cleaned from the plate because 'the people in Europe are starving', and who sadistically enforces this dictum, or it is the spouse—on whom the patient is pathologically dependent—that has a deeply neurotic need to see the patient eat up everything sight. What these

patients are doing therefore is compulsively repeating a pattern that brought them mirroring approval from the vital selfobject in the past and is being repeated in the present in order to maintain a false self, which is less unbearable than fragmentation and rage. The role of such compulsive rituals in controlling aggression is predominant, as I have mentioned.<sup>2</sup>

Pernicious familial interference with reducing regimens can therefore be expected. In the case of children and adolescents it is the parents who undermine the dietary regime, and in the case of married people it is quite frequently the spouse who has an unconscious vested interest in keeping the patient fat, and therefore undermines all efforts to reduce. This may come to the point where the therapist has to insist that other members of the family go into treatment if the case is to be successful. Reducing weight is made

impossible if the patient is surrounded by continual pressure from the persons most important in his or her life, and on which the patient is often pathologically dependent, to remain obese. It is actually astonishing to what extreme family members will go to undermine psychotherapy and dietary regimens that at the same time they are paying for. Every kind of ancillary support group such as Weight Watchers or TOPS, as well as medical supervision of diet and exercise, should be encouraged and supported for these patients, and it has been my clinical experience that they really do help. Introduction of such 'parameters' in the psychoanalytic treatment of obesity is also advocated by Ingram (1976).

Bruch (1975) insists that cases of anorexia are unsuccessfully treated the more a therapist conceives of the disorder as expressing 'oral dependency, incorporative cannibalism, and

rejection of pregnancy' (p. 807). She prefers to focus on the patient's defective tools and concepts for organizing and expressing their own needs and their bewilderment in dealing with others:

Instead of interpreting intrapsychic conflicts and the disturbed eating functions, therapy will attempt to help him deal with the underlying sense of incompetence, encourage correction of the conceptual deficits and distortions, and thus enable a patient to emerge from his isolation and dissatisfaction. The patients need help with their lacking sense of autonomy, their disturbed self-concept and self-awareness, (p. 807)

It does not follow from any of this however, that the eventual understanding of the unconscious meaning of the disorganized eating patterns through traditional methods is a mistake in the intensive psychotherapy of eating disorders; all that follows is that classical psychoanalysis without parameters runs a serious risk of ignoring

all that has been learned even since the time of Fenichel about the treatment of such disorders and that, as in the case of borderline patients, intensive psychoanalytic psychotherapy as I have described it (1977a, 1991, 1993b, 1997a), offers greater hope with these patients. Such therapy, as Bruch (1974, 1979, 1982) would agree, concentrates first on the building of structure—'an attempt to repair the conceptual defects and distortions, the deep-seated sense of dissatisfaction and isolation, and the conviction of incompetence' (1979, p. 143)—and secondarily—except in self-destructive emergencies or the early appearance of negative, transference based on the projection of all-bad self and object representations as described by Kernberg (Wilson 1983)—on conflict interpretation, and is consistent with Fenichel's characterization of most eating disorders as an organ neurosis rather than

a conversion neurosis.

In my clinical experience the most serious problem in the intensive psychotherapy of the eating disorders is not that of a schizophrenic loss of reality testing as Bruch suggests, but of a deep characterologic depression often with core paranoid features—manifested by a derogatory self-image, cynicism and hopelessness and reinforced by the long-standing nature of the condition—as well as profound narcissistic rage that begins to show itself as the eating disorder itself is corrected. Thus a long and difficult intensive psychotherapy is to be expected in such patients because we are dealing with a profound preoedipal disorder characterized by severe early structural defects.

Two conflicts that must be faced eventually are also suggested here, following the views of Glover



(1956) and Woollcott (1981) rather than Kohut's explanation carrying the implication of a relatively non-conflictual use of the addictive substance for self-soothing. These are (a) the fear of the loss of individual autonomy in the blissful union with the mother and (b) the addictive substance as a poisonous antidote for the purpose of neutralizing dangerous sadistic substances felt as within, representing the painful early bad experiences with the mother and producing the hateful self-image. The best measure of basic change, I believe, is in the reduction of the derogatory body image distortion (see also Casper et al. 1979, 1981, Garner et al. 1976).

Most authors currently agree—with some notable exceptions (Wilson 1983)—that insight into unconscious conflicts and symbolic meanings usually does not by itself lead to a cure of eating disorders. Some are so pessimistic about eating

disorders as to insist that the psychosis which they feel underlies the overt clinical picture can never yield to any verbal form of treatment. Similar to what I (1993b, 1997a) have recommended in the early phase of the treatment of borderline patients, rather than transference interpretations most authors advocate concentration on paying attention to both discrepancies in the patient's recall of his past and to the way he misperceives or misinterprets current events and often responds to them in an inappropriate way, especially at the beginning of therapy. It is at first a kind of ego-building therapy in which the therapist has to function as an accessory ego for the patient to help sharpen his powers of self-examination and engage him as a partner in exploration. Even the strict psychoanalysts in the New York Group (Wilson 1983) agree that 'The analyst provides auxiliary ego strength and a

rational superego' (p. 185).

Each episode within the eating disorder has to be studied in detail in at least two or three sessions weekly, preferably with the patient on the analytic couch, to uncover a specific sequence and psychodynamic meaning that led to the episode. Paranoid distortions and fuzzy reality testing need to be corrected by careful attention to the realistic situation and current details. As Bruch (1973) writes:

They suffer from an abiding sense of loneliness, or the feeling of not being respected by others, or of being insulted or abused, though the realistic situation may not contain these elements. The anticipation or recall of real or imagined insults may lead to withdrawal from the actual situation and flight into an eating binge, (p. 337)

Even the confusion of body image is complicated (Powers 1980), combining inaccurate perception of actual size or shape with an unrealistic negative

self-appraisal often consolidated in adolescence.

Such patients tolerate a silent psychoanalytic therapist very poorly and the therapist at least at the beginning of treatment must be willing to actively participate with the patient in discussion of the details of the patient's current situation; at the beginning of therapy the patient must experience the therapist as being literally practically useful and helpful in getting the patient to explore the details of and the solutions to the problems of everyday living. At the beginning of therapy this is usually more important than any interpretations that might be made. Krystal and Raskin (1970) call this 'facilitating the establishment of a benign introject', in which the therapist is used 'to create an object-representation which they can utilize for inspiration and achieving a major change in their identity and function' (p. 106).

At the same time the autonomy of the patient must be carefully preserved by the technique of not telling the patient actually what to do but by getting the patient to explore in greater detail the options and also the inaccuracies in his perceptions and expectations. If this early phase of psychotherapy is properly traversed, an addictive transference to the therapist forms, often resembling the narcissistic transferences described by Kohut,<sup>3</sup> and the intensive psychotherapy shifts increasingly into an interpretative psychoanalytic mode.

Furthermore, in all cases of severe obesity or anorexia, outside help is necessary; the patient must get proper medical supervision of weight reduction and exercise, be encouraged to deliberately increase social activities, and participate in support groups (Casper 1982). The temporary substitution of anxiolytic agents for

binge eating occasionally is very helpful. I believe it is unrealistic on the part of a psychotherapist to think that by interpretations alone he is going to reverse a long-standing, deeply embedded, and effective archaic process of tension reduction in an adult patient, especially, as Glucksman et al. (1978) point out, since complex unexplored neurophysiological, histological, and endocrinological mechanisms are also possibly involved.

It is a grave clinical mistake to form a therapeutic contract at the beginning of treatment with any patient in which therapy is seen as aimed primarily at either the reduction of or the gaining of weight, or the cessation of a bulimarexic pattern. The patient must be told firmly at the beginning of treatment that the eating disorder represents symptoms of an underlying important emotional disturbance, and that the only function

of the psychotherapy is to understand and try to ameliorate the underlying emotional disturbance. If this is successful then the gaining or losing of weight will be accomplished by the patient when the patient is ready for it and with a steady pressure from the therapist, but under no circumstances should change in weight or eating patterns be seen as the primary goal of an intensive psychotherapy.

No attempt should be made to minimize the difficulty of substantial weight reduction as well as of keeping the weight down once it is down. Thus a therapist should never convey to a patient a promise that once his problems and conflicts have been analyzed and solved the fat will just melt away and stay away. Furthermore, as long as the body weight is within reasonable nutritional limits, no value judgment needs to be placed on the fact that the patient is 'fat' or 'skinny'. No

absolute 'correct' or 'ideal' weight should be predicted, and the final weight at which the patient stabilizes should be that with which the patient—not necessarily the therapist—seems comfortable and satisfied. It is even sometimes best to tell certain overweight patients to live with it, or even offer some supportive treatment to help them accept their obesity, rather than make the assumption—often based on cultural or medical prejudice—that every patient who is overweight should be vigorously treated. The same is true with certain 'thin fat people' and certain mild anorexics who have achieved a stable condition.

The most serious special countertransference problem encountered in the intensive psychotherapy of eating disorders is frustration from the long and tedious treatment required. The deep empty depression in many of these patients produces a painful sensation in the therapist, as



his normal liveliness, enthusiasm, and human investment in the patient is often met by a silent and depleted response or narcissistic self-preoccupation. This constitutes repeated narcissistic disappointment for the therapist over years of time, so any therapist who works with eating disorders must have ample independent sources of emotional supply and empathy in his personal life and be free of the temptation to turn to his patients for gratification, soothing, or narcissistic massage. These are the worst kind of patients for producing 'strokes' for the therapist, and as the weight problem begins to correct itself they become 'worse' as the anger, despair, projective proclivities, and intolerance to any frustration or humiliation shows itself more and more in the interactions with the therapist, as Ingram (1976) points out.

The therapist may deal with his frustration,

hatred, and rage at such patients in a reaction formation, becoming a replica of the over-anxious parent and shifting to a so-called supportive treatment because of excessive concerns about the patient's fragility. The situation this leads to, in my consultation experience, is that the patient gets control of the therapy and leads the therapist a merry chase by threats of suicide or psychosis or dangerously extreme fluctuations in weight. Because of the typical projection fantasy of these patients, as reported by Offenkrantz and Tobin (1974), that 'the therapist needs the patient to become abstinent in order to alleviate the therapist's own sense of inner emptiness, lack of pleasure, and craving for relief', careful continuing self-analysis is required to prevent externalization (Chessick 1972) of this phantasy.

The therapist in the intensive psychotherapy of these disorders is often called upon to decide

when recommendations of outside medical help, groups, and even anxiolytic drugs are appropriate and necessary. The danger of course is in pushing these out of countertransference disappointment, anger, and frustration, rather than in the service of the patient's actual need at the time. If this occurs, the patient re-experiences empathic failure with the 'food-stuffing mother'. Conversely, withholding these when they would be appropriate is also a destructive manifestation of countertransference, so careful self-analytic investigation on each occasion is required.

When the time comes that the patient must take some realistic steps to change his lifestyle, the previously compliant and cooperative patient begins to show a tough capacity to engage the therapist in a bitter struggle. The willingness of the therapist to enter into this struggle with the patient and still maintain an empathic and analytic

interpretative stance is probably the crucial factor that determines whether or not the treatment will succeed. In these cases, as Nacht (1962) said, it is not so much what the therapist says as the person he really is that counts in psychotherapy. The capacity to maintain empathic contact with and a deep sense of inner commitment to an extremely disturbed patient who is only very slowly responding to the treatment, and whose eating disorder seems deeply fixed, while at the same time resisting the temptation to soothe oneself by adopting a supportive or messianic role is an extremely difficult accomplishment. It represents a serious test of the therapist's skills, capacities, training, and personal analysis. The case reported of severe anorexia treated by Mintz (Wilson 1983) is a beautiful demonstration of this.

## Summary

In this chapter I have reviewed the clinical experience of others and of my own, gained in the intensive psychoanalytic psychotherapy of adult eating disorders. I have emphasized the narcissistic rage secondary to the failure of early selfobjects as producing a variety of the features of the eating disorders, including migraine, tantrums, self-destructive activity, paranoid proclivities, body image disturbances, and compulsive rituals. Such rage floods a defective self-soothing apparatus, and the patient regressively turns to the drama of the eating disorders to gain temporary relief and to counteract threatened fragmentation of the self. Psychoanalytic psychotherapy of these disorders requires a combination of modalities, but insight into what has happened and into the unconscious phantasies, which differ in each individual case and determine the particular disorder pattern, is

consistently required for lasting changes in the patient's lifestyle.

The defective self-soothing mechanisms must be repaired by appropriate idealization and transmuting internalizations, and the patient must be enlisted as a partner in developing better reality testing and a new lifestyle based on a stronger functioning ego developed both through appropriate interpretations, and a more cohesive sense of self. This constitutes a long and difficult task for both the patient and the therapist, but it can be accomplished, and there is no reason to be pessimistic about the results of structure-building therapy aimed primarily at the resumption of psychic development.

### *Notes*

Originally published in the *Annual of Psychoanalysis* 12/13: 301-22, 1985. Reprinted by permission.

2 Other patients compulsively eat only certain selected foods

such as sweet rolls or ice cream, etc. In these patients there seems to be a combination of an organ neurosis and a conversion disorder. I have been able in some cases to trace back the specific food that is compulsively ingested to a vital association with the longed-for lost parent.

- 3 Indeed, Glover (1956) labels the addictions 'circumscribed narcissistic neuroses'.

## Psychoanalytic Treatment of Ulcerative Colitis

The attempt to understand ulcerative colitis by the application of psychoanalytic study has not been one of the brighter chapters in the history of psychoanalysis. There is a long history of psychodynamic observations on ulcerative colitis, and recent literature has contributed little more on the topic. Many of the studies are poorly designed and unconvincing, as others (North et al. 1990) have claimed, and there is no final agreement on the role, if any, of psychological factors in this disease. In this chapter I will review some of the earlier reports more or less in chronological order to illustrate the shifts and



changes in psychoanalytic thinking about the disorder and consider why this thinking has changed. I will then present a current unusual psychoanalytic case spanning many years of observations on a patient with ulcerative colitis. I have treated a number of patients with this disorder in psychoanalysis and psychotherapy and wish to share with the reader a perspective on what has developed in the last few decades in this area, not just out of interest in the history of medicine but because I feel such treatment has much to offer patients with ulcerative colitis.

## I

As early as the work of Murray (1930) it was noticed that there seemed to be striking psychopathological features in patients with ulcerative colitis. He investigated twelve patients who were suffering from bloody diarrhoea or

ulcerative colitis and noted 'a close association in time between the emergence of a difficult psychologic situation and the onset of the symptoms' (p. 248). Alexander (1950), also citing references preliminary to the investigation he pioneered at the Chicago Institute for Psychoanalysis, brought the notion of the 'specificity hypothesis' to its highest point in development by psychoanalytic investigators. For Alexander 'the first symptom of ulcerative colitis frequently appears when the patient is facing a life situation which requires some outstanding accomplishment for which the patient feels unprepared' (p. 125). When there is some block to this need for accomplishment Alexander postulated a regression to 'the anal form of giving or accomplishment' (p. 126). But he hastened to add that such regression can occur in patients with neuroses or diarrhoea other than ulcerative

colitis who do not display somatic symptoms, and therefore he postulated 'some specific local somatic factor' (p. 126) to explain how anal regression produces ulceration in the bowels. For Alexander this was some kind of constitutional or genetic factor affecting the vulnerability of the mucosa of the colon; details of the research approach of his group are presented by Alexander et al. (1968).

Weinstock (1962) pointed out that since ulcerative colitis was first described in 1875, it has been a serious challenge to the medical profession and its etiology remains unknown, although the mortality has dropped because of improvements in medical and surgical techniques. In his study, which rests on a rather superficial survey, twenty-eight cases of severe ulcerative colitis were treated from one and a half to five years 'by experienced psychoanalysts'. Half of the cases 'had

fairly classical psychoanalysis and half had psychoanalytically oriented psychotherapy' (p. 248). His respondents produced very enthusiastic and hopeful results, even suggesting that psychoanalysis could cure ulcerative colitis of the severe remitting type.

Lewis (1963) wrote, in a study of attitude statements in patients with psychosomatic illness, that 'as stress waxes and wanes, rational verbal responses give way to more and more primitive somatic responses, which can reverse as pressure lessens' (p. 139). He suggested that certain primitive defense precursors could be called 'mantle defenses', and are rooted in the biological mechanisms of the undifferentiated ego and specifically related to psychosomatic illness. This rather abstract metapsychological concept was not much followed up in the literature, and is probably based on the ideas of Schur (1955), who

suggested that in psychosomatic disorders there is a resomatization of response linked with primary process thinking and the use of deneutralized energy.

O'Connor et al. (1964) described ulcerative colitis as characterized by inflammation and ulceration of the colon and often accompanied by systemic manifestations. The disease tends to become chronic. Remission of symptoms can either be of short duration or last for many years, in a course marked by remissions and exacerbations. They are convinced that psychological factors play an important role both in the onset of an exacerbation and in determining how the patient handles the illness. In their survey of thirty-two female and twenty-five male ulcerative colitis patients at the Columbia-Presbyterian Medical Center, they noted that the type of psychological therapy the patient received,

whether short-term therapy, psychoanalytically oriented psychotherapy, or psychoanalysis, as well as the amount of time in treatment and the number of sessions, showed no relationship to physiological improvement but did relate to the assessed level of psychological improvement. Nichols et al. (1967) suggested in an anecdotal report that even a 'muscle strengthening program' can lead to improvement in ulcerative colitis by improving the patient's concept of his or her own body. O'Connor (1966) later importantly added that none of the patients in his 1964 series showed an alternation of symptoms, that is, a substitutive or transformative phenomenon in which there is relief of the psychophysiologic disease when a psychosis appears or a remission of the psychosis when the psychophysiologic disease gets worse.

Marder (1967) reviewed sixty-four cases of

ulcerative colitis at the University of Florida Teaching Hospital. He emphasized the importance of narcissistic wounding as the precursor in acute cases, where the disease breaks out after a latent period of one or two days following 'verbal humiliation, often in the presence of others, which hurts the patient's self-respect and leaves him defeated and humiliated. Often this offense refers to his own concepts of sexual inadequacy' (p. 1281). In less acute cases Marder claimed that a series of minor offenses of a similar type leads up to the illness. The problem is that the patient does not respond by outwardly directed aggressive or defensive behavior:

This inhibition of a behavioral discharge converts the external personal trauma into an internal conflict situation. It is this emotional conflict within the individual, which through mechanisms and a long pathway not clearly understood, produce the changes in the colonic mucosa that are

responsible for the clinical and pathological signs of the disease, (p. 1281)

The centerpiece of Marder's argument is that the expression of anger is very difficult for ulcerative colitis patients; he believed this to be due to conscious or unconscious guilt.

There was little further development in the literature after 1970 of Alexander's specificity hypothesis, although it was frequently cited. Sundby and Auestad (1967) surveyed thirty-one children with ulcerative colitis and described similarities in their behavior and personality structure: 'Contact disturbances, rigidity, conformity, hypersensitivity and inhibition of affect' (p. 421). Their study is suggested as confirmation of the early work of Engel (1954, 1955, 1956, 1958, 1961), which outlined alleged psychological features of ulcerative colitis patients and their families in detail. Engel (1958) also



emphasized the conscious or unconscious feeling of object loss or impending object loss as the setting in which 'the colitic process' (p. 336) begins or recurs. His work had great influence on investigators in the 1950s and 1960s.

What is striking in the literature, however, is that the publication of each author seems to go off in its own individualistic direction. So Feldman et al. (1967) maintained that there is too much 'innocent acceptance of previous reports' (p. 17) and argued that there is nothing unusual about the distribution of emotional problems in their series of thirty-four ulcerative colitis patients. They specifically raised the question of whether the disease should be regarded as 'psychosomatic' at all. To the contrary, Adams (1968) maintained on the basis of anecdotal reports that even in children with ulcerative colitis there is difficulty in verbalizing strong feeling and O'Connor (1968) in

a review of the literature again claimed that psychological factors have a significant influence in both the onset of the individual exacerbation and in determining the patient's response to and handling of ulcerative colitis. He concluded his careful review as follows:

The effects of psychotherapy on the course of ulcerative colitis are not yet fully understood. Reports of individual cases tend to be optimistic, and recent sizable series, although less optimistic, have shown that it can favorably modify the course of the disease. Advantageous environmental changes have contributed significantly to somatic improvement in many cases. There are also indications that even when psychotherapy does not improve the physical picture, it can help the individual adapt more readily to the handicaps of chronic illness and provide for a better life adjustment.

Karush et al. (1968), in their outcome survey of thirty patients with chronic ulcerative colitis

treated with psychotherapy, reported that there were no defenses characteristic of colitis although chronic hostility coexisted with anxiety about loss of control. The same group of authors (1969) concluded from the survey that psychoanalysis 'was indicated' in the therapy of selected patients with ulcerative colitis; although 'less intensive psychotherapy helped the majority' (p. 201), 'longer therapies generally gave more lasting results' (p. 201). Freyberger (1970) described ten patients who showed 'continuous suppression of aggressive impulses' (p. 84). This seems to be consistent with the earlier report of Lepore (1965) who found from his clinical experience that the single trait appearing with the greatest frequency in patients with ulcerative colitis is the inability to ventilate or give expression to feelings of anger, resentment, or rage. But Hornsby (1970), in his brief review of the various reports on emotional

factors in ulcerative colitis, pointed out that Lepore (1965) did not think ulcerative colitis qualifies as a strict psychosomatic disorder, i.e. one in which stimuli or emotional origin induce organic somatic disease.

A charming anecdotal report by DeLuca (1970) describes her experiences as a student nurse taking care of several patients with ulcerative colitis. She noted the important emotional and psychologic basis that seemed to stand out in these patients even from a nursing point of view. This convinced her that there is 'an ulcerative colitis personality' (p. 23), a person who puts on his call light for seemingly unimportant reasons and gets labeled as the 'crock' on the ward. She adds:

As a nursing student whose idealism has not yet been destroyed by years of practice, and who is attempting to remain sensitive to the needs of every patient, it is very frustrating

and saddening to me when I see older members of my profession (or younger members) avoiding or not heeding the call light of the 'crock' on the ward, since 'it's probably not important', (p. 24)

DeLuca reviewed the formulations of the psychodynamics of such patients and mentioned that they seem unable to be overtly aggressive, which appears to contradict her reported experiences on the ward. This is because often in the literature there is little distinction between the personality characteristics appearing as a response to having a serious life-threatening and rather humiliating disease, and those which are possibly involved in either the etiology of the disease or in producing exacerbations of it.

West (1971) maintained that 'there are good reasons why, during recent years, we have heard less and less about the psychogenesis and psychotherapy of ulcerative colitis' (p. 19). He

pointed out that we lack a hypothesis that can hold the physician, surgeon, and psychiatrist together in our present knowledge of the disease. He emphasized, in his series of forty-four cases, the patients' sensitivity to sorrow, suspicion, loss, and criticism, and wondered about the possible underlying physiological correlates or perhaps even the physiological basis of this sensitivity, concluding that we simply have an unanswered dilemma at the present time. Shields (1972) was much less charitable to the contributions from psychiatry, arguing from his experience in practice that this field 'has not yet established its right to be present in the treatment schedule' (p. 858), and Kellner (1975), in a review of published controlled studies, suggested that no definite conclusions can be drawn about the effect of psychotherapy in ulcerative colitis although it appears favorably to influence the course in those patients who do not

suffer also from schizophrenia. MacLean (1976) concluded that 'ulcerative colitis is a serious, chronic inflammatory disease of the large intestine in which the mucous membrane becomes hyperemic and friable, bleeds easily, ulcerates, and tends to form pseudopolyps which are subject to malignant degeneration' (p. 287); it remains a baffling problem for psychiatrists, internists, pediatricians, and surgeons and there is no definitive evidence of specific psychological causative factors in either adult or childhood ulcerative colitis. Weiner (1977) reviewed the literature up to this point and concluded, 'Psychological factors do account for an unidentified proportion of the etiological and pathogenetical variance' (p. 547), but clearly serious problems in methodology and design are pervasive. Some of the early cases studied were confused with Crohn's disease, and even amebiasis

(Aronowitz and Spiro 1988).

Bonfils and M'Uzan (1974) supported earlier studies by claiming that two fundamental types of precipitating emotional factors can be observed in the disease in the experience of their clinical team. The first of these is the loss of a crucial person who had an essential part in the patient's life and the second of these involves narcissistic wounding. They gave Lindemann (1950) the credit for noting the importance of the loss of a crucial person. Savitt (1977) reported on four years of psychoanalytic treatment of a patient with ulcerative colitis who was in remission by the end of the treatment. However, 'his internist acknowledged his return to good health, but cautiously wondered if this was merely a remission, with complications to come later' (p. 616). He suggested that before patients with gastrointestinal disorders receive radical surgical



intervention, a psychoanalytic consultation should be made.

Karush et al. (1977) devoted a book to the subject of psychotherapy in chronic ulcerative colitis. They claimed from a study of 103 cases that most patients with ulcerative colitis report a well-defined event of powerful emotional impact preceding the onset of the disease by a few days or weeks: 'The stress usually involved the loss of a significant person through death, separation, illness or simple rejection. It evoked an overwhelming sense of despair and helplessness in some' (p. 63). These authors also maintained that there is central internal conflict common to all ulcerative colitis patients: 'An unresolved struggle between the wish to be dependent upon a parent or a parent substitute and the grandiose wish to control absolutely the feelings and attitudes of the object of dependency' (p. 65). If a parent reacts to

the patient's demand as if it were too aggressive or destructive, the patient has to repress the impulse to control the parent or, 'instead of fearful submission, the patient may react with paranoid and sociopathological behavior' (p. 66), with a corresponding shift to projection.

Their substantial work marked a shift from emphasis on a central internal conflict in ulcerative colitis similar to Alexander's specificity hypothesis, to a focus on the nature of the emotional ties between colitis patients and others. They considered object relations problems to represent a critical predisposing factor to the development of the disease as well as strongly influencing the outcome of psychotherapy. This shift parallels the shift in recent psychoanalytic explanatory thinking from Freud's one-person drive theory to object relations theory (Greenberg and Mitchell 1983). They tried to classify the

dominant modes of object attachments in their patients into three groups, 'individuated, symbiotic and transitional' (p. 75). They concluded, 'Direct emotional expression becomes increasingly difficult and is replaced by a nonverbal discharge through activation of an internal organ system' (p. 139). However, they rejected the notion of the bodily reaction as expressing any specific emotional conflict state but rather, 'It can signify rage, anxious helplessness, a need to suffer, or even a suicidal wish to die' (p. 139).

They believed that the crucial factor in the psychotherapy of such patients is identification with the idealized therapist who becomes 'a new addition to their character armor'. When this works, 'pathogenic somatic activity becomes less important as a maladaptive mode of emotional discharge' (p. 139). But they conceded it is only

speculation as to how the structural tolerance of the colon to abnormally intense activation and functional disruption from psychological excitation is reduced, suggesting that vascular disturbances in the colon seem to be an important factor. They deplored what they called 'the stubborn refusal to consider mental etiological factors' (p. 140) and urged the use of dynamic psychotherapy to help such patients.

Shoenberg (1983) confirmed from his 'experience' that there are very intense but muted feelings in the 'colitic patient' (p. 518) which can sometimes usefully emerge in psychotherapy. Khorana (1983) studied twenty cases of ulcerative colitis in India and compared them with twenty controls. He found that severe psychological stresses, especially financial pressures, were evident before the onset of illness, and claimed that his study highlights the significance of

psychological factors and the importance of combining the medical with the psychotherapeutic approach. However, in a critical evaluation of therapy for ulcerative colitis Riis (1983) concluded that, although psychological and psychiatric aspects of ulcerative colitis have attracted attention and many anecdotal reports favoring such treatment, 'the sum of scientific evidence does not contain controlled, or semi-controlled, studies pointing to a direct therapeutic effect' (p. 27).

Murray (1984) reviewed almost fifty years of studies of psychodynamics and personality structures specific to ulcerative colitis and concluded that it remains as much of a riddle as it was fifty years ago. He pointed out that the incidence of the disease has increased between 1950 and 1975 and no major advances in knowledge or treatment of the cause of ulcerative

colitis have been reported during the 1980s. He mentioned that the *Psychoanalytic Quarterly* Index for 1967 to 1976 listed fewer articles on the topic than the same index for 1932 to 1966; there seem to be more studies in the European and South American journals than in the United States. He concluded, 'Psychological factors, which once dominated reports on ulcerative colitis, rarely are mentioned now' (p. 202). He pointed out that the early reports, such as those of Alexander, did not include control groups, statistical analysis of data, and proper experimental design.

There seems to be general agreement that a psychological or stress factor is involved in ulcerative colitis, but there are far too many early overgeneralizations; all we know is that emotional states might accompany, precede, or follow ulcerative colitis attacks. Murray (1984) concluded:

Ulcerative colitis remains unknown in etiology and no specific treatment is effective for all patients. Many problems await the attention of clinical investigations, clinicians, and researchers if the puzzle of ulcerative colitis is to be solved. Sophisticated experimental designs will be needed to tease out the many physiological, psychological, and social variables, internal and external factors, which have been identified as operative in ulcerative colitis, (p. 213)

Recent work by Freyberger et al. (1985), in Hanover, Germany, on those ulcerative colitis inpatients with alexithymia and focused on an attempt to reverse the alexithymia, showed that even student auxiliary therapists giving supportive psychotherapy provided some improvement in the condition. Deutsch (1980) suggested that alexithymic characteristics are analyzable ego defensive structures, whereas Taylor (1987) and other authors view them as representing a psychic defect, emphasizing

biological and genetic factors.

Drossman (1986) reviewed many clinical studies and concluded that there is no proof for the psychosomatic specificity hypothesis but that it is frequent in ulcerative colitis patients to find conflicts relating to real or threatened loss, and to 'extreme dependency with parental figures' (p. 119). Psychosomatic medicine shifted, he wrote, from focus on an antecedent specific characteristic conflict to the study of interpersonal relations, describing ulcerative colitis patients as dependent, immature, overly attached to parents, and quite sensitive to interpersonal rejection. Illness exacerbation has frequently been shown to occur in ulcerative colitis when a crucial relationship is lost through separation or bereavement. Attempts to validate the specificity of various personality features, in ulcerative colitis have not been successful. Enormous methodological problems



are involved and there is no convincing proof that such patients have specific personality characteristics although a special vulnerability to real or threatened loss is commonly reported. In a subsequent publication Drossman (1988) emphasized the need for an integrated model involving hierarchical subsystems extending from the molecule to the organ to the person to the family to society, showing an interrelationship between these subsystems.

Aronowitz and Spiro (1988) point out that the recent popularity of immunological hypotheses in diseases formerly thought of as psychosomatic may be a paradigm shift in which we have 'substituted one large concept for another to explain the etiology of still poorly understood chronic illnesses' (p. 303). They add, 'The role of psychological factors in ulcerative colitis is far from settled' (p. 304). A review of the literature

through 1990 by North et al. (1990) concludes that, 'Most of the 138 studies contained serious flaws in research design, such as lack of control subjects, unspecified manner of data collection, and absence of diagnostic criteria' (p. 974). The best-designed studies, they say, found no association between psychiatric factors and ulcerative colitis. Weiner (1992) called for a substantial refinement in the methodology of research in psychosomatic medicine, before further advances will be possible.

Moore and Fine (1990) pointed out, 'In recent decades psychoanalysis has moved away from the treatment of psychosomatic conditions. One reason may be that the treatment of such patients is incompatible with usual psychoanalytic practice; too many parameters and supportive interventions are necessary' (p. 201). Yet Lefebvre (1988) devoted an entire paper to his analysis of

one patient with ulcerative colitis in an attempt to demonstrate 'how the intensity of drives, and the vicissitudes of fantasy and affect were related to the intensity of resistances and set limits to the capacity for change' (p. 43). The thrust of this paper is not so much a study of ulcerative colitis, in my opinion, as it is a study of what limits the capacity for change in psychoanalysis, a matter of special importance to those who work with psychosomatic disorders. He wrote:

Freud (1908) was skeptical about the capacity of instincts to relinquish their love-objects totally, ever. At best what can be hoped for is postponement, substitution, symbolization, sublimation and trying to make the best of what's possible. Perhaps the most realistic hope in analysis between two people is that the analysand acquire a capacity for self-analysis by the enduring internalization of the analytic function of the analyst. Thereafter, depending on the continuity of the analytic achievements and the vagaries of fate, self-analysis may suffice

or a measure of reanalysis may be wanted and needed, (p. 51)

In his case Lefebvre described two unconscious fantasies that impaired progress. The first was what he called a narcissistic impasse 'in which the patient could not orchestrate an optimal distance with the object, who always seemed too perilously near or far' (p. 52) and the second, resulting in pathological splitting, repeated 'an infantile disposition to effect a tradeoff with a needed but elusive ideal object' (p. 52). He emphasized the regularity with which his patient's colitis recurred whenever she entered or left a relationship and whenever her analyst left or returned.

Castelnuovo-Tedesco (1991) claimed that ulcerative colitis patients 'have had an enormous amount of pressure applied to them' (p. 305) and have had to submit to circumstances 'which they felt offered no avenue of escape and no other

possibility of resolution' (p. 305). He stated that ulcerative colitis is a rarity among practicing homosexuals. But Rice (1992) retorted that gastroenterologists cannot accept the notion that the etiology of ulcerative colitis is based on unconscious conflicts, although they may accept that emotional conflict, trauma, or both may trigger an attack. He disagreed with the claim that ulcerative colitis seldom occurs in cases of overt homosexuality.

Podolsky (1991) offered in the prestigious *New England Journal of Medicine* a complete current review of the medical aspects of inflammatory bowel disease. He said nothing about psychological factors in the etiology, exacerbation, or course of this disease, nor did he mention the role of psychotherapy as having any significance in the treatment. Considering the fact that there have been sixty years of publications in the psychiatric

literature on this entity, this omission is quite significant. How are we to explain the fact that there is such a striking divarication in the literature between those who emphasize the dramatic psychological features of patients with ulcerative colitis and those who ignore it entirely? I believe this indicates an underlying controversy as to the nature and importance of psychological factors in the production and exacerbation of inflammatory bowel disease. The majority of nonpsychiatric and nonpsychoanalytic physicians, while they are willing to admit that stress has a role in exacerbating the disease, leave it at that. On the other hand, an impressive body of anecdotal and descriptive material has accumulated that indicates at least a problem in such patients involving a hypersensitivity to loss and difficulty in expressing aggression with fear of loss of control. What role this plays in the etiology and

exacerbation of inflammatory bowel disease is simply not understood.

## II

Grossman (1992) briefly presented a case of ulcerative colitis that responded well to psychoanalytic psychotherapy. He speculated that the imagined loss of the patient's husband led to dysregulation of her bowel function. Her apparent 'alexithyma' disappeared over six years of twice-weekly psychoanalytic psychotherapy; the colitis 'briefly recurred' during termination. The following case presentation describes the phenomena that emerged in the psychoanalytic treatment of a patient of mine with life-threatening ulcerative colitis. Anyone who works in intensive psychotherapy or psychoanalysis with such patients should be prepared to encounter these phenomena. I first saw this white young man

twenty-eight years ago, a few months after his first episode of ulcerative colitis. He was an only child raised by two women in South America. He was illegitimate and one of the women was his mother, but they both told him they were his aunts and that he was an orphan they had adopted, and that he ought to be very grateful to them for their kindness to him because otherwise he would have to go to the orphan home. His real mother was a very pious Catholic and a hot-tempered woman; his earliest memory was of her beating him when he was about two and a half years old because he had, in front of visitors, contradicted some things that she said that were not true. The other sister, his aunt, was more mature and was the breadwinner of the two, although his mother was a constantly complaining an office worker.

At the age of 16 he was sent away to a boarding school in the United States which was



run very strictly and where the atmosphere was very religious and subdued. He progressed to a theological college environment where the headmaster was endowed with dictatorial powers. It was after the replacement of this cruel headmaster with another headmaster that his ulcerative colitis broke out. The most obvious and intense precipitating event was disappointment in the new headmaster; all the students had hoped and fervently prayed that the new one would be better, but he turned out to be even more hot-tempered, ferocious, and dictatorial than the previous headmaster.

I saw the patient for a few months in supportive therapy while he was recovering from the acute bout of ulcerative colitis. He was not motivated for treatment and came only because he was ordered to by the headmaster. He was terrified that I might say something to the

headmaster that would get him in trouble and he found the sessions very painful and difficult. I made no effort at that time to do any uncovering psychotherapy but simply to support him and help him ventilate about his disappointment.

After a few months he was allowed to stop coming by the headmaster and I lost track of him for seventeen years. During that time he became an academic in a small South American college environment, occupying a minor post and doing well at it. However, he was ambitious to emigrate permanently to the United States, which he finally did. In his new position, again in a small college, he found himself once more facing an extremely dictatorial dean who was notorious for undermining and getting rid of any faculty that he did not like. The patient was very frightened, and doubted his ability to find another position easily, which was probably a correct assessment based

on his background and education. His ulcerative colitis flared up. He entered therapy with a psychiatrist and for two years went three times a week and free associated on the couch. Noting that his therapy sessions occurred right after the lunch hour, while he was free associating he would hear his therapist snore, taking an after-lunch nap. The patient continued to free associate while the therapist was snoring, and was pleased with this arrangement. He wanted therapy but he did not want anything to change because he felt his life was precariously balanced and any change would be for the worse. After two years of this he suggested to his therapist that he had made as much progress as was possible, and the therapist agreed. They quietly parted.

He returned to me in a desperate state when the new dean of the school that he taught at, who had replaced the previous dean, again turned out

to be worse. He said, 'I am illegitimate and I must tread very carefully to be liked. I do everything in a round-about fashion.' He related that during the time between his first encounter with me and the present both of his 'aunts' had died. When his real mother died he felt little, but the death of the real aunt, which came suddenly as a complete surprise, touched off a very severe bout of ulcerative colitis to the point where he was twice hospitalized and a total colectomy was being considered. This bout lasted for some time and was finally brought under control by medication. At the present time the patient was under the care of a gastroenterologist who he noticed was unnecessarily rough in his proctoscopic and physical examinations, but the patient was afraid to say anything. It was only when this gastroenterologist suggested total colectomy, although he was in remission, as a protection

against a possible development of colon cancer, that he changed gastroenterologists.

A long period of the analysis, which took place four times weekly, was taken up with the conflict between a very severe and vicious superego that drove him relentlessly and gave him no rest or relaxation, and his yearnings for dependency gratification and for allowing himself some pleasure in life. He had both homosexual and heterosexual interests, but he rarely had any sexual relations, keeping busy with his academic work from morning to night and piling one burden after another on himself. There was a constant underlying anxiety about developing another episode of ulcerative colitis, and this anxiety seemed appropriate.

With the analysis his psychosomatic state stabilized for quite a long time. What was

apparent was an extreme narcissistic sensitivity, leading to much raging that was very carefully hidden. At worst there was projection in which he imagined all authority figures as cruel and brutal and felt that he must be a good little boy with them and please them at all costs. He felt he had to be perfect so he could never be criticized, because when he was criticized he never forgot it and went into a rage that he carefully had to hide.

For the first two years of his life there was a loving grandmother in the house who then died. He had no memories of her at all and after she died his care was exclusively in the realm of his two 'aunts'. He recovered an early memory at the age of 3 of receiving a doll from someone and bashing its head in, after which he felt very upset and guilty.

By the third year of analysis he began having

more successful heterosexual experiences with an occasional homosexual masturbatory experience. A very powerful memory emerged in which as a young schoolboy, perhaps about the age of 7, he was sick with the flu and sent to school by his mother who said, 'There is nothing the matter with you.' The teacher realized that he was ill and insisted that he go home. Only with remembering that episode did he begin to get a glimpse of the depth of his anger at his 'aunts'.

Gradually he became able to express some of his anger at me without so much fear. A transference formed which was characterized primarily by idealization. Using this idealization, as has been described in the above literature review, through identification he was able to modify his superego and improve his life. However, the important moments of the therapy really came when he was angry at me for one

reason or another, such as my going on vacation, and gradually he became able to tell me how he felt, very much like Dostoevsky's 'underground man', angry, alienated, and alone. He developed a friendship with a young academic woman that he really began to enjoy. For the first time he went to the beach.

In the fourth year of analysis he developed acute appendicitis and missed three weeks of the treatment. He came back wild with rage because during his time in the hospital nobody in the academic department that he was in bothered to come and visit. He was extremely wounded and disappointed by this, and it was followed by a short bout of colitis which resulted in a change in his medication. This bout lasted about a month and was not very serious, but it was enough to incapacitate him.



During my vacation in the fifth year of analysis he entered into a homosexual affair for the period that I was gone. He had little investment in this affair and dropped it as soon as I returned. The biggest problem that he had in the treatment was getting in touch with the massive rage he felt at his 'aunts'. Derivatives of this would occur from time to time, and he recalled one incident as a student where some man was teasing him and he began chasing the man and probably would have inflicted physical harm if he had caught him. He associated this not only with his rage at his 'aunts' but at his father who had abandoned him. For the most part, however, he was extremely compliant, polite, and sedulously avoided any argument with anybody. Then he would hate himself for behaving in that fashion.

The first oedipal material appeared in the sixth year of analysis, directed towards the aunt who

was not his mother, the aunt that suddenly died preceding his most severe bout of ulcerative colitis. He revealed that he knew from a young age that one of the 'aunts' was his mother, but he never brought this matter up and lived in a state of false pretense during his entire childhood.

As he was able to express his libidinal and aggressive drives more freely in the context of the analysis, he began training himself for a career change. In his fantasies he saw the image of his relentless unforgiving mother everywhere. He felt that he could not feel secure or allow himself to be 'real' except with a selected few friends. He became able to confront me on matters that he was angry about. He stated, 'My basic fear is that people will check on whether my performance is good and, if not, I will be asked to leave. Volcanic rage keeps me afraid that it will erupt.' The wish to kill his 'aunts' appeared in his dream material and

it became clear that neither of his 'aunts' ever had any concept of where he was emotionally. He revealed that just before his real aunt died he had written her an affectionate letter. When he arrived at her funeral the letter was just delivered and he realized she would never see it. Shortly after this the serious ulcerative colitis episode took place. He said, 'I must have been very angry at her for deserting me. But I could never feel the anger at my aunts.'

He became more and more enraged by his academic position, and felt trapped by it. His fear of criticism involved a terrible sensitivity to humiliation and revealment. He dreamed that he was drilling into a girl's eye because she, a 10-year-old girl, had done something to a 3- or 4-year-old: 'Then there was an explosion and I didn't dare look.' His association was to the deliberate sadistic cruelty of his mother. He also dreamed

that he was a prisoner being forced to have sexual relations with a man. To his surprise he got an erection and he was very embarrassed. In his associations he longed for a soothing good father who would be the parent he needed and serve as an antidote to his aunts. He was very embarrassed about these homosexual longings and quite frightened they would be found out and humiliate and disgrace him.

Shortly before he was about to take an examination for a new position, his girlfriend decided to stop seeing him and he was extremely wounded and insulted. He felt as he had at his real aunt's sudden death, very alone, and he recognized that this episode with his girlfriend was a rerun of a sudden unexpected loss. He stated, 'If I told her off, my anger would be frightening and I would blow up and lose her forever.' He realized that he had lost her anyway,

but somehow he could not give up the hope that she would reconsider. What was striking and dramatic about this painful episode for him was that it was not followed by a full-fledged bout of ulcerative colitis (there was a day or two of diarrhoea and some blood in the stool, but it stopped spontaneously).

The last two years of analysis were characterized by his gradually increased capacity to express aggression and to find a new, independent, and more gratifying academic position. No further bouts of ulcerative colitis took place and the patient was seriously contemplating marriage to a new woman with whom he was having a regular sexual life. The trickiest part of the analysis was enabling him to get in touch with his archaic rage in such a fashion that it did not explode and disrupt his existence or result in a paranoid psychosis, which was always a

threatened possibility. I was fortunate enough that his defensive structures were sufficiently intact so that he could allow just enough regression in the analytic situation to express some of these feelings in an attenuated form in the transference and in a more direct form in his dreams. His idealization of me allowed for a modification of the superego and the revision of his compromise formations to allow him more assertiveness and more independence and less obsessive clinging to a false self under all circumstances. Simultaneously his alienation diminished and he was able to make a better heterosexual adjustment.

We both felt near the termination that this was sufficient progress for him and that it was dangerous and unnecessary to be perfectionistic and work through further and deeper layers of his archaic longing and rage, since he was now living a reasonably comfortable life and he felt that his

future was hopeful. We are now in the termination phase and I am tapering the frequency of the treatment slowly rather than setting an abrupt termination date. I am leaving the separation pace essentially up to him and this is working out quite satisfactorily. The fact that there has to be such a prolonged and gradual termination is more evidence that a complete working through of the archaic preoedipal conflicts has not been accomplished, but I believe that out of consideration for the danger of a recurrence of ulcerative colitis it was better to conduct the therapy in this fashion rather than to aim for a theoretically perfect and total structural change.

I believe this treatment still constituted a psychoanalysis because an intense transference formed, sometimes idealizing and sometimes negative, which was resolved by interpretation and resulted in a distinct change in his

compromise formations, a modification of his superego and a strengthening of his ego via both insight, identification, and a corrective emotional experience which I (Chessick 1994, 1996a) believe takes place in every analysis. It was not necessary to introduce any unusual parameters and I did very little in the way of supportive therapy during the analysis; I did not advise him on decisions and I respected his autonomy throughout the treatment, confining my interventions essentially to questions, clarifications, and interpretations.

## Summary

A review of the literature indicates that very little is known about the role of psychological factors in the etiology, exacerbation, and treatment of ulcerative colitis. Most phenomenological consensus seems to take place around recognizing that the patient has great



difficulty in expressing aggression and is frightened of loss of control. Episodes of ulcerative colitis are often related to the sudden loss of an important love-object and/or severe narcissistic wounding. Chronic narcissistic rage is not at the center of the psychological phenomena as I (Chessick 1985a) have described it in narcissistic psychosomatic disorders. In ulcerative colitis, acute episodes of object loss, narcissistic wounding, or bitter disappointment, along with a sense of entrapment and helplessness, produce the threat of an explosion of uncontrollable rage. Such an explosion would result in disruption of the patient's life and expulsion from significant and needed relationships. This produces an acute internal conflict, hopelessness, and despair, with the danger of resolution by paranoid projection. Why in these patients these events seem to be followed by changes in the colonic mucosa is

simply unknown, nor is it clear whether they are related to these changes directly or indirectly. The defensive inability to feel the archaic rage at early significant caretakers or their later life substitutes is clearly an important determinant of the psychosomatic condition.

I believe that the treatment problems raised by the patient presented here are fairly typical of what will be encountered in any effort to psychoanalyze a patient with ulcerative colitis. Perhaps because of the failure of Alexander's specificity hypothesis, there has been a loss of interest in the psychoanalytic treatment of such patients, and this is regrettable because at least some of them, like the present case, respond well and it makes a vital difference in their future. One certainly cannot say that psychoanalytic treatment represents any sort of 'cure' for ulcerative colitis, but it seems clear that resolving underlying

psychopathology to whatever extent is possible lessens the chance for ulcerative colitis to be exacerbated by stressful events such as severe narcissistic wounding or substantial unexpected object loss, because the ego has been strengthened and the patient has an improved tension-reduction capacity. Psychoanalysts should not be afraid to consider the treatment of such patients as long as they are not in the acute phase of the disease. Acute manifestations require active medical, pharmacological, and supportive psychological intervention.

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 23: 243-61. Reprinted by permission.

## Externalization and Existential Anguish in the Borderline Patient

In this chapter I hope to clarify the concepts of externalization and existential anguish, to discuss the interrelationship of these concepts, and to explore their usefulness both in the clinical practice of intensive psychotherapy and in understanding the psychodynamics of the borderline patient.

It is best to begin this task with a review of Winnicott's (1958, 1965) notion of 'maternal function'. Winnicott points out that the function of the 'good-enough mother' in the early phases of life can be boiled down to *holding*, *handling*, and

*object-presenting*. He writes:

Holding is very much related to the mother's capacity to identify with her infant. Satisfactory holding is a basic ration of care, only experienced in the reactions to faulty holding. Faulty holding produces an extreme distress in the infant, giving a basis for:

the sense of going to pieces, the sense of falling for ever,  
the feeling that external reality cannot be used for reassurance,  
and other anxieties that are usually described as 'psychotic'.

(1968, p. 18)

Winnicott also points out that handling facilitates the formation of a psychosomatic partnership in the infant. This contributes to the sense of 'real' as opposed to 'unreal'. 'Faulty handling militates against the development of muscle tone, and that which is called "coordination", and against the capacity of the infant to enjoy the experience of body functioning, and of BEING.' Object-presenting

is of course very important also, in that faulty object-presenting blocks the way for the development of the 'infant's capacity to feel real in relating to the actual world of object and phenomena'. In addition, Winnicott feels that this development is a matter of maturational process, the accumulation of living experiences, and must take place in a 'facilitating environment'.

From his point of view, with which I entirely agree, defective holding and defective handling of the infant in the early stages of development will produce extreme distress that results later on in a profound sense of unreality, the inability to have a sense of identity, disturbances of body functioning, and a lack of the experience of Being—a concept that philosophers recently have written a great deal about. He points out (1968, p. 84) that:

Young people can be seen searching for a form of identification which does not let

them down in their struggle, *the struggle to feel real*, the struggle to establish a personal identity, not to fit into an assigned role, but to go through whatever has to be gone through.

There are many approaches to this hypothesis, as illustrated by the current burgeoning research in child development (Hilgard and Bower 1966, Kagen 1971, Mussen et al. 1969), too voluminous for review in the present chapter.

A severe disturbance in holding and handling in the early stages of infancy leads to certain definitive conscious and unconscious phenomena. Taking this as a basic premise subject to further scientific investigation, I should now like to discuss selected aspects of these conscious and unconscious phenomena. First I will discuss the unconscious phenomena with special emphasis on the repetition compulsion and the development of externalization as a way of life. Then I will discuss

the conscious phenomena, especially what is known as existential anguish and which leads to what I call existential despair. I will then discuss the results of the development of externalization and existential anguish or existential despair, both from the point of view of the successful overcoming of these problems and in terms of the disasters that they can lead to. These preliminary discussions will be illustrated by two case histories. The first of these will be of Soren Kierkegaard and the second that of Trudy, a patient in my private practice.

Beginning with the selected aspects of the unconscious phenomena that result as a consequence of defective maternal functioning or defective holding and handling in infancy, let me review briefly Freud's famous concept of the repetition compulsion. This remarkable universal human tendency to repeat over and over again in



human relationships some earlier—often extremely unpleasant or even disastrous—emotional experiences, usually involving one or the other of the parents, is a remarkable clinical fact that is illustrated again and again in the practice of intensive psychotherapy. The main demonstration of the repetition compulsion in psychotherapy occurs in the classic transference neurosis. Experience with borderline patients has called the attention of clinicians to another related and extremely important and dramatic aspect of the repetition compulsion as it appears both in the psychotherapy situation and in the patient's general relationships with other people. This is externalization.

Credit for coining the term externalization is usually given to Anna Freud (1965). She described externalization as a subspecies of transference and separated it from the transference. Her main

experience with externalization is, of course, in the analysis of children, and she sees externalization in child analysis as a process in which the person of the analyst is used to represent one or the other part of the patient's personality structure.

The concept of externalization was made a great deal sharper and more precise with respect to the psychotherapy of borderline patients with deep narcissistic problems in a paper by Brodey (1965). Brodey points out that in his experience while working with family units externalization appeared as a mechanism of defense defined by the following characteristics: (1) projection is combined with the manipulation of reality selected for the purpose of verifying the projection; (2) the reality that cannot be used to verify the projection is not perceived; (3) information known by the externalizing person is not transmitted to others except as it is useful to

train or manipulate them into validating what will then become the realization of the projection. In other words, externalization makes possible:

A way of life based on relationships with unseparated but distant aspects of the self. What is perceived as reality is an *as-if* reality, a projection of inner expectation. The senses are trained to validate; the intense searching for what is expected dominates and enforces validation. It is difficult not to validate an unquestionable conclusion. Each validation makes the conclusion even less questionable. The restricted reality perceived is experienced as if it were the total world, (p. 167)

The psychotherapist feels the intensity of his patient's effort to manipulate him into validating projections. He feels the conflict as he struggles against this manipulation, but behavior that will be used as validation seems the only way to gain relationship with the patient.

Thus, the manipulation of the therapist into

behavior that is symmetrical with the projection is different from the simple transfer of feelings to a therapist.

Even if the therapist does not wish to conform, he still finds himself conforming to the narcissistic image. For no matter what he does, pieces of the therapist's actual behavior irrelevant to the therapist's self-identity are seized on by the patient, to whom they are predominant *as-if* characteristics. The identity that the patient sees may be unknown to the therapist (although it holds a kernel of truth which usually is disturbing to the therapist), (pp. 168-9)

Even the therapist's active denial of the patient's presumption is used by the patient in the service of proving to the patient that the therapist is actually congruent with his projective image.

Brodey points out that the therapist of the ego-disturbed patient must become skilled at managing his congruence with the patient's

projected image. This management is often intuitive and usually very demanding emotionally. 'Being a distorted object is much easier than being nonexistent.'

Fundamentally, externalization is a combination of projection followed by selective perception and manipulation of other people for the purpose of verifying the initial projection and only those aspects of other people which have this value are perceived at all. Thus, the most benign therapist approaching the borderline patient finds himself transformed into a horrible monster very quickly by the patient's selective perception, and unless he is aware of this danger he is inclined either to retaliate or to quarrel with the patient's extremely unflattering image of him, which usually contains a kernel of truth and a direct assault on the therapist's narcissistic conception of himself as a benevolent physician.

Giovacchini (1967) emphasizes paradoxical self-defeating behavior that has a defensive purpose which is usually the result of externalization. This must be distinguished from self-defeating behavior resulting from a breakdown of the personality. Patients of this nature cannot cope with a warm and nonthreatening environment:

They react to a benign situation as if it were beyond their level of comprehension. These patients do not have the adjustive techniques to interact with a reasonable environment. Their formative years were irrational and violent. They internalize this chaos and their inner excitement clashes with their surroundings. When the world becomes benign and generous, the patient withdraws in panic and confusion, (pp. 575-6)

Giovacchini points out that the patient expects and brings about his failure, and adapts himself to life by feeling beaten in an unpredictable and ungiving world. He distinguishes this from a masochistic

adjustment, and points out the relationship of externalization to the repetition compulsion, upon which it is based.

Thus, when the therapist presents the patient with a consistently benign environment, one which Winnicott (1958) has described as being parallel to the healthy maternal environment, the patient cannot trust the lack of frustration. Instead of risking the inevitable disappointment that he expects, the patient prefers relating:

... in a setting in which he has learned to adjust. If the analyst does not frustrate him the patient's psychic balance is upset. To reinstitute ego equilibrium the patient attempts to make the analyst representative of the world that is familiar to him.

Externalization is not simply a projection of internal aspects of the personality onto the therapist but contains also a mode of adaptation or adjustment that makes any interaction between

the ego and the outer world possible. As Giovacchini (1967) points out, 'Externalization provides the patient with a setting that enables him to use adjustive techniques that he has acquired during his early development.'

If we now converse with this patient who is busy using externalization as a significant ego defense and as a method of adaptation to reality based on repeated failure, we begin to get an understanding of the concepts of existential anguish and subsequent existential despair. The credit for introducing the concept of existential anguish into western thought belongs to Kierkegaard, although the concept itself can be found repeatedly in the Bible in an implicit fashion—for example in the Book of Job. It was Kierkegaard, however, who based his entire philosophical creative accomplishment on the concept of existential anguish.



I have distinguished in this chapter between anxiety as it is used in the clinical psychotherapeutic sense and the 'anxiety' or 'dread' of Kierkegaard (Kierkegaard's (1946) term *Angst* is usually translated as 'dread', although May uses 'anxiety', Unamuno rendered it as *agonie* and Sartre by *angoisse*), which I am calling existential anguish because the technical meanings of the two are really rather different and it confuses matters considerably to loosely include both under the term 'anxiety'. May (1950) and others have reviewed Kierkegaard's concept and I will not spend much time on the subject. It is sufficient to point out that Kierkegaard also views existential anguish developmentally, beginning with the original state of the child. He does not, in my opinion, really pin down the source of existential anguish, believing it to be a universal condition related to the freedom and the

possibilities of human decisions and choices.

Kierkegaard and many philosophers who followed him have overemphasized the importance of existential anguish in the life of the ordinary, relatively normal human being. Existential anguish does unquestionably tend to become an extremely important concept in people who suffer from emotional difficulties or, to put it another way, it is a conscious consequence of disturbance of holding and handling in the early stages of infancy, a disturbance which leaves the individual, as Winnicott says, with a defective sense of Being, a preoccupation with the meaning of life, confusion over his own identity, and lack of a place in the panorama of human events.

Existential anguish, if prolonged, can lead to an increasing sense of the hopelessness and meaninglessness of life. Kierkegaard (Jones 1969)

gives an excellent description of this sense of 'melancholy'—which again to distinguish from the psychiatric terminology I have termed existential dread, in his journal:

I feel so dull and so completely without joy, my soul is so empty and void that I cannot even conceive what could satisfy it—oh not even the blessedness of heaven.

It is terrible when I think even for a single moment, over the dark background which, from the very earliest time, was part of my life. The dread with which my father filled my soul, his own frightful melancholy, and all the things in this connection which I do not even note down.

From a child I was under the sway of a prodigious melancholy, the depth of which finds its only adequate measure in the equally prodigious dexterity I possessed of hiding it under an apparent gayety and *joie de vivre*. (Jones 1969, p. 211)

One of the most remarkable and fascinating features of philosophers who are preoccupied

with the concepts of existence and Being is that their lives are so deeply wound up in their philosophy. There are no better examples than the dramatic lives of Kierkegaard and Nietzsche. Both of these famous writers—who are difficult even to classify as philosophers—illustrate in many different ways the combination of the unconscious need for the use of externalization as an adaptive defense and the conscious preoccupation with existential anguish and existential despair. Furthermore, there is a self-reinforcing circle involved in this situation, for it is obvious that a person who is using externalization, and who as a result of it experiences from the world only repeated failure in interpersonal relations and a sense of persecution or rejection and abandonment by all other people, will find in his life experience and life pattern ample evidence to preoccupy himself morbidly with the meaning of

life, with a profound sense of despair and the meaninglessness of all his efforts, and with a deep inner need—often manifested by agitation and chaos in his behavior—to find some way out of the dilemma and what he perceives to be a universal existential agony.

In this situation there are a few typical results. The patient who is predominantly using externalization, especially if he does not come to psychotherapy, always carries the risk of becoming an impulsive suicide. A certain percentage of these patients, having experienced repeatedly rejection, abandonment, and failure—which they attribute to a variety of external causes running all the way from the wrath of God to a general malevolence on the part of all people—can often reach a point where suicide seems preferable to continuing in the mode of life that they have suffered (Kahn 1963).

Similarly, patients who are in the throes of existential despair, if they do not enter psychotherapy or attempt suicide, often show certain other characteristic resolutions. The destructive resolutions that tend to appear are either megalomania and even insanity or, more commonly, a chronic despair and depression which leads to a permanent constriction of their creative potential (see Chessick 1999b), and even to self-destructive escapes such as drugs and alcohol.

A more constructive solution to existential despair can be found in the urging of Kierkegaard towards the formation of a passionate commitment. Indeed, a number of remarkable people have been able to overcome existential despair by passionate commitment to some system or other. Examples of these are Kierkegaard's and Tolstoy's highly personalized

religious commitments and, perhaps at the other end of the spectrum, Schopenhauer's professional pessimism—which represents a passionate commitment of another kind but with the same fortunate result. The life of Albert Schweitzer is probably the best known contemporary example.

On a less spectacular level, many psychotherapy patients resolve their reality problems by a passionate commitment to some good cause or philosophical or religious system. The most famous example of this is Freud's patient Anna O., who became passionately committed to social work on the European continent. The variety of difficulties that patients immersed in a combination of unconscious externalization and conscious suffering from existential despair can present should be obvious from this discussion. To illustrate these concepts, I will now review the life of Kierkegaard, (1813-55) and then present a

patient in the process of intensive psychotherapy as a second example.

The life of Kierkegaard (see Lowrie 1971) can be viewed as revolving around a series of personal crises, as certain authors (Kahn 1963) prefer to do, or the famous crises of his life can be viewed as high points in Kierkegaard's chronic externalization, in which the crises show like an iceberg—sticking above the water but really having a large contiguous mass beneath. The most well-known crises that I am referring to are, first, the discovery of his father's infidelity (before 1836) and their subsequent reconciliation shortly before the death of his father (1838) and, second, the breaking of his engagement to Regina Olsen in 1841. Other crises of less dramatic import also occurred, such as the affair of the *Corsair* in 1846, in which he precipitated his own persecution in the media—a classical example of externalization.



Kierkegaard's father was an old man when Kierkegaard was born, a successful businessman who rose from the peasantry by a combination of good luck and hard work. Kierkegaard was the youngest of seven children from his father's second marriage to his housekeeper. He was hunchbacked, physically weak, and very sensitive, but was a very good scholar and debater. He wrote that he was never a child and had always been old. The father was a quite intelligent but a depressed, morose, and guilt-ridden man, who reared his children in a stuffy religious atmosphere. Kierkegaard claims to have adored him like a God and they spent much time together in his childhood.

Only once does Kierkegaard ever mention his mother in his writings. As Kahn (1963) points out, 'He certainly had observed that his father treated the mother more like a servant than like the lady

of the house.' In spite of this obvious fact, Kierkegaard claimed to have been shaken as if by an earthquake by the revelation that his father had not been faithful to his mother. Around 1836, probably related to this confession, Kierkegaard became seriously immersed in suicidal thoughts and dissolute living. Shortly before his father's death they became emotionally reunited (Lowrie 1971). When his father died Kierkegaard experienced a religious conversion which was accompanied by 'indescribable joy'. He also inherited a fortune.

Sometimes the confession from his father and the death of his father are considered as precipitating separate 'crises', since the one led to melancholy and delinquency and the other to religious restoration. At any rate Kahn (1963) claims that his early life crisis (or two crises) clearly interrupted his way of life or career-line,

and allowed him to come back to the father and to God in new adoration. Weigert (1960) offers a psychoanalytic view of the relationship of his inner struggle with his father to his creative work.

It does not take a brilliant clinician to realize that Kierkegaard was suffering from a considerable problem with respect to his mother as well as his difficulties with his father. The absence of writing about his mother must be regarded as extremely significant (and 'ominous', Lowrie 1971). The difficulties regarding women surfaced again in the crisis of his betrothal to Regina Olsen, a teenage girl. After considerable internal rumination Kierkegaard broke his engagement to her, which he regarded as a matter of fantastic importance. Imagine his chagrin when Regina promptly married the suitor whom Kierkegaard had replaced! She seems to have gone on to lead a reasonable existence in spite of not

having the great honor of marrying Kierkegaard.

His inner struggle continued, and beginning with the remarkable *Either/Or*, led to the creation of an important body of religious or quasi-philosophical works (Bretall 1947) which take as their starting point his concepts of existential anguish and existential dread. He wrote voluminously in a difficult literary style suffused with religious allusions that some readers find repellent. Jones (1969) points out:

He was persuaded—again by personal experience—that no rational, scientific, or economic procedure could heal the break within the self and between the self and its world; only a leap of faith could accomplish that. And God—this was his faith—had helped him, Soren Kierkegaard, to make the leap that had brought his life into 'focus' and given it a 'center', (p. 234)

Jones discusses 'the cure for the agony', which according to Kierkegaard is to become

passionately committed to one of the options that life offers. Jones writes:

It is a psychological fact that, to the extent that we commit ourselves utterly and passionately to one option (from the psychological point of view, it does not matter which one), we no longer care about the others. At this moment the agony of decision obviously disappears. Passion alone may be satisfactory psychologically, but it is hardly satisfactory ethically.... This is why Kierkegaard emphasizes commitment as well as passion. His point was that the act to which one becomes passionately committed must be deliberately chosen, (p. 218)

Jones tries to contrast Kierkegaard's position with that of a psychiatrist who wishes to help a patient agonizing over a decision: 'If the psychiatrist adopted Kierkegaard's psychological theory, he would aim at getting his patient to interpenetrate consciousness with passion. If the patient's agony was thereby alleviated, he would be satisfied; he [Kierkegaard] was not a psychiatrist, but a

Christian advocate.'

In *Sickness Unto Death* (1954), written in 1849, Kierkegaard reminds us of three general ways of coping with existential despair. He labels these the unsuccessful, the demoniacal, and the religious. There is a marvelous discussion of boredom and despair, especially in what Kierkegaard has labeled the esthetic life, marked by hedonism and childish behavior. For Kierkegaard the leap from esthetic life to the ethical life—the latter marked by immersion in marriage, family, and object relations—is not sufficient. He advocates a further leap to the Christian God in which one breaks the ordinary moral code in a way similar to Kierkegaard's renunciation of Regina. One can easily argue that this is a rationalization of a need on the part of Kierkegaard to externalize and produce a repetition compulsion of the defective holding that he experienced from his mother.

A careful study of the lives and writings of Kierkegaard (and Nietzsche) brings these problems into very sharp focus, and presents a dramatic exposition of the struggle of a superior mind with these deep feelings—feelings that must be almost compulsively written about, ruminated on, and that force some kind of resolution out of the troubled psyche of the victim. Jaspers (1965) has presented a remarkable nonpsychoanalytic approach to the life of Nietzsche, trying to explain the agony of his life pattern as representing and illustrating the same intellectual problems of existential anguish and despair that he was writing about as a philosopher and poet (for an extended discussion see Chessick 1999b).

On a more practical level, let me turn finally now to the case of Trudy, which illustrates a number of these problems as they present themselves to the practicing psychotherapist.

Trudy first appeared in my office in November 1968, and she has presented some extremely difficult psychotherapeutic problems. At 27 years of age, she was exceptionally beautiful, extremely intelligent, and very sick. It is impossible to exaggerate her immediate attractiveness and the remarkable capacity that she radiates to be a desirable and loving woman to some lucky man. At the same time, anyone who responds to her emotionally finds himself in the situation of getting too close to a porcupine; an incredible number of barbs are stuck into him, and he comes away with the feeling of having tried to embrace the rainbow.

When she first came to me, her life was in total chaos. I was the third psychiatrist she had seen within the year, and this was the only year she had ever seen a psychiatrist. The immediate problem was that her husband of four years, a man the



same age as herself, had announced at the beginning of 1968 that he was having an affair and wanted a divorce. She refused, and visited a psychiatrist once weekly for five months, where she learned she was 'aggressive to cover up her insecurity, and unfeminine'. During that time, her husband gave up the affair but soon afterwards was arrested for indecent exposure, and was fired from his job as a public relations man for a publishing company.

He obtained another job in another city and wanted her to stay with him, but she could not tolerate it and abruptly moved by herself to Chicago. An incredible amount of legal tangle developed, involving what state and residency requirements were necessary for a divorce, and so on. Upon moving to Chicago, she tried a psychotherapist, but felt he was 'too wrapped up in research'. She wanted a young therapist, and

later admitted she was hoping to seduce the therapist. He referred her to me, but she spent the first two sessions demanding to know how she could be sure I was qualified to do psychotherapy. She insisted on a consultation with a well-known 'big-name' psychiatrist and when he reassured her I was not a charlatan, she began coming regularly, at first twice a week and soon afterwards three times weekly.

Much of the first six months were spent on the legal tangles of the divorce, which the patient eventually obtained through considerable effort of her own. She demonstrated remarkable ability to carry through a series of complex maneuvers, but during that time she impulsively had sexual relations with three lawyers involved in the case. Although the patient had otherwise only a few sexual affairs, it was soon apparent that if she set her mind to it she was irresistible. During this six

months she also began a more serious love affair with a young businessman, and it was clear that she drew the strength to reorganize her life from a combination of psychotherapy and the physical contact with these various men.

The patient was born and raised in Springfield, as the oldest of a Catholic family of five children. There were five pregnancies in six years resulting in the patient, a sister one year younger, premature twins who died at birth, a brother, and another sister. Eight years later a final sister was born. The one brother had been killed in Vietnam eighteen months previously, and the patient showed a startling lack of affect in discussing the matter.

Her childhood is described as a literal hell. Her mother, a rigid German woman who enforced the rules and scrubbed the front stairs daily, was

'screaming from morning to night'. As soon as possible the patient joined all the clubs she could to be away from the house as much as possible. She was forced to work in order to earn money, although the other children were not, and describes herself as a 'fat, ugly, and unpopular' child, with no friends. She always got excellent grades in school, for which there was no recognition whatever from her parents. She went all the way through college in Catholic, all-girl schools, and was neither popular nor recognized by the faculty.

There was no communication with her father, who ran a dental laboratory and gambled on the horses. At one point he took the patient's school scholarship money and gambled it away. The entire relationship with the parents seems marked by what Leuba (1949) has called 'deception', a lack of recognition, a lack of communication, a lack of

empathy or affectual contact, and, above all, a variety of broken promises. At the same time, her father is described as a 'dashing dresser', and her earliest memory is of his buttoning her 'custom-made yellow coat' and carrying her up the steps. When her mother was out of the house, there were some episodes of fun with her father. 'Then mother would come and take it all away.'

She had no sexual education whatsoever, was not prepared for menstruation, and had no intercourse prior to her marriage and few dates. She met her husband at her job, which she took after college. In college she lost weight and apparently developed a certain glamorous attractiveness, which made her desirable to her husband both because of his public relations work (with many cocktail parties) and his extremely materialistic and wealthy parents, who regarded her as sort of a fashion plate to enhance her

husband. She learned the ropes quickly and was an exceptional hostess, winning everybody's approval with what Winnicott would call her 'false self' (1965). The only apparent flaw in the marriage was that her husband had no sexual interest in her. She was frigid and he rarely attempted intercourse.

During the marriage there was only one sexual affair, which began when a close friend of her husband began trying to help her in their marital difficulties; somehow it ended up with his trying to teach her 'how to make love', to their mutual surprise. To my knowledge there was no actual sexual play with the previous two psychiatrists mentioned, and I feel convinced that her history as given above is reliable. Her physical health was always excellent, and there was no history of drug ingestion or any sort of obvious well-defined psychiatric disorder.

The patient claimed she 'never dreams', but after five months, she had her first reported dream, and a number of dreams after that. The first dream was: 'I was at work. There were many men around, but no women. My boss said he liked my work, but he couldn't stand me. No one stuck up for me.' Her associations to the dream were: 'My mother disliked me from birth. I was a stubborn ugly baby, and any appreciation could only come by accomplishment on my own.' There was considerable feeling of yearning and longing simply to be held in somebody's arms. At the same time the patient felt utterly and totally alone, and suffered from a deep sense of inner emptiness. There was a constant anguish about the meaninglessness of life and a perpetual feeling of boredom and indifference to everything. She had repeated fantasies of suicide, but made no attempts.

In these early months of the therapy I felt I was dealing with a character disorder or borderline patient, who was very empty and in a chaotic state. Cautious exploration and listening on my part clearly had a supportive value, but the patient had a desperate need to be physically in contact with somebody, which she was acting out with the various men. A pattern emerged in her acting out, which indicated that she chose men she could seduce and then, when they really fell for her and lusted for her, she backed away and left them to suffer. This was clearly a reversal of her childhood experiences.

After the first six months the patient settled down and found a reasonable job. She began another affair, with a man who was divorcing his wife and who seemed really interested in marrying her. Therapy appeared to be moving quite well, but outside of this one man she had no



friends and her social contacts were purely for business purposes. Interpretations were aimed at understanding her existential anguish and her difficulties in developing relationships with people that could be meaningful and gratifying because of her deep mistrust of everybody. The sources of this mistrust, from the early relationships with her parents, were repeatedly explored in the following year of treatment, and there was considerable discussion of her 'false self' or the 'smiling depression' that she put on and hid behind.

Her boyfriend found a better job and moved to California, and there were vague plans to follow him there after he obtained his divorce, or after more progress in therapy; the patient spent a lot of money on the telephone and on airplane trips back and forth to California. She continued to come regularly to therapy. There was no further sexual acting out with anybody else; this was

limited to her boyfriend when they were together. As their separation became longer and longer, I began to notice a remarkable situation beginning to develop.

By simply doing nothing about anything, the patient had set up a series of egregious failures for herself, in her personal life, at her job, and in her psychotherapy! It was almost like the unfolding of a master plan, carefully devised to unfold in a series of events over years of time! The entire purpose of this plan seemed to guarantee that I would not affectually reach her, that we would never become too close emotionally, and that she would never change one bit. The repeated transference projections (that I was like her mother and taking everything away from her) were now beginning to prove themselves to her, in spite of my efforts at interpretation. She claimed to experience nothing but icy indifference from me

during the psychotherapy sessions, and her entire life was a proof at that point that she had nothing but misfortune, and that her existential despair was completely justified.

By simply doing nothing—just going through the motions of coming to treatment, going to work, and sitting at home on the weekends—she remained lonely, alienated, developed no friendships, was failing at psychotherapy, and finally exasperated her boyfriend in California to the point that he ultimately gave up on her, insisting that she needed a 'mg to wipe your feet on', not a boyfriend. Thus, her life was a constant series of failures that completely justifies her deep sense of aloneness and existential anguish.

This remarkable and dramatic externalization was used in two ways. In the first place it cleverly put me on the spot, calling forth guilt over all the

time and money I took from her, and demanding over and over again that I prove that I care—by leaving my wife and children for her—which would have been an ultimate victory for her and destruction for me, as in her other affairs described above. In this sense the externalization was a punishment for my being the first man in a lasting relationship that she could not seduce.

The second use of externalization was to avoid any true emotional closeness, which the patient genuinely feared. This fear was really overwhelming, and the patient oscillated for years between a timid approach to genuine affectual contact with me and raging complaint, with externalization providing endless ready ammunition and stopping her ears to interpretations. The patient was frightened of her own overwhelming need for holding and handling, and deeply mistrustful of any implications on my

part that the therapeutic relationship could even take the edge off this horrendous yearning. I could really empathize with her profound fear and inner emptiness and, above all, her deep mistrust of human contact.

Perhaps because of this empathy I was able to sit with her through countless hours of complaining and raging, patiently interpreting again and again how the process of externalization was at work in her setting up the situation. Remarkably, along with the externalization, an observing ego gradually emerged in her, allowing her to observe herself and report about herself while she was externalizing and manipulating and complaining and raging. She really wanted to make affectual contact with me, but the defenses kept butting in like a reflex; with a remarkable regularity, whenever we became emotionally closer for a few sessions, disastrous and

frustrating events would occur 'out of the blue' in her life. This would produce a forceful 'spitting out' of the benevolent introject, and many sessions of raging and pushing me away emotionally. There were many fantasies of killing both herself and me. The only time the patient could reach inner peace was by raging herself into a state of exhaustion. She wrote, 'Life is still as hopeless as it always was and always will be ... what I want are results, not your crummy promises that don't mean a shit anyway, do you hear?—something tangible and touchable.'

In this case everything depended on recognition by the therapist of the insidious and all-pervasive externalization unfolding itself underneath the patient's repeated claims of existential despair. The outcome clearly hinges on a race between the patient's capacity to develop an observing ego and check the externalization

and other defenses against affectual contact, and the patient's profound fear and mistrust of human closeness. The greatest problem is the therapist's frustration and temptation to do more and more 'tangible and touchable' for the patient.

The determination of limits constitutes one of the thorniest problems in the psychotherapy of the borderline patient (Chessick 1983d). Winnicott (1965) speaks of the borderline patient as breaking through 'the barriers of the analyst's technique and professional attitude' and forcing 'a direct relationship of a primitive kind, even to the extent of merging', although he cautions that, 'This is done in a gradual and orderly manner.' In his view, the 'holding' by the therapist is presented primarily by proper interpretations with empathic understanding and soothing terminology, and by a consistent and reliable psychotherapeutic setting—the therapist 'behaves himself'. Actual physical

holding is only 'occasional' and represents a 'delay in the analyst's understanding'. In my opinion this is *never* a good idea.

The problem of the compelling need to be held, 'resembling an addiction', has been described by Hollender et al. (1969, 1970). In this case, the patient's wish to be given to passively is behind *both* the demand for holding and the 'doing nothing'. Proof of love is to be fondled and supported physically—held in one's lap—with *no* demands made in return. If she cannot have this, she lies passively and rages herself into exhaustion, which gives her a sense of cathartic relief and temporary peace. In this situation, all adult relationships become irrelevant, since they involve give and take.

Perhaps there is no better way to sum up this terrible dilemma than with the immortal words of



## Freud (1905) from the case of Dora:

No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed. Might I perhaps have kept the girl under my treatment if I myself had acted a part, if I had exaggerated the importance to me of her staying on, and had shown a warm personal interest in her—a course which, even after allowing for my position as her physician, would have been tantamount to providing her with a substitute for the affection she longed for? I do not know ... . In spite of every theoretical interest and of every endeavor to be of assistance as a physician, I keep the fact in mind that there must be some limits to the extent to which psychological influence may be used, and I respect as one of these limits the patient's own will and understanding. (p. 109)<sup>4</sup>

### Notes

Originally published in *Archives of General Psychiatry* 27: 764-70, 1972. Reprinted by permission.

[4](#) Reprinted by permission of Sigmund Freud Copyrights, the  
Institute of Psycho-Analysis, the Hogarth Press and Basic  
Books, NY.

## Psychoanalytic Treatment of the Borderline Patient

Every author seems to have his or her own method for the treatment of borderline patients as well as differing diagnostic criteria to determine whether or not a patient is to be labeled 'borderline'. *DSM-IV* defines the essential feature of borderline personality disorder as a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts. This pattern is observable in many kinds of *DSM-IV* personality disorders, and as a result the borderline personality diagnosis overlaps with many other

types of *DSM-IV* disorders. Unfortunately, a substantial segment of psychotherapeutic practice is made up of difficult, usually female patients who fall more or less under this *DSM-IV* rubric.

## **Treatment Approaches**

Of the making of books about borderline patients there seems to be no end. Techniques range from those of Abend et al. (1983), who recommend a more or less standard psychoanalytic treatment without parameters, to the cognitive therapy methods of Young (1996) and the recently presented 'dialectical behavior therapy' of Linehan (1993). Somewhere in between lie the techniques of Kernberg (1975, 1987) and Masterson (1981), which are a bit idiosyncratic and are each based on an extremely specific developmental theory, as well as pragmatic techniques such as my own (Chessick

1971, 1977a, 1993b).

The issue of whether borderline patients can form stable therapeutic alliances remains controversial. Although Adler (1985) claims they cannot, there is evidence presented by Linehan (1993) that seems to indicate that Adler is wrong. In my experience the problem with borderline patients is not whether or not they can form a therapeutic alliance—I believe that given the proper psychoanalytic approach and an appropriate holding environment they can—but rather it is how to get them to come three or four times weekly for intensive psychoanalytic therapy or psychoanalysis. Most of these patients are unsuccessful or even being supported by family members, and in this age of managed care and greedy insurance companies they receive little support from third party corporate so-called health care payments. This is a catastrophe for a

substantial segment of our patient population, as without intensive long-term psychoanalytic treatment the life situation of borderline patients tends to deteriorate (although their psychic condition is a relatively stable one), lurching from crisis to crisis, and often involving drug addiction, alcoholism, episodes of self-mutilation, and suicide attempts that are sometimes successful. Our society is deliberately throwing these patients onto the trash heap, along with all the unfortunate occupants of our public mental hospitals who have been ejected to live in our streets, alleys, and doorways. Foucault was certainly correct when he said that every society should be judged by how it treats the poor, the sick, and the mad.

There is a general middle-of-the-road consensus in the literature regarding the treatment of borderline patients. For example, Horowitz et al. (1996), as I (1977a, 1993b) have

done, advocate a flexible shift on the part of the therapist back and forth from expressive to supportive techniques as needed, sometimes repeatedly in the same hour. One must be careful with transference interpretations because such interpretations can be experienced as narcissistic wounds. By now it is well known that borderline patients tend to entice therapists to cross professional boundaries and therefore such boundaries must be maintained with care. Improved functioning, as a practical matter, is even more important than insight with such patients. There certainly exists a trial and error factor in the treatment of borderline patients, a 'flying by the seat of one's pants' in psychoanalytic psychotherapy, in which one must constantly titrate the anxiety level of the patient and constantly reassess one's treatment strategy with respect to the patient's needs, even within one

session. It is especially important that the therapist be a reliable and safe container who does not retaliate but 'metabolizes' (Kernberg) and interprets whatever the borderline patient wishes to project or present, e.g., Bion's 'beta elements'.

No single theory or technique can be applied to all of these patients. They constitute a vast spectrum (Meissner 1988) ranging from the more neurotic or the narcissistic personality disorders to the psychoses. I like Kohut's (Tolpin and Tolpin 1996) criterion that the time length of the patient's fragmentation after a perceived empathic lapse or other narcissistic wound is the crucial factor in determining whether or not a borderline patient can be treated by psychoanalytic therapy. This varies from patient to patient and must be actually tested out in the sessions. A preliminary period of supportive therapy may be necessary in order to build a relationship so that the patient



can endure the inevitable fragmentation when she perceives an empathic lapse or a narcissistic wound in or out of the therapy situation.

Horowitz et al. (1996) emphasize the important ego capacity of being able to play in an 'analytic space' as described by Ogden (1986). This capacity of being able to create and maintain a space 'in which the dialectic between fantasy and reality is continually entertained' is mandatory for analytic work: 'When patients become excessively fixated on the "reality" of their experience, for example, the analytic space is contracted or collapsed, and the exploration of the patient's inner world becomes drastically limited' (Horowitz et al. 1996, p. 25). This concept has not received sufficient attention in the literature on the borderline patient and is worth keeping in mind.

The sudden intense transferences formed by borderline patients explain why a patient fails with one therapist and gets labeled 'borderline', and yet may succeed with another. Also, as I (1977a) pointed out, a small percentage of borderlines are untreatable because they are actually sealed-over paranoid psychotics. My approach is based on the idea that borderline patients do not constitute a homogeneous group with a specific pathology or developmental defect. Their treatment requires special attention to the everyday phenomena of their interpersonal difficulties as well as to archaic transference problems they pose for the therapist.

### **Special Problems**

It is well known that the exquisite sensitivity of these patients, their quick propensity to narcissistic rage, and their impulsive behavior

pose the central issues in their treatment. This profound volatility and anger probably has a constitutional and genetic basis as well as genesis in environmental and developmental factors. Studies are beginning to appear in which an attempt is made to link the so-called 'borderline personality disorder' to other disorders such as alcoholism, or the affective disorders which have a more generally accepted genetic basis (Akiskal 1981; Gunderson and Elliott 1985; McGlashan 1983a; Soloff and Millward 1983; Stone 1980), but recent research suggests that impulse dysregulation rather than affect dysregulation is primary in this disorder.

Either the tremendous rage of these patients or their extraordinary capacity for seductiveness produce what Kernberg (1975) has labeled a global countertransference, according to him a diagnostic indicator that the therapist is

encountering a borderline patient. Such patients often insist there should be 'no limits' to their entitlement and behavior, often leading to a number of self-defeating characteristics that get the patient in trouble. There is an obvious overlap with the narcissistic personality disorders, but reality testing is at times more impaired. Borderline patients provoke hatred and exhaust the endurance of the therapist in order to substantiate their projections, assaulting especially the narcissism and self-esteem of the therapist.

Typical therapist defenses against such global countertransferences are repression, in which the therapist becomes bored, restless, or inattentive; a turning against the self in which the therapist feels low self-esteem and even 'sick'; a reaction formation of over-concern, or 'love', and fantasies of rescuing the patient; projection, which

manifests itself by a dread that the patient will commit suicide, act out, or leave treatment (in extreme cases therapists may even fear loss of control of their own aggression towards the patient); distortion of the therapist's reality testing to validate countertransference hatred, in which the patient is devalued as hopeless or dangerous. All of this may result in the development and acting out of a sadomasochistic relationship with the patient or, alternatively, getting involved in erotic interchanges or gross sexual acting out with the patient. The result is destruction of the treatment and may entail serious consequences for both parties.

Classical psychoanalysis conceptualizes all symptoms and all behavior as a compromise formed by the ego among the demands of the id, the superego, and reality. An abrupt negative shift based on a change in compromise formations

occurs in severely damaged patients who experience disappointment in archaic selfobject expectations. Here the narcissistic rage can become so overwhelming that a critical value is crossed; previous compromise formations such as obsessional rituals or masochism are suddenly overshadowed by massive projection and projective identification. This produces an emergency and can break up the treatment if the ego's capacity to respond to interpretation is overwhelmed. In my experience it poses a common serious problem in the outpatient psychotherapy of borderline patients and constitutes an ever-present danger in the treatment no matter how long the treatment has been going on and how confident the therapist might be that he or she has formed a good 'working alliance' with the patient.

## Diagnosis

There are no 'pathognomonic symptoms' of borderline patients, and no consensus on their characteristic metapsychology, dynamics, or precise stage of failure in development. Signals to watch for at the start of therapy are a sense of entitlement, magical expectations or thinking, an impaired differentiation between fantasy and reality, episodes of anger and suspicion with no sense of humor, and fears of rejection or hints of paranoia. It is the quality of the therapist's ongoing experiences with the patient that is key to the diagnosis, which introduces an unavoidable controversy about establishing the diagnosis in some cases where *DSM-IV* criteria are not immediately apparent (Chessick 1982b).

The identification of borderline disorders is a clinical judgment and rests on the therapist's sensitivity to the predominance of archaic elements in the material in spite of the manifest

themes, as well as the sense of disquiet and agitation produced in the therapist out of the ambience of the therapist-patient interaction. These are important clinical markers of an underlying borderline disorder and have obvious important manifestations for treatment planning and strategy. The therapist must remain alert to the appearance of such manifestations even in patients who present with what appear to be nuclear oedipal themes in their preoccupations.

It is not necessary to insist that all borderline patients are arrested at one specific point or stage of development. The borderline condition arises as a consequence of the first three years of a disastrous and disappointing ambience in the mother-child interaction combined with genetic or constitutional factors, which is then complicated by the inevitable failure of an appropriate solution to the Oedipus complex. The role of the father is



also very important. It is not necessary in practical clinical work to have recourse to a highly complex developmental theory of object relations in dealing with the day-to-day treatment, although the temperament and cognitive functioning of some therapists may require such an elaborate theoretical structure to enhance their own sense of understanding of the patient. I question the value of speculations based on adult patient material as to what kind of psychodynamic processes and images occur in the mind of the 1- or 2-year-old pre-linguistic infant.

It is a mistake not to take into consideration that adult patients have to undergo all developmental phases by the time they come into treatment; certainly failures of the later phases because of a faulty foundation or structure are also going to affect the symptomatology and behavior of the patient. I am not convinced there

will be much further theoretical understanding of the borderline patient because I am not convinced that the diagnosis constitutes an independent autonomous entity,- the value of the concept lies in the clinical description with the implications of poor ego functioning and consequent special requirements for a proper therapeutic approach.

It is very misleading to label any patient one does not understand as 'borderline'. For example, a patient reacting with rage to a gross empathic failure on the part of the therapist is showing neither a 'transference' nor a 'borderline personality organization', but rather is responding appropriately to deep disappointment. Borderline patients typically react with angry disruption or suicidal behavior to therapies they intuitively recognize are inappropriate to their intense personal suffering, such as certain types of paternalistic counseling or so-called touching and

feeling treatments; these reactions are not simply manifestations of psychopathology but rather represent an increase in desperation and disappointment in yet another encounter with lack of empathy and inappropriate misunderstanding of the patient's basic needs by a parental figure.

### **Psychoanalytic Technique**

A substantial and important portion of the psychoanalytic therapy of borderline patients, once a working alliance develops, consists of meticulous exploration of the patient's current ways of relating to people and dealing with problems, and gradually discovering from this exploration how these methods of adaptation formed in response to the disaster of their childhood and the consequent intrapsychic problem of overwhelming rage and distorted core fantasies. Change in adaptive techniques with

subsequent improvement in their lives is dependent on borderline patients' examination of the nature of their initial and presenting adaptive techniques and how these came to be. Often borderlines try out new adaptive techniques in the psychotherapy first since it is a protected situation, and then successfully apply them outside the treatment.

It is usually not possible to predict which patients can get more out of the psychotherapy than simple pacification and unification. I believe that every patient should be given a chance at psychoanalysis if it seems at all feasible, and at a modified form of psychoanalysis or intensive psychotherapy if it is not. My experience (1971, 1972, 1977a, 1982b, 1993b) has been that many of these patients, some even seen three or four times a week and using the couch can, if the therapist is patient and does not get sucked into

the dramatics or develop an interfering countertransference of a major nature, eventually form transferences which are analyzable. The limiting factors are how much the patient is acting out and keeping himself or herself involved in immediate current chaos, and whether the patient is willing to come consistently to the sessions and cooperate with the treatment. So the patients really tell us whether or not they are suitable for a psychoanalytic form of treatment, and what modifications will have to be introduced.

One is usually compelled to be more active in the psychoanalysis of borderline patients than in the treatment of many other conditions. For example, one must often actively inquire what is going on outside of therapy hours. The fact that the therapist is interested in the patient's real everyday life, although it can be viewed as a form of gratification, helps the patient in self-

observation and limit-setting. The therapist must have a great deal of flexibility to work with borderline patients and must learn to suit the treatment to the patient, not the patient to the treatment. Careful listening often tells us what the patient needs in the way of treatment and what the patient can and cannot tolerate. If we follow this, we will have as smooth and workable a relationship as possible and also demonstrate that we have some empathy with the patient's fears and anxieties.

It is extremely important for the structure of the treatment to be flexible and reasonable, and above all it has to make sense to the patient. If borderline patients can even vaguely understand the reason for the structure and the limitations, although they may still fight against the framework of the treatment they will not be basically impeded by it. Such patients do very

badly if structure is simply imposed on them by fiat without discussion and if the therapist is unwilling to negotiate. Problems come up over such issues as fees, frequency of sessions, limits on telephone calls to the therapist, charging for missed hours, changes of appointment time, and so forth, that often result in narcissistic rage explosions and disruptions of therapy, making the treatment quite stressful for the therapist. Therapists who are puritanical, anxious about possible malpractice litigation, extremely over-conventional, or prone to sermonize about ethics and sexuality do poorly with borderline patients.

There are times when it is inhumane not to give a patient medication for various conditions such as extreme anxiety or insomnia, and it can be a manifestation of countertransference to withhold medication in emergency situations as well as to prescribe indiscriminately. If one is

reasonable and careful, there is a place for psychopharmacologic agents in the treatment of borderline patients. When prescriptions have to be written they should be marked 'not refillable' and only a small number of pills or capsules should be given to the patient at a time, so each time the patient runs out it forces a new discussion of the use of the medication.

Dangerous acting out becomes limited as a function of the growing working alliance, in which the patient becomes increasingly interested in working on and understanding her own problems rather than in the primary-process gratification of impulses; but at times, especially early in treatment, sharp limitations may have to be demanded by the therapist, always presented as being in the best interest of preserving the patient's life and enabling therapy to proceed. It is our task during the entire therapy to demand a



limitation on any behavior on the part of the patient that is future-foreclosing either for the patient's career or life or therapy. This limitation comes first and nothing else should be discussed in the therapy until it is observed; if the patient refuses to limit such activities no therapy can take place. The ultimate test of whether the patient is really motivated for psychotherapy rests on a willingness to limit self-destructive behavior. If it continues, the patient must be hospitalized and vital limits set by the hospital milieu.

'Deep' interpretations early in the treatment are ineffective in many cases of borderline patients. It may be argued that such interpretations were ineffective because they were simply wrong. However, I believe it is because the patient is not in a cognitive state or self state to utilize any interpretation, since the ego is occupied fully in dealing with the flood of

affect. The therapeutic relationship must first be established and utilized as a soothing selfobject and unifying instrument over a substantial period of time before the patient is ready to move slowly into deeper dynamics and self-understanding.

From the beginning of the therapy I focus on the development of the patient's autonomous ego functioning, beginning with the simple clear tasks of dealing with the reality at hand. Whenever possible I always take an uncovering stance rather than an authoritative 'counseling' or 'advising' stance. Taking an authoritative or counseling stance invites the patient to trap us and frustrate us by following our advice and yet somehow ending up making a greater mess than ever before.

A substantial period of time is usually required for the patient's ego capacity for adaptation to daily life to improve to the point where there is

time in the therapy to begin to look in detail at the patient's past. This length of time varies from case to case and is sometimes hastened by pointing out to the borderline patient that the sooner she is able to deal appropriately with reality situations, the sooner we will be able to go deeper in understanding the developmental aspects of what has happened.

## Transference

During this time of preparation for in-depth exploration, we often observe the development of certain characteristic archaic transferences in the borderline patient. The first group contains the narcissistic transferences depicted by Kohut (1971, 1977). Borderline patients, who shade over into narcissistic personality disorders at the healthier end of the spectrum, often show typical mirror or idealizing transferences. Another

characteristic type of transference that develops is the transitional object transference described by Modell (1968, 1975), in which the patient clings to the therapist or therapy as a kind of magical protection and security against the hardships of the external world.

An important aspect of the transference of borderline patients is the intensity of the annihilation anxiety and the primitive defenses of magical thinking, denial, and narcissistic omnipotence used against it. The therapist is experienced as an object (or 'selfobject', Kohut 1977) perceived somewhat vaguely outside of the self, whose qualities are distorted by fantasies arising from the patient, and the therapist is assigned a real role in the life of the patient. Borderline patients will put the therapist in this role no matter what the therapist says or does and whether he or she likes it or not.

A third group of transferences is described by Kernberg (1975); these appear early and are often disruptive. They are marked by extreme affect, usually negative, but sometimes highly eroticized. Such transferences must be resolved by interpretation and not allowed to continue unabated; the question is what kind of interpretation to choose? Kernberg uses interpretations based on his developmental theory of object relations. I utilize a technique less bound to that theory, which consists at first of helping the patient again and again, as tactfully and as calmly as possible, to examine phenomenologically (Chessick 1992b) the therapeutic situation, and pointing out the discrepancy between the kinds of affect the patient is experiencing—or even the kinds of cognitive distortions the patient is experiencing—and the reality of the therapy and the relationship. The better the working alliance,

the easier this is to do; thus early in the therapy it is a most difficult and potentially disruptive problem.

Certain borderline patients develop highly negative or strongly eroticized disruptive transferences very early, even in a once a week psychotherapy. This must be resolved by interpretation, for example based on Kernberg's (1975) modified Kleinian concepts of projected split-off all-bad or all-good self and object representations. Or, if self psychology is utilized, transferences powerfully infused with lust and aggression appearing early and suddenly in therapy are analyzed as manifestations of profound disappointment in the patient's expectations of empathy from the subjectively perceived selfobject analyst. Failure to resolve such disruptive transferences typically destroys the therapy.

Kernberg (1987) argues that borderline patients achieve better reality testing if one interprets projective identification. My approach is somewhat different. When a patient suddenly shows tremendous manifestations of lust or rage I first try to get the patient to join me in attempting to identify the point at which this occurred; if this can be done, it is a good exercise for the patient in learning self-examination and improving ego functioning. With borderline patients this is often not possible because the patient is so angry or so overwhelmed with acting out of rage and sexuality. A second and more interpretative tactic is to try to get the patient to identify the point at which he or she felt disappointment, panic, or fragmentation, and to then see how these generated the sense of rage or sexual acting out. Some borderline patients are able to do this, especially if the therapist has the patience to wait

until they calm down, and, if they are able, it serves as a template to be used in the appearance later on of similar surges of uncontrolled affect.

If none of this works and disruption threatens the treatment, I do attempt to interpret projection or projective identification very much in the style advocated by Kernberg (Kernberg et al. 1989), but this technique carries a certain danger with it if the patient hears the therapist posing as the arbiter of reality and feels in some sense that the interpretation is accusatory and demeaning. Because of this the patient may then use such interpretations as confirmatory evidence of the humiliation and attack coming from the authority-therapist. This must be carefully discussed with the patient.

An important pitfall in dealing with the archaic transferences of these patients is the danger of the



therapist's panic. Flamboyant acting out often stirs up countertransference anxiety and hatred manifested by fears of patient suicide or malpractice litigation. It looks as if the patient is exploding and unless the therapist has a dynamic grasp of what is going on, he or she can be stampeded into doing something radical, or into getting rid of the patient.

Another pitfall is therapist impatience. The therapist must be willing to sit sometimes for years with a borderline patient while he or she gradually catalyzes the rebuilding of ego structure. Many therapists simply don't want to do this, as it is stressful, tedious, and painstaking work that can be ungratifying for long periods of time. Borderline patients tend to set up in external reality the kinds of situations they need to have occurring. Sometimes they are quite expert at this, and the therapist gets sucked into playing various

kinds of roles, depending on the projection assigned to the therapist. This leads to serious chronic countertransference problems.

The clinical phenomena must be studied to see what the therapist is actually doing with the patient regardless of the theoretical model that the therapist professes to follow. For example, the technique of Kohut, in which the idealization of the therapist is permitted over a long period of time so that the full transference involving the search for the idealized parent imago is permitted to develop, can easily be used by an untrained or untreated therapist as an excuse to permit a flattering kind of worship and massage for the narcissism of the therapist. Conversely, the technique of Kernberg, in which more confrontation goes on, can be used by the therapist to act out hostility and aggressiveness and to produce chaos, or even a sort of counter-

projective identification.

## Rage

When raging begins it is usually impossible to argue a borderline patient out of his or her accusations. If on careful objective assessment it turns out that the accusations are valid, the therapist needs to self-correct and sometimes apologize. If the accusations are based on distortions or projection, the proper approach to this is a calm, non-anxious and patient non-retaliatory stance, with eventual interpretation of what is happening. It is this consistent stance that provides the basic ambience of the treatment. Any disruption of it interrupts the subliminal soothing that is always going on in a well-conducted treatment of a borderline patient. No matter how we may wish to get away from this in our sophisticated theoretical conceptions, the

ambience or subliminal soothing the therapist provides coming from his or her consistency, reliability, and integrity as manifest in the ambience of the therapist's office, the therapist's personality, and the deep inner attitude towards patients which cannot be faked, constitutes the basic requirement that permits the psychoanalysis of the borderline to go forward.

Sometimes the rage of the borderline patient is stirred up directly by frustration of the narcissistic need for omnipotent control of everything and sometimes the rage is a secondary phenomenon to paranoid projection or an intense transference. In a sense these patients are correct when they predict that all human relationships will end up badly for them, with disappointment and dislike coming from everyone around them. This is known as externalization in the borderline patient (Chessick 1972). The patient responds selectively

to the negative aspects of significant people and develops a dossier based on selective negative perceptions, which then, coupled to projection that leads to expecting attack from all sides, justifies a pre-emptive strike. The chronic calculated attacks on the therapist's inevitable defects, if not interpreted, can easily lead to countertransference acting out on the part of the therapist, even to the point of directly or indirectly getting rid of the patient. This is quickly used as 'proof' by the patient of his or her expectation of apparently unprovoked betrayal and abandonment.

Psychotherapists of borderline patients painfully experience the intensity of the patient's effort to manipulate them into validating the patient's projections. The therapist feels the inner conflict as he or she struggles against this manipulation. The most benign therapist

approaching a borderline patient engrossed in a raging archaic transference finds himself or herself transformed into a horrible monster very quickly by the patient's selective perception, and unless the therapist is aware of this danger the tendency is either to retaliate or to quarrel with the patient's extremely unflattering portrayal. A sudden transformation of the therapist into a horrible monster can occur at any time in the treatment, even when there seems to be a good working alliance. It often leads to therapist discouragement and 'burn-out', with a lingering sense of depression and injured self-esteem.

Meticulous attention to the phenomenological details of the interaction is the best starting point in dealing with patients who are subject to explosions of rage in the treatment. What is important is not the therapist's minor empathic failures per se, but the way in which they are

experienced by the patient. The patient uses these minor empathic failures to relive previous dreadful interpersonal experiences in a protective effort to demonstrate further the need for distancing in interpersonal relationships. What we are listening for is how the patient is experiencing the interaction with the therapist and in what context these experiences are being placed within the patient's pre-existing fantasies and in the patient's internalized object relations patterns. It is only after we have been able to establish this information with the patient that we can begin asking why these experiences are placed in a particular context.

The most common fantasies emerging from the unconscious of the borderline patient are not oedipal fantasies but narcissistic fantasies and fantasies of rage and of world- and self-destruction, covering a deep fear of physical and

psychic penetration and annihilation. The acting out of conscious derivatives of the rage and of world- and self-destruction fantasies endangers the very life of the patient; the acting out of disavowed narcissistic fantasies often renders the patient poorly adapted and causes great difficulties in interpersonal relationships.

At the deepest point of the treatment these narcissistic and destructive fantasies are worked through by allowing them to emerge into the light, studying their genesis, and showing the patient how the acting out of such fantasies interferes with aims and goals in life. The borderline disorder is similar to the narcissistic disorder in that narcissistic transferences and fantasies often appear, but is different from the narcissistic personality disorder in that the intensity of the raging, fear, mistrust, and annihilation fantasies is greater.



## Treatment Process

Borderline patients seem to present a combination of structural defects and conflicts. The conflict areas are more amenable to an eventual psychoanalytic approach, but the structural defects sometimes have to be dealt with by techniques 'beyond interpretation' that Gedo (1979) advocates. Failure to help borderline patients with structural defects by deliberate after-education simply represents another failure of parental empathy. But this is a parameter in the psychoanalytic treatment of borderline patients and should not be undertaken unless the therapist is convinced that the defect exists and is not an apparent defect as the consequence of a structural conflict, a clinical judgment that is often quite difficult to make.

If one must err, in my experience it is best to err on the side of mistaking a defect for a conflict-

related problem because in due time this error can be corrected; approaching a conflict-related problem as a defect by direct after-education produces a therapist-patient collusion that tends to drive the conflict out of sight and make it no longer amenable to the uncovering process. A therapist should also be very cautious in offering any patient after-education, for this is a common manifestation of countertransference acting out when the therapist's narcissistic equilibrium is wounded because the patient is not responding to analytically based interpretations.

Empathic attunement to the patient is very important, as is staying with the patient through the many vicissitudes of long-term treatment. The patient makes developmental use of the long treatment, reliving certain phases of development in the transference. Acquisition of internalized controls may need to occur in this way before the

patient is even ready to utilize interpretations. The extreme difficulties in convincing insurance companies and other third parties to support the long-term psychotherapy of the borderline patient remains one of the most serious practical problems in the treatment of such patients.

As with the schizophrenic patient in psychotherapy, Fromm-Reichmann (1950) was correct when she said that the patient needs an experience, not an explanation. Therefore, I do not think that interpretation in the early phases of the treatment of the borderline patient is as important as do those authors who feel an imperative to interpret projections in the transference at once and also to interpret idealization as a defense against rage. I think most of the early phase of treatment, besides allowing the self-cohering effect of the holding environment to take over, should be devoted to the identification of conflicts

and a minute study of the day-to-day production and disappearance of rages, a phenomenological investigation, along with the experience on the part of the patient that these rages do not bring retaliation or separation. Focus is on the crucial borderline problem, the patient's inability to work cooperatively with another person.

As the patient in a holding environment slowly builds tension- reduction capacities through internalization, the psychoanalysis begins to resemble more and more a classical treatment, the transferences become less archaic, and the patient is more ready and more amenable to proper interpretation and genetic reconstruction. But early interpretations and genetic reconstructions strike the highly tense and upset patient, who is struggling desperately with impulse control, as an unempathic lack of understanding of where the patient is at, and generate a rage on that basis

alone. The danger is then subsequently to interpret that rage as due to the projection of an 'all-bad' object representation.

My (1985a) approach to the borderline patient and the narcissistic patient, especially in the earlier phases of the treatment, is closer to the work of the self psychologists; the primordial meaning of the psychoanalytic situation lies in the reverberations of it for the preoedipal child in the patient. But after one has worked through the narcissistic transferences and oedipal material begins to appear, the treatment is not over. Rather, the stage has now been properly set for a traditional analysis. After the archaic transferences have been worked through and a reasonably firm tension-regulation system has been established so the patient can tolerate the development of more traditional transferences and the frustrations and tensions that the rule of

abstinence entails, the treatment becomes more akin to a standard psychoanalytic therapy, and may need to go on for some further time.

## **Countertransference**

The problem of how much gratification to give a patient in psychoanalytic therapy is a very thorny one indeed. There are some situations in which the archaic transference demands become so overwhelming that the therapy cannot go on unless something is done. When this repeatedly happens, it is often an indication that the patient cannot tolerate uncovering psychotherapy, or, that the therapist is doing something wrong. Some therapists are so concerned about avoiding gratification of the patient that they create a cold and sterile ambience in the treatment, which leads the patient to withdraw into an iatrogenic narcissistic neurosis. This is not a borderline

condition.

The archaic transference is marked in preoedipal disorders by an intense and overt demand for gratification, making the therapist feel almost like a prisoner and forced away from the analytic analyzing attitude. Refusal to comply is often followed by seriously disruptive rage and chaos. Adler (1980) points out that the hallmark of the borderline patient's transference is the rapid disintegration of the selfobject transference as soon as gratification is not forthcoming; he recommends the use of one's best judgment about how much deprivation is tolerable in such situations. Instability is indeed an important hallmark of the archaic transference and it poses extremely difficult problems for the therapist.

Basically I function as an auxiliary ego microscope, and I hope the patient's ego will

eventually learn to focus on herself. At the same time I provide an ambience or holding environment with structure for the patient to facilitate tension-reduction. It is extremely rare that I have had to hospitalize a borderline patient, and when that has occurred, it has often been only for a brief 'cooling off' period. It is inadvisable to hospitalize borderline patients unless it is absolutely necessary for the safety of either the patient or those around the patient, because it is all too common for a vicious cycle to be set up in which the patient is going in and out of the hospital every time there is a disruption. Although some must be treated in the hospital, a great many borderline patients can be successfully treated without recourse to hospitalization at all and usually with little medication.

Therapist-patient disasters and the kinds of lurid situations that become trumpeted in the



popular press or in malpractice suits occur during attempts to treat borderline patients by therapists who have not properly resolved their own personal difficulties. The borderline patient has an uncanny ability to spot these difficulties and to utilize them in the service of acting out, just as they do with everybody else in their environment. Once this has occurred between a therapist and a patient it makes subsequent treatment much more difficult. Therapists should not take on many of these patients at one time as they constitute a serious drain on the psychological resources of the therapist; similarly, if the therapist is suffering some personal problem such as a recent bereavement or illness, and so forth, this is a very bad time to take on the treatment of borderline patients.

Gunther (1976), utilizing self psychology, explains countertransference phenomena as

aimed at restoring narcissistic equilibrium in the therapist, which is endangered especially in preoedipal cases by raging archaic demands from the patient. When a countertransference problem is severe, there are at least three alternatives. The first is to keep one's therapeutic interventions and activity at a minimum for a short period of time, while busily working through countertransference problems in self-analysis. It is never a good time to make interpretations or therapeutic interventions when one is anxious, because they will almost invariably be meant to allay one's own anxiety.

If the therapist feels chronically anxious with a patient, the therapist should seek help from a colleague. Many cases of personal disaster, suicide, sexual acting out, failure, and stalemate in psychotherapy could have been prevented by consultation when countertransference persisted. If consultation does not suffice, the third and most

courageous alternative when severe countertransference appears is for the therapist to re-enter personal analysis.

The borderline personality disorder remains a tremendous challenge to our theories of therapy and our actual clinical practice and it is in the fiery crucible of working with such patients that the therapist becomes most painfully acquainted with his or her own deficiencies. Countertransference is ubiquitous and only interferes in psychotherapy when it is not correctly recognized and handled. The aim of the therapy of the therapist is not to remove all countertransference reactions but to make the therapist capable of becoming more quickly aware of these reactions and deal with them appropriately and maturely. Countertransference, if studied objectively, can lead to further important information and data about the patient. Psychoanalytic treatment of

borderline patients is long, tedious, and requires the willingness patiently to catalyze the patient's resumed development while enduring periodic unpleasant disruptions.

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 28: 91-105, 1997. Reprinted by permission.

## **Malignant Eroticized Countertransference**

In a seminal paper Blum (1973) differentiated between the erotic transference which is ego-dystonic and which the patient realizes is not reasonable, and the erotized transference in which the patient is flooded with erotic preoccupations and fantasies about the analyst and hopes fervently that the analyst shares them. Preenatal factors may actually dominate but the patient resists interpretation and wishes to enact urgently the gratification of sexual desires with the analyst. Blum insists this phenomenon is not always pregenital or uninterpretable and he correctly points out that there has often been sexual

seduction and overstimulation in the childhood of such patients. Erotized transferences have multiple determinants and a variable course.

### **Some Definitions**

In this chapter I wish to focus on the obverse of the erotized transference, that I will label the malignant eroticized countertransference. I am using the term countertransference in its most general sense, namely to represent any sort of reaction that the analyst has to the patient, whether it is a reaction to the patient's transference or to any other aspects of the patient that stir up nuclear conflicts in the analyst. This sort of eroticized countertransference is malignant because it has the potential for destroying the therapy, harming the patient's life, and destroying the career and harming the life of the analyst. The terms 'erotized' and 'eroticized' are used

interchangeably in the psychoanalytic literature, and I have chosen 'eroticized' here to arbitrarily emphasize that this phenomenon is not primarily one of sexual lust but rather represents the sexualization of serious psychopathology in the analyst.

The mark of malignant eroticized countertransference, of course, is that it often leads to sexual enactment, usually described under the rubric of boundary crossing in the psychoanalytic or psychotherapeutic situation. It does not have to lead to actual sexual enactment, but even if it does not it destroys the therapy and seriously interferes with the life of the analyst. Boundaries in psychoanalytic practice constitute the well-known analytic frame, a vital aspect of the treatment. It is the sole responsibility of the analyst to produce and maintain this frame. Gabbard and Lester (1996) describe the analyst's

role as:

...relative restraint; an avoidance of excessive self-disclosure; a regularity and predictability of sessions; a devotion to understanding the patient; a generally nonjudgmental attitude; an acknowledgment of complexity in motives, wishes, and needs; a sense of courtesy and respect for the patient; and a willingness to put one's own desires aside in the service of a greater understanding of the patient, (p. 54)

The purpose of analytic boundaries is to emphasize that it is not the function of the analyst to gratify the patient's wishes and needs but rather to catalyze the patient's emotional development and maturation and help the patient make sense out of his or her past experience. It is when the analyst attempts deliberate corrective experiences or tries to gratify the patient and/or him- or herself directly that a serious potential for boundary violations occurs.



Although minor boundary crossings inevitably take place at times, if these are noted and discussed they do not become violations. Enactments which are repetitive and unresponsive to the analyst's own self-analytic efforts and are not discussed in the therapy often are the introduction to a boundary violation. In my experience it is much easier to get into boundary violations than to get out of them; it is when the analyst attempts to remove himself or herself from the enactment that the patient's rage surfaces and malpractice litigation as well as reports to ethics and licensure committees may result.

It is the thesis of this chapter that the enactment or boundary crossing based on malignant eroticized countertransference represents serious psychopathology in the analyst. All psychoanalysts and psychotherapists experience transient erotic countertransference

and this is normal and even useful in the treatment situation if it is properly analyzed and understood; but the experience of malignant eroticized countertransference is not normal and is a cardinal indication for reanalysis of the analyst.

### **Clinical Vignette**

Balint (1953) points out in his discussion of 'genital love' that there are three common dangers for a weak ego. These are psychoses, either in a transitory state, in an acute anxiety state, or chronic as in paranoia; intoxication, involving alcohol or other chemical addictions; and falling in love:

All the poets since the beginning of time have known that these three are closely related, and have often spoken of love as mad or intoxicating. The psychological basis of the similarity is the danger of the breakdown of the ego structure, (p. 137)

For a long time in my (1983c, 1996a) writings I suggested that malignant eroticized countertransference could be kept in check by the simple shibboleth 'do not do what you would not have known', borrowed from Benjamin Franklin, but it now appears that suggestion was inadequate. Consider for example the following almost unbelievable (to me) vignette: Dr. A. was a patient in analysis with me for a number of years. A derivative of her core fantasy was that eventually I would realize how wonderful she was and divorce my wife, marry her, and take care of her for the rest of her life, a fantasy that has been reported (Gabbard 1995b) as not unusual in the analysis of mental health professionals. She had a close friend, Dr. B., who was in analysis with an elderly well-known senior male psychoanalyst from a local psychoanalytic institute. Dr. A. and Dr. B. were both women candidates at a different local

psychoanalytic institute and were well known to their friends and colleagues. At one point in her analysis Dr. A. began to show considerable signs of resistance, irritability, and confusion. She began dropping comments about what was going on between Dr. B. and the senior psychoanalyst, behavior that did not seem proper. Without going into the details, suffice it to say that eventually Dr. B. began appearing at public gatherings with her analyst, including parties that were given jointly by colleagues from both psychoanalytic institutes. Dr. A. eventually reported that the psychoanalyst's wife had died and not long after that he began making overtures to Dr. B.; they became lovers and a public and inseparable couple. Nobody from either of the psychoanalytic institutes, even those who were at these parties and knew all about this, ever made any complaints. The effect of this on Dr. A.'s psychoanalysis can be imagined.

So it turns out there are two kinds of enactments that are the consequence of malignant eroticized countertransference. One type occurs surreptitiously, in which the analyst does not wish anyone to know about it and keeps it hidden as much as possible. The other type occurs as if it were a perfectly natural phenomenon and the analyst has no compunction about who does or does not know. I hasten to add that malignant eroticized countertransference certainly occurs in female analysts and therapists, although it seems to occur less frequently.

This whole matter poses an important social problem and requires our serious consideration. In my judgment, based on the reanalysis of five therapists or analysts who have been involved in enactments as a consequence of malignant eroticized countertransference, some of these individuals should undergo reanalysis and careful

supervision of their patient work rather than automatic punishment and extrusion from the profession. A typical problem I have encountered is that when these ethical violations are judged to have occurred after a hearing, the license of the therapist is suspended so he or she can no longer make a living and afford the very reanalysis that he or she needs even if willing to undergo reanalysis. It is inhumane to throw one of our colleagues out of the profession automatically because that individual has serious psychopathology; it would be more consistent with our psychoanalytic orientation and understanding of psychodynamics carefully to work out individualized therapeutic strategies for dealing with these situations if rehabilitation seems feasible.

### **View from Self Psychology**

The psychodynamics of malignant eroticized countertransference involve serious pregenital and oedipal problems. For example, it could be thought of as forming a sort of perversion. Goldberg (1995) points out that the perversions involve three features: (a) what he calls 'sexualization', (b) a splitting of the psyche, and (c) certain specific psychodynamics. The patients suffer from what Goldberg labels as a structural defect in both the idealization and grandiosity poles of the self, as well as from the developmental result of a vertical split of the self allowing for the coexistence of perverse activity and a reality self. He points out that perversions are commonly used to counteract the anguish of the feeling of hollowness experienced by persons with an empty depleted self. So one might view the elderly psychoanalyst mentioned in the vignette above as engaging in pathological mourning for the death of

his wife.

The lives of some of these individuals are continuously dominated by this sexualization, says Goldberg, in order to prevent further regressive fragmentation; for others sexualization occurs intermittently and is secondary to the temporary unavailability of selfobjects. Sexualization forestalls further regression, gives pleasure in mastery, and of course sexual pleasure, but sexualization is to be differentiated from mature sexual activity just as I have in this chapter tried to differentiate malignant eroticism from ordinary fleeting erotic sensations experienced by all of us. Those with perversions may or may not, at times when selfobjects are available and their self is cohesive, engage in mature sexual activity, while regressing to sexualization at other times as a consequence of narcissistic wounding, bereavement, disappointment in selfobjects, and



so forth.

I wrote and presented a play in 1994 at the annual meeting of the American Psychiatric Association illustrating the fragmentation of an aging psychiatrist as he was repeatedly disappointed in selfobjects (Chessick 1999b). The first stage of this disintegration manifested itself in sexual activities with a patient. Goldberg (1995) refers to 'lovesickness', the sudden deep 'head over heels' falling in love that can even reach delusional proportions, as a form of sexualization used in order to handle narcissistic injury. The point is that according to self psychologists it is a form of tension-regulation and does not have to have specific Freudian conflict psychodynamics; it is an attempt to restore narcissistic equilibrium and reveals the depth of despair of the hollow depleted self. Under the influence of treatment, when sexualization fades the narcissistic rage

appears, and the patient may have no interest in even ordinary sexual activity. Regardless of whether one agrees with or even comprehends the self psychology concepts involved, there is a solid common sense about this approach and it certainly fits my clinical experience. The patient's structural defect is temporarily filled by others and sexualization surges up when these vital others are lost. In this way lovesickness belongs with the perversions; the urgency of the search for someone to love reveals the depths of one's despair at confronting their empty depleted self.

The narcissistic disorder aspect of this is obvious. There is often a split-off or a disavowed sector of the behavioral enactment in a way as if it were done by another person. Goldberg says the patient is ashamed of it, but the above vignette shows this not always to be true. In these patients the vertical split of the self allows the coexistence

of the perversion and the reality self and, as Goldberg says and consistent with my own clinical experience, eroticism often follows the failure of an idealized selfobject or the loss of it. But notice that the traditional psychoanalytic concepts of the Oedipus complex, castration anxiety, introjects, object relations enactments, and hostility are downplayed in this self psychological approach.

### **Other Psychodynamic Descriptions**

Some authors (Hirsch 1996; Renik 1993b, 1996) believe that a transference-countertransference enactment, or series of these, is required and always goes on in psychoanalysis. Awareness of it comes afterwards and Renik thinks that the analyst's conscience is the key to limiting this kind of enactment. Here we must differentiate between transference-countertransference enactment which the analyst

is unaware of until it is actually going on and then takes steps involving self-analysis to limit and interpret it to the patient rather than continue it, and the enactment that is produced by malignant eroticized countertransference, which is sometimes held in a vertical split but takes place deliberately or due to loss of control. Gabbard and Lester (1996) similarly distinguish between 'boundary crossings' and 'boundary violations'.

Kernberg (1995) identifies three situations commonly found to generate countertransference love: (1) a male analyst is treating a masochistic woman; (2) both the patient and analyst are engaged in a mutually narcissistic process; (3) a woman analyst who is masochistic is dealing with a narcissistic seductive male patient. Kernberg, as might be expected, stresses the hidden aggressive aspects of countertransference love. He claims that the idealization of the loved other is a

projection of the ego ideal, and leads to a sublimated realization of Oedipal desires. So for Kernberg as well as for other authors (Gabbard 1989), the enactment of malignant eroticized countertransference is highly ambivalent and carries a powerful aggressive component.

For Gabbard (1996a), eroticized (what I call eroticized) countertransference represents the analyst functioning in a paranoid-schizoid mode. The patient becomes a projected idealized object who will rescue the therapist from despair, and the 'as-if' character of the countertransference is lost. The analyst's wish to be the only one for the patient is predominant and the patient's erotic longings are irresistible for the needy and beleaguered analyst. Sometimes the analyst loses his or her bearings under the patient's expressions of love and lust when exposed to the patient's overly instinctualized transferences, which

actually have unconscious aggressive underpinnings linked to the desire to harm and degrade the analyst. Gabbard argues that the undoing of humiliation that the patient suffered in childhood is a crucial issue, especially with a male analyst and a female patient, and he claims that termination is a special time of risk for sexualized countertransference enactments. Gabbard correctly emphasizes the collapse of the analytic space in all these situations that leads to the paranoid-schizoid mode in which action is substituted for understanding and articulation.

When, as in Kernberg's third situation mentioned above, a female analyst is sexually excited by a non-conforming male patient, there exists a masochistic problem in the analyst and there is an undercurrent of contempt and sadomasochistic excitement in the enactment of the malignant eroticized countertransference. For

example, a female therapist may attempt to rescue a male patient:

In such scenarios, the patient tends to be a young man with a personality disorder diagnosis characterized by impulsivity, action orientation, and substance abuse. Despite these characterological symptoms, however, the young man usually possesses considerable interpersonal charm and may have a knack for engaging females in a treatment capacity. A female clinician is often drawn to such men with an unconscious fantasy that her love and attention will somehow influence this essentially decent young man to give up his wayward tendencies. (Gabbard 1994, p. 131)

This situation, a common one in movies and novels, inevitably leads to disaster.

In an earlier work Gabbard (1989) describes the 'lovesick' therapist, a middle-aged man with a female patient who is about sixteen years younger. The lovesick therapist is tormented by intrusive

thoughts about the patient and feels that their relationship is so special it transcends ordinary professional and ethical rules. He is in a drugged or dream-like state when he is with the patient—another way of describing the vertical split—and so he takes extraordinary risks and tries to heal the patient's torment directly. The therapist here is a well functioning narcissist who gets into a mid-life crisis and regresses to blurred ego boundaries often only with this patient, working well with his other patients. This is important information in support of my suggestion above that perhaps some therapists who get into this kind of trouble should be allowed to continue their profession with reanalysis and under close supervision rather than summarily have their license suspended. Gabbard claims that the sadistic wish to destroy forms the perverse core of the enactment of malignant eroticized



countertransference, and this distinguishes it from normal lovesickness. He maintains that the patient at the same time is defending against hatred when she becomes involved sexually with the therapist. The therapist's unsatisfactory marriage is often a problem that precipitates these difficulties.

I do not agree with these claims of a sadistic perverse core in the therapist and a hatred of men in the patient when sexual enactment occurs if they are meant to apply to every instance. Other psychodynamics may be involved that are sometimes more crucial and central, and each situation deserves careful evaluation free of prior assumptions about what has to be at the core. For example, Bollas (1994) discusses one important variant of eroticism of a transference that exerts a greatly pressured bid from the patient for actual re-enactment so as to end unbearable tension. I believe this is an important factor in bringing

about boundary crossing and acting out of malignant eroticized countertransference also; the analyst is under unbearable tension for various reasons and/or has at the time a faulty tension-regulating intrapsychic system. This could even be on the basis of incipient organic damage in an aging psychoanalyst, or it could be part of a long-standing character disorder or other pathology. Various authors (Blum 1994; Coen 1981) have discussed sexualization as a defense against hostility, loss, narcissistic injury, homosexuality, and a feeling of deadness and depression, while simultaneously gratifying oedipal strivings, repeating parental seduction for the purpose of mastery, and using it for the regulation of self-esteem. The analyst and the patient wish for love to cure the wounds that have been inflicted by infantile objects. There is often an element of narcissistic conquest which may disguise the rage

and revenge motives present in both or either the analyst and the patient, but also may provide soothing and gratification of archaic needs.

Eroticized countertransference is rooted in preoedipal psychopathology and should never be confused with mature love. But in my experience, the new couple (analyst and patient) may enjoy intensely gratifying sexual relations. Sometimes the patient is willing and able to perform sexual acts that the analyst never dared to ask from his wife or girlfriends (or husband or boyfriends) in the outside world due to various inhibitions or psychological problems of the analyst. So the patient is sometimes able to give the analyst gratification of archaic needs that for various reasons the analyst was not able to get elsewhere. Patients are extremely sensitive to the needs of the therapist and may be willing to do many things that men or women in ordinary situations might

resist or use to humiliate or embarrass the other person. In my clinical experience there is nothing even nearly as powerful as the sudden gratification of long pent-up archaic needs, and when this happens a powerful bond is formed between the analyst and the patient as an enacting couple. Because of this such bonds may continue for the rest of the life of both! I have known therapists who have divorced their wives and married a patient, living the rest of their life in apparent domestic harmony with the new wife, and I believe this is the reason that such enactments can become stable. In my experience they become unstable when the analyst tries to get out of them for one or another reason; it is at this point there is often an explosion, and destruction looms for both members of the dyad. Similar phenomena take place in the situation between a female analyst and a male patient.

Dahlberg (1970) describes therapists engaged in sexual acting out with patients who were aging depressed men who convinced themselves, perhaps by their patients' fantasies, that they might recapture a real or fancied youth. This is a reality testing issue that indicates a blurring of ego boundaries. Such a blurring indicates there is a more severe pathology behind what appears phenomenologically as a simple depression in an aging individual. The fantasy is of being young, attractive, and having beautiful girls throwing themselves at him without the therapist having to take the chance of being rejected if he makes the first move. Here we have either a schizoid or narcissistic problem, and I have encountered the same problem in female therapists suffering from malignant eroticized countertransference.

## **Deeper Psychodynamics**

It is well known that sexual activity between a patient and a therapist represents a crossing of the incest barrier. There is complete agreement that the responsibility from an ethical point of view clearly and unequivocally always belongs solely to the therapist, who should have been trained to deal with the powerful needs of the patient and the patient's low self-esteem, and who should have had a thorough personal psychoanalysis before attempting to treat others. The release of either strong or inappropriate sexual or aggressive feelings by the therapist in a treatment situation always represents an exploitation of the patient and is for the purpose of servicing the therapist, no matter what theoretical, lovely, or poetic language is used to describe it. Some authors have maintained that the woman patient in this situation rarely reaches sexual orgasm, but the therapists I have had in reanalysis claimed that

both parties received powerful sexual gratification. But when the patient experiences what might be called an 'id assault' from the therapist, intense rage and a sense of violation is stored up which, as previously mentioned, often does not surface until the therapist wishes to terminate the relationship.

As stated above, Gabbard (1989) claims that the lovesick therapist presents a perversion in which the core is the sadistic wish to destroy the female and the patient being exploited is defending against her great rage and hostility towards men, usually generated by an abusing or sadistic father. I believe another factor is present. The patient wants to be 'special' in the most desperate way, out of an intense archaic need for mirroring that is often generated by regression in the transference, or that may be present to some extent in all her relationships as part of a

character disorder. The therapist, on the other hand, because of the narcissistic disequilibrium from which he suffers, wants sadistically enforced control of an archaic selfobject to restore that equilibrium. So the enactment may represent a reversal of roles for a therapist who as a helpless child was sadistically controlled in every aspect of his mental and bodily functions by a narcissistic mother who used him as a selfobject for the purpose of maintaining her own narcissistic equilibrium or, even worse, to prevent a total fragmentation of herself. Here we have a restitutive situation acted out by the therapist at a time, for example, in a middle-age crisis, upon the loss of a spouse, etc., when his or her own self is threatened.

But one must never forget the sexual pleasure involved which, like the use of drugs, can set up a self-reinforcing feedback loop, an artificial 'drive',



both out of the pleasure from the experience and, perhaps more importantly, from the tension-reduction that takes place as a consequence of the orgasm and reassurance of his or her control over the archaic selfobject that is acted out in the sexual encounter.

One way of identifying this factor is that therapists so involved notice an increasing frequency of sexual acting out or drug-taking or alcoholism just at times when for various reasons they are engaged in some tense activity such as giving a paper, finalizing a risky business deal, having trouble with their children, being investigated by the IRS, and so forth. In my experience, when the enactment is stopped for one reason or another, the patient suffers from a profound loss of an important mirroring selfobject function and often the risk of suicide appears (Gabbard 1989). The patient is left with the

possibility of psychic fragmentation and an unbearable narcissistic rage that must be dealt with in some manner. This rage is a secondary phenomenon and should not be confused with the causes of why the patient consented to the sexual activity in the first place.

Schafer (1993) explains that a subtle countertransference 'fanning the flames of the female analysand's desires' (p. 86) might be present in the male analyst who wishes to avoid overt manifestations of hostility and aggression, or for narcissistic reasons, or to avoid recognition of the analysand's maternal transference by heating up the heterosexual transference, or to avoid recognition that one is 'dealing with an analysand who at that time is emotionally dead' (p. 86). The patient's development of intense transference-love could be viewed as blocking access to negative transference, as a desperate effort to feel

something other than deadness, or as offering a bargain in which sexual favors are provided in exchange for gratifying the wish to be held and soothed. The latter situation is often characteristic of borderline patients as I (1977a) have discussed elsewhere, and that is why it is often borderline female patients who get involved in massive enactments of malignant eroticized countertransference with their therapists (Gutheil 1989). The narcissistic and sexual gratification as well as the isolation of the dyad taking part in the enactment (Gutheil 1989), seems to account at least in part for the failure of so many of these therapists to obtain consultation and for the suspension of their critical judgment or, as self psychologists would put it, keeping the enactment disavowed behind the vertical split in a narcissistic personality disorder.

### **Extent of the Pathology**

I believe the literature has been too optimistic about the extent of the pathology found in therapists who have engaged in major boundary violations and too optimistic about their prognosis. My experience in the reanalysis of such therapists has been that they require a long treatment and one that is extremely difficult, although this should not be construed to mean that I do not think that a chance at rehabilitation should be offered. We do not yet have enough detailed reports of the psychoanalysis of psychoanalysts and psychotherapists who have engaged in sexual or other egregious enactments of malignant eroticized countertransference, to have a thorough understanding of this phenomenon. Clearly there is no one underlying deep psychodynamic constellation to boundary violation behavior. It represents a variety of multidetermined factors, like all other

symptomatic and pathologic behavior. The term 'lovesick' bothers me because it does not carry a sufficient pathological implication. There is a certain Gilbert and Sullivan humorous or light-hearted aspect to calling an individual 'lovesick', which I am sure does not belong in a discussion about the enactment of malignant eroticized countertransference. I (1997b) have suggested substituting the term 'pathologically love/lust-obsessed' for this kind of 'lovesickness'.

There are valuable insights from self psychology that could be used to explain how otherwise apparently well functioning psychoanalysts are carried away by uncontrollable waves of lust and/or a pathological obsession with loving a patient (see, for example, Kohut 1982). Lacan's (1978) concept of *objet petit a* also deserves mention in trying to explain this pathological searching; I think this was one of

Lacan's most important contributions to psychoanalysis. Pathologically love/ lust-obsessed analysts always seem to present narcissistic problems including grandiosity as well as sadomasochism, a tendency to action over reflection, and a disturbed superego. Sometimes the therapist attempts to fill a deficit in the patient by some sort of enactment, an attempt often stirred up by life circumstances of the analyst, who may then project his or her own deficit onto the patient or attempt to get gratification of his or her deficit by vicariously filling up something in the patient.

A common rationalization used in those situations when therapists announce that they wish to stop the therapy and become personally involved with the patient is that since the therapy is over, a sexual affair is now reasonable and appropriate. In my opinion, 'once an analyst

always an analyst' for every patient in one's practice. Research has demonstrated a great readiness for the revival of the transference even many years later when one meets one's analyst, and therefore any involvement of a social nature with a previous patient is bound to be contaminated by transference-countertransference configurations. I am convinced that it is a disservice to the patient to ever change roles even after the patient has ceased to be a patient, because the analyst should always be available in the same analytic role for the patient to return to as needed. It is quite common, as in the vignette presented above, for patients to approach analysis with the hope of paving the way for a post-analytic relationship; such hopes must be analyzed and interpreted rather than ever enacted.

This entire subject is politically explosive

because sometimes boundary violations are committed by famous and/or professionally powerful psychiatrists or psychoanalysts, some of whom even consider themselves 'pathfinders' or 'pioneers' and therefore outside the common rules of ethics and proper psychoanalytic practice. There is a history of malignant eroticized countertransference leading to boundary violations that goes back to the beginning of psychoanalysis (Gabbard 1995a) and so the well-known boundary violations of famous analytic pioneers have unfortunately contributed to these legitimacy claims. For example, as a young psychiatrist coming out of military service to my first academic appointment in local psychiatry, my position as chair-person of the training program required me to confront one of the most famous psychoanalysts in the United States with the fact that he was corrupt and engaging in numerous



and repeated boundary violations. This individual ever after left no opportunity unturned to interfere with my career development until his boundary violations became so egregious that he was sued by a group of patients and lost his license to practice. By that time he had subjected me to severe hardship and retaliation for daring to challenge his behavior, a good example of what one is up against when attempting to report such behavior, and perhaps an explanation why everyone in the vignette described at in the beginning of this chapter is turning a blind eye. These days an individual or group of individuals who would make such a confrontation also run the serious risk of litigation.

## **Prevention**

Blum (1986) explains that, 'The analyst has to be able to tolerate and comprehend the patient's

archaic communications. The primary countertransference issue concerns the analyst's anxieties and fear of the regressive pull of archaic fantasy and relatedness' (p. 322). For this reason Blum argues that a capacity for self-analysis ought to be a requirement for the termination of a training analysis. Elsewhere (1990) I have discussed in detail an example of the analyst's ongoing self analysis as it is generated by his or her work with patients.

In our training programs we need to make therapists aware of the serious difficulties they can become involved in if they attempt to do intensive psychotherapy or psychoanalysis without themselves having undergone a thorough training analysis. The dangers of the isolation of the office need to be stressed and much emphasis should be placed on consultation. Those who do consultation and supervision need to be instructed

to be extremely careful not to inflict narcissistic wounding on the supervisee or individual seeking consultation because when this has happened once or twice no further supervision or consultation will be sought. Because an individual is an excellent clinical psychoanalyst it does not follow that that individual will be an excellent supervisor, and the converse is also correct. Furthermore, there are certain productive personality 'fits' between supervisor and trainee or consultant and consultee that are optimal, and the supervisor or consultant should recognize when a productive 'fit' has not taken place and refer the individual elsewhere without inflicting humiliation. In this unfortunate era, when psychiatric training programs no longer stress psychotherapy, trainees are often not even instructed about the problems of transference and countertransference; as far as I am concerned this

is a scandal. Even convinced psychopharmacologists can get involved in malignant eroticized countertransference. For all of us, as Gabbard (1996a) says, 'Colleagues must also be willing to sit down and talk with the therapist who raises concerns, long before a complaint comes to the ethics committee or licensing board' (p. 320).

## Summary

Gabbard (1994) divided the pathology of therapists, both male and female, who commit sexual boundary violations into those who are psychotic, those who are predatory psychopaths, those engaging in masochistic surrender, and those called 'the lovesick therapist'. Lovesick therapists are the most common type and manifest crucial narcissistic themes of 'a desperate need for validation by their patients, a hunger to be loved

and idealized, and a tendency to use patients to regulate their own self-esteem' (p. 127). Among the psychodynamic aspects of this curiously circumscribed area of loss of reality testing that makes it difficult for the therapist to see how self-destructive and harmful such enactment is, are an unconscious re-enactment of incestuous longings, a misperception of the patient's wish for maternal nurturance as a sexual overture, enactments of rescue fantasies, a projected idealization of the self of the therapist, a confusion of the therapist's needs with the patient's needs, a fantasy that love is curative, acting out disavowed rage at the patient, or rage at an organization, an institute, or one's training analyst, a manic defense against mourning, a narcissistic fantasy that their sexual affair is an exception, insecurity regarding masculine identity, and assorted primitive preoedipal themes.

Gabbard's (1991) eroticized countertransference is one variety of what I have termed malignant eroticized countertransference. His variety is a development that occurs under the pressure of the patient's pre-emptive and compelling expressions of lust and love, the patient's erotic transference. But malignant eroticized countertransference can also occur without the patient having offered any such expressions; it can even occur upon first meeting the patient when he or she walks into the office! This is akin to the romantic 'love at first sight' theme so favored in the movies and by novelists, but it is always pathological when it occurs in the therapeutic situation. Countertransference enactments are a creation between the patient and the therapist on a continuum from one pole, where the patient has just walked into the office and contributes almost nothing directly, to the other

pole, where the therapist loses control of himself or herself as a response to the unbearable pressure of the patient's lust.

In the treatment of malignant eroticized countertransference it seems clear from this discussion that every case should be evaluated psychodynamically and the treatment should be made to fit the patient, not the patient to the treatment. Each situation should be studied in psychodynamic depth without preconceptions based on generalizations or formulas. Therapists who are psychotic should of course be treated with antipsychotic drugs and usually should not be allowed to practice any further. Therapists who are psychopathic or sociopathic predators should certainly never be allowed to practice. Some of the individuals who are 'lovesick' or, as I put it 'love/lust obsessed', or those who have made a masochistic surrender to a sadistic destructive

patient, are in need of reanalysis and have the potential to continue as effective therapists under careful supervision. Therapists like this do not deserve to be summarily dismissed from the profession but, like therapists who develop other serious neurotic problems, should receive appropriate help from us.

### *Note*

Originally published in the *American Academy of Psychoanalysis* 25: 219-36, 1997. Reprinted by permission.



## In the Clutches of the Devil

### Preface

From my parental home I brought only precious memories, for no memories are more precious to a man than those of his earliest childhood and his parental home, and that is almost always so, as long as there is even a little bit of love and unity in the family. But from a very bad family, too, one can keep precious memories, if only one's soul knows how to seek out what is precious ... (Dostoevsky 1991, p. 20)

Two of Nietzsche's most important ideas are found in *The Brothers Karamazov* (Dostoevsky 1991). The doctrine of the eternal return of the same (p. 644) and the notion that if God is dead everything is permitted (p. 589, p. 649) are

introduced in Dostoevsky's great novel. Ivan's dialogue with a projection of him experienced as the devil marks Dostoevsky as one of the world's great psychologists. This chapter is an imaginary twentieth-century version of this, a preface to the development of 'brain fever' that led Ivan to his eventual hallucinatory psychosis and that will similarly be depicted in the play about 'Barry' that constitutes this chapter (for details about my imaginary 'Barry' see Chessick 1999b). From Barry's diary:

As you were preparing to leave this afternoon I noticed that tears were coming to my eyes—in fact I almost started to cry. I was not sure what was producing these tears, for after all you would only be gone for the late afternoon and the evening, and it was an event that had happened before for good reasons. I did not give it much thought then but only whined to myself and wondered how I would be nurtured and taken

care of for the rest of the day.

You simply laughed and indicated that I would have to take care of myself, but there was a twinge of guilt in your voice, and at the end with a mournful countenance you looked askance and wondered whether you should come back at the dinner hour. Of course at that time my guilt overrode any of my other feelings and I scoffed at the idea and wished you a good trip. At the same time I recalled with a shudder how Schreber's psychosis centered on his relationship to his wife. Freud (1911) writes about Schreber, who considered himself 'a plaything of the devil':

The patient had a fresh 'nervous collapse', which exercised a decisive effect upon the course of his illness, at a time when his wife was taking a short holiday on account of her own health. Up till then she had spent several hours with him every day and had taken her mid-day meal with him. But when she returned after an absence of four days, she found him most sadly altered: so much

so, indeed, that he himself no longer wished to see her. 'What especially determined my mental breakdown was a particular night, during which I had a quite extraordinary number of emissions—quite half a dozen, all in that one night.' (p. 45)

Much later on in the evening, after I had finished reading the new translation of *The Brothers Karamazov*, I found myself wandering back to the thoughts of the afternoon and I realized with almost a jolt that you were the last person living that had any emotional investment in me. One by one a parade of individuals who had a deep emotional significance in my life has disappeared into their graves or been cremated and scattered to the wind, leaving you as the only survivor of that small but intensely important aggregate. This gave me the first clue as to why it was so difficult for us to be parted even for a short time.

For with that parting came utter nothingness (see Chessick 1996d) and for the first time I experienced

what it was like to be unrelated to everything and everybody. This is the closest to the despair of the psychotic that I have ever been able to come and the first glimpse of what it is like to be so utterly alone that one is willing to die. Surely it is this gradually encroaching aloneness which causes people to become more and more self-preoccupied in their old age and disenchanted with life. So Kohut (1977) was right when he said that one needs an empathic matrix from the beginning to the end of life. He did not explain, however, how one was to develop and maintain such a matrix if one's emotional investments were focused only on a certain group of individuals and the members of that group were gradually disappearing. It takes an unusual talent to be able to keep replenishing such a group as one gets older, and I have my doubts whether it is possible to do this if one does not have the innate talent.

Finally, I glimpsed what it would be like if you also were to disappear. For all through this afternoon and

evening there has been a tomb-like silence and it is indeed like a living death, or an immersion in a sensory deprivation tank, an experiment, in which the soul involutes into itself and gradually withers and dies so that one is left with a horrible sense of negativity. What is most painful and deafening of all is the silence, the utter silence that is perpetually around one in such a situation, to such an extent that one loses hope it will ever end. Is this not the conscious experience of what it is like to be dead? Remove the consciousness and it is all the same.

And yet with this clinging, and in spite of your being the one slender thread that keeps me from this perpetual living death, I will even betray you. For, as Dostoevsky points out in his novel, the soul of man is an incongruous combination of lofty ideals and aspirations and the most base impulsive desires which rattle his head perpetually. There is a situation where the intensity becomes so overwhelming and the temptation becomes so unbearable

that all reality testing is swept away and temporarily there is a greedy leap upon the opportunity for the sudden discharge of long dammed up emotional tensions and infantile desires. When this moment offers itself, everything and everybody becomes betrayed. Here we have the secret of Lord Action's famous maxim that power corrupts and absolute power corrupts absolutely, for the more power one has, the more likely one will be able to set up those remarkable situations for one's self. When that happens, God is dead and everything is permitted! So Dimitri is obsessed by his need for Grushenka, and I can understand this, and I can understand why even parricide becomes a distinct possibility in his mind in that situation.

Of course, all this was written before Freud, but Freud's explanation that it is simply another version of the Oedipus complex is wrong because it is too superficial. It is really a preoedipal phenomenon which goes to the very roots of the yearning for the

attachment, the intense emotional relationship with the mother that forms the very core of one's sense of being alive, to say nothing of one's sense of hopefulness and trust in the future and in other people. When that archaic yearning bursts forth, even as it often does in a sexual disguise, everything threatens to be carried away before it. Yet to give in to such a yearning runs the danger of destroying the very thread that one has to adult life, and so we have the terrible paradox. of human existence which nobody has ever been able to resolve.

The affectionate and the sensual currents rarely stay together in the longing for one person, and soon after even the best of relationships the sensual current threatens to break out and be displaced to another because it carries with it the displaced sadism and the inevitable disappointment in the discovery that the other person can never be a perfect selfobject. When an individual comes along who offers to be the container for that combination of the sensual current and the



displaced sadistic drives, the temptation can be overwhelming to take advantage of the opportunity. So what we have here is an additional insightful discovery that these betrayals are not simply the expression of frustrated sexual desire or of lovesickness or of the need for a selfobject more perfect than the one that one has, but also represent the vehicle of discharge for the polymorphous perverse infantile wishes and the sadistic or aggressive accumulation from the original relationships with the mother and the wife.

We are left then with a final paradox: if the slender thread that you represent is cut, regardless of the reason for it, there is nothing but eternal silence and a living death before one. At the same time the tremendous tensions which accumulate must be discharged in some fashion, and that method of discharge, as in Dostoevsky's Dimitri, threatens to destroy the very empathic matrix that one must have to stay alive. This is the tragedy of the Karamazovs, and of any persons who

are constituted like them. This is what my brother-in-law Edward meant when he said, 'I cannot live without her', abandoning his wife and children for another woman.

What must he be thinking as he withers away from amyotrophic lateral sclerosis? His was a life of pure hedonism, with the instantaneous discharge of every impulse encouraged and fostered by the parental value system. And in front of his eyes he watches this pleasure instrument, the body, wither and shrivel up as if some god-delivered curse had come down upon him! But this is only my projection onto him, for it assumes a superego at war with an id, which was not at all his state, since the superego in his situation was utterly corrupt. The notion of eternal damnation and god-sent punishments, although it is at the center of the Old Testament, and he is Jewish, has no meaning for someone like this. It is far more appropriate to a Russian Orthodox Catholic like Dostoevsky.

Indeed we have a Dostoevsky novella in the story of Edward and his adventures with his parents and his wives. In fact, if the truth were written everyone would say this is simply another novella produced in an imitation of Dostoevsky, or perhaps Balzac! A symbiosis is established through the use of money which keeps the child perpetually dependent and yet enhances a myth that he is a superman. So he lives out the fantasy of the parents until he can stand it no longer; he abandons two families, each of which have generated children, and suddenly breaks out of the matrix in which he has been embedded until he is about 58 years old. No sooner does he break out of this matrix than he is struck down with a terminal illness that probably occurred as a result of a violent period of intense sexual promiscuity that took place between his last divorce and his last marriage. The whole thing degenerates into a bitter squabble over money very similar to the battle between Dimitri and his father. Indeed, if there were a Smerdyakov, Edward

would employ him to destroy his father; in Smerdyakov's place is his new wife's dangerous gangster family.

So it is in an effort to understand this tremendous reluctance to be separated from you that I get a glimpse of living death unrelieved by any sort of hope or fantasy. Here is generated the temptation for what Kohut (1977) called the depressive use of pornography to maintain some kind of feeling of self-cohesion, but it is like pouring water into a sieve. ... How strange it is that one can identify with a baby and at the same time project into the baby one's own deep depression and sadness and despair! What is most extraordinary about our postmodern situation is that one is faced either with an utter lack of hope for the future or with the option of destroying everything by unbridled hedonism—a big green pleasure machine (The Graduate)—which leads in the end to the same result. In my kind of life only an intense looking inward, a searching of the soul in every respect with ferocious honesty, can set up a double, a

self-created but tormenting selfobject matrix like Ivan and his devil (or Luther and his devil). A psychotherapist could then project this onto his or her discourse partner, a patient, and, 'falling in love', lock into a sadomasochistic destruction. The eventual result can be worse than Siberia. But I'm sure that would never happen to me -

### **In the Clutches of the Devil**

This dramatic presentation, first enacted at the 1987 annual meeting of the American Psychiatric Association and repeatedly at various professional meetings thereafter, attempts to address some of the important questions raised by Gartrell et al. (1986) and Herman et al. (1987) in their recent articles on psychiatrist-patient sexual contact. It consists of a short and preliminary attempt to weave together the themes of cultural pressures, individual life pressures, and personal

psychopathology impinging on a psychiatrist, all leading to his ultimate fragmentation in middle age. Because of his inferior training and lack of personal psychoanalysis, the psychiatrist in this clinical example is unprepared and unable to cope with these disintegrating forces, and succumbs to using the patient to treat himself. It also illustrates the phenomenological approach, letting the facts speak for themselves without classifications and formulations, in an effort to generate a more genuine encounter with the patient (here the psychiatrist). This, it is hoped, will lead to treatment in these situations, rather than simply condemnation and punishment for what is clearly an ethical violation.

*[The setting: a typical medical case conference room with a podium at the front, considerably toward the left of the audience. A blackboard and perhaps one or two x-ray viewing boxes in the background. Dr. Richard D. Chessick walks on stage and stands behind the podium when*

*all is ready to begin, casually carrying some notes and a plastic drinking cup, which he places on the podium. He is nondescript and uninteresting, with a vaguely scholarly look, dressed in a quite ordinary business suit, He is somewhat aging and needs a haircut.)*

Dr. Richard Chessick: Good morning ladies and gentlemen. Today's psychiatry department grand rounds will be devoted to a case presentation. I am happy to introduce to you my distinguished cousin, Dr. Barry Chessick, who is also a psychiatrist and practices in California. Barry has worked considerably over the past twenty years with borderline patients and you may have read some of his publications in various journals. He is here on a family visit and has most kindly accepted my invitation to give a case presentation of a borderline individual to our group this morning. I think we will find the case to be of great practical interest, since these patients are so common and pose great therapeutic difficulties and countertransference problems (Chessick 1977a, 1982b, 1983c, 1985a).

*[Barry Chessick takes the podium. He is a dignified middle-aged man, quite well groomed and clearly more tanned and*

*attractive than his cousin, but his body shows the middle-age process clearly. He is dressed in a better fitting suit with polished shoes. His suit is attractive and appropriate, but it does not look very expensive or rich: he is rather a middle-class doctor whose financial success is not loudly stamped on his appearance. He begins speaking very clearly and professionally, at first using the notes on the podium.)*

Dr. Barry Chessick: Thank you very much Richard (*looks toward his cousin and smiles*) for inviting me to present a case to your group today. The patient I will describe and discuss is an attractive 35-year-old white married Catholic woman who is clearly a borderline personality disorder by *DSM-III-R* standards. I treated her for the past four years using multiple doses of Xanax (alprazolam) as recommended by Faltus (1984), along with supportive psychotherapy. The treatment has been very successful. This new approach in my opinion will soon obviate the need for intensive, extensive, and expensive psychoanalytic treatment of such patients, and represents one of the newest and best approaches in eclectic psychiatry, combining



psychopharmacology with commonsense down-to-earth psychotherapy—surely the cost-effective optimum in modern psychiatric practice.

The patient consulted me about four years ago, complaining that her husband 'did not hold her properly'. She described him as an awkward man with few social skills, and generally a grating and unpleasant person. He changed jobs frequently, but he was always able to make a living and they had been allied in an uneasy marriage for about five years at the time I first met her. She reported that she was frigid and did not like to have sexual intercourse with her husband at all; he was the only sexual partner she ever had. She was subject to rages, especially at him, but also at other family members. Her self-esteem was very low, and she considered herself a failure and inferior to the other people in her social and occupational environment. She had a lot of trouble making and keeping friends and was extremely uncomfortable in social situations, especially if she was the hostess. This discomfort was made worse by the fact that her husband was not supportive in these affairs and often left the entertaining up to

her. The patient gave no history of taking any drugs or of excessive use of alcohol; she was in excellent physical condition and quite intelligent, young, nubile, and vigorous.

There was little of significance revealed by the mental status examination. She was quite tense and anxious. She conducted herself properly, her thought associations were intact, and her emotions, although strong and passionate when they flared up, were appropriate. She did not seem clinically depressed and there was no evidence of suicidal ideation, but she was certainly a chronically unhappy person deeply distressed with the course of her life. She no longer paid attention to the Catholic religion and went to church only on holidays.

She described her mother as cold and distant, a very preoccupied woman who apparently only had children because it was the thing to do. She has one brother three years younger who suffers from severe incapacitating migraine headaches, and an alcoholic four years younger sister. She rarely sees her family and when she does she dreads it for weeks before they visit. Her father was always a teaser and practical joker; her first

memory is of him waking her up in the morning when it was time for school by pulling off the covers of her bed and pinching her naked buttocks (*pauses*) ... her naked buttocks [*pauses*].

*(He looks to his left a couple of times as if something is disturbing him from that direction. He looks again to his left and whispers loudly, in a stage whisper:)*

Stop it! Stop it!

*(He appears rattled, but he turns back to the audience and continues, although somewhat less professionally.)*

I began seeing her two times a week for supportive and counselling psychotherapy and started her on Xanax 0.5 milligrams t.i.d. at once. She soon showed a remarkable improvement. In fact, before my very eyes over the next year or two she blossomed like a lovely rose into a beautiful woman; a stunning transformation, almost magical.

*(He looks again to his left as if disturbed, and speaks now out loud.)*

Could I help that? Stop it!

*(He looks back to the front.)*

Excuse me. She came to her sessions regularly and as the months passed into years she began discussing her sexual frustration and her growing sense of sexual desire. She said she wanted to be held by someone other than her husband, someone strong and confident. She longed to dance, to feel her body swaying in the firm calm arms of another, to feel his weight on her, soothing her, calming her, protecting her.

*(He looks to his left and says:)*

What could I do? What could I do?

*(He comes out from behind the podium and stands near and to the front of it. Now obviously upset, he speaks to the audience. From this point on it is essential that he dominate the stage with a presence of gradually ever-increasing intensity.)*

What could I do?

She was lovely ... that beautiful shape! I thought of it a lot (*pause*) in the night... haunting visions of her loveliness, what the ancient Greeks called *χαρις* (pronounces it

charis with a rough 'ch'): grace, graciousness, loveliness, a providential favor.

*[He looks to his left.]*

Stop laughing! I say. ... Stop it!

*[He looks to the front and tries to get control of himself, but is gradually becoming more disheveled.]*

Excuse me. To continue, toward the end of the second year of therapy the patient reported a dream. She dreamed that we were lying on the couch together in my office. She was naked. I was stroking her buttocks. It was warm and wonderful [speaks more slowly and begins in a kind of a dream-like tone himself]. I was holding her and she said to me, 'It's all right. It's all right. Don't be so sad, put your head on my breasts, drink ... drink, take me inside ... '

*[For just a moment buries his head in his hands. Looks up and moves across the stage to the center and continues brightly, still facing the audience;]*

But I don't pay much attention to dreams. We had this guy as a teacher when I was a

resident. He was always making crazy deep interpretations of such things. What a ball he would have had with this one! What a far-out overheated imagination he had! Well, he used to irritate the hell out of me when he did that, he was an old fashioned nutty Viennese type and he never shut up and the residents finally got rid of him. Ha! He used to quote the great cellist Janos Starker, who said his teaching consisted of 'upsetting students'... (*draws himself up like a professor giving a lecture and imitates one, seriously quoting:*) 'I'm not interested in what they can do. I concentrate only on what's impossible for them. But music is first and foremost a question of awareness. If someone plays badly and is satisfied with it, there's nothing you can do for him' (Ray 1986). ... Upsetting students indeed! Out of date, that character. He faded away into the woodwork, the ashes of an earlier unscientific time.

No, I wasn't led into any of that deep stuff. I saw bringing such a dream as a seductive ploy on her part. I gave her more Xanax—increased it from t.i.d. to q.i.d.—and I told her, 'The dream is about you—it's about your need for me.'

When I said that, for some strange reason at first she got very angry and looked deeply disappointed ... and then she cried. *(Pauses and moves back across the stage toward the podium: faces the audience and continues.)* Damn it, she cried! She cried for real, like something terribly had hurt her. She was so miserable, so lonely, what could I do?

So I took her hand, and I looked at that beautiful form, that beautiful shape, and I thought, How lovely, how lovely she is. How I would like to caress that body! *(Holds up his right hand and looks at it.)* And I took her hand in mine and I said, 'Don't cry, I love you.'

*[He looks to his left and cries out despairingly:]*

Stop it!

*(Becomes more disheveled and, by running his right hand through it, he rumples his hair. Moves to the center of the stage and speaks to audience.)*

That beautiful shape, that beautiful form, that beautiful body, that lovely skin, like satin, warm, pulsating flesh. I knew now that I had to have it! *(Pauses)* I thought of telling my

wife about it, of sort of confessing to her, but she was busy with her new profession and she was never home any more. I couldn't say anything to my friends who were psychiatrists because I knew what they would say. Freud (Joseph and Widlocher 1983) remarked, 'What is moral is self-evident.' But my house was empty. My kids were grown up and gone. I was tired, so tired. Years and years of dishing out Xanax and support! I knew it was wrong, I knew it was wrong.

*(Begins pacing up and down and speaks loud enough so everyone can hear, but oblivious to the audience in a soliloquy to himself.)*

Sure, I had lots of money, a beautiful Mercedes car in the garage ... even though it was an old model ... stocks and bonds (*pause*) a big shot I was with a dragon for a mother-in-law! I had a fancy house with a view, but now it was all so empty, and she was so lovely, and she was young and she was beautiful, and I said ...

*(Stops pacing and stands at center of stage, speaking now in almost a trance-like state, and looking just above the heads of the*



*audience:)*

I said, 'I love you' (*pause*). She melted into my arms (*long pause*).

*(Buries his head in his hands for a moment:  
then he looks up and rapidly continues:)*

It was heaven, ecstasy, all my aging slipped away. I felt desire and desirable, rejuvenated, alive again! I was young, strong, potent, full of masculine energy! A voice said to me (Dahlberg 1970), 'You're not as old as you thought!' Then I remembered the idea that sprang to the mind of Paul Lorenz, Freud's (1909) case of the 'rat man', during his first sexual intercourse: 'This is glorious! One might murder one's father for this!' So at first I had doubts. I thought, 'My God! Is this another reawakening of the oedipal conflict in middle age that I read about somewhere (Prosen et al. 1972), a third edition after the upsurge in puberty?' She said all she wanted was holding and cuddling (Bouhoutsos 1985), but I couldn't believe it, I was so excited I felt so alive and erect .... And God did not answer.

There she was, naked. My eyes feasted, my hands feasted, we melted together, we drank each other. We fused together. It made

everything all right for us both—a moment of ecstasy in the depths of hell, a hell on earth where we had both been living for years.

*(Pauses and looks abruptly to his left and shouts to the left:)*

Stop laughing, you son of a bitch!—You made me do it. Yes, you! Pressing me so hard, sneering at my balding head, at my growing pot belly, reminding me in the health club over and over: 'Look at those young guys, you dumb mother-fucker! You will never look like that again, you're getting old, you're being left behind.'

*(Looking now directly at the audience, speaks to them:)*

And then the young residents, they graduate, they come into my building, they rent fancy offices, they take the new patients. And the social workers, and the psychologists, and my fucking mother-in-law: *(imitates her nagging tone)* 'When are you going to get a new car? I told you to go into family practice.'

And my wife was gone to some damn professional meeting—ever since the children grew up she rocketed out of the

house into her new career like a bird let out of its cage—and it was dead quiet in the house, and there was a sandwich in the ice-box that she left for me to eat, and I was alone with nothing to do in the evenings. But now there was something to do—to think about her, to dream about her. I wrote confused poems to her—many, many poems in my head, but I only showed her a few of them.

*(Moves to the podium area of the stage and then looks at the audience: recites the poem like a professional dramatic reading.)*

I long for you on the lonely dreary nights.  
I long for you when the dawn breaks through.  
Oh! You will never understand it,  
How the empty night for me never ends.  
How the day world is cold and metallic  
While the night world is calling us, phallic  
In solitude I pray  
Never another day.

Somewhere, somehow in all this confusion  
May we mentally, physically achieve that fusion  
That dying, ecstasy brings  
To all living things.

How can I explain to you who see only the  
day?

How can I show you—what can I say  
To convince you what you mean to me?

How I dwell upon that special intimacy  
Where only you can sail across the sea  
Of my desire, setting my heart on fire.

Longing like Odysseus on Circe's isle  
Longing for a home with you.

Together at last.

Peace at last.

Forever.

Love.

*(Sighs and pauses. Paces up and down and  
begins talking loudly in a soliloquy again.)*

I went to Mexico on a vacation with my wife  
and one of my daughters, but I was obsessed  
with thoughts of her. I asked myself: is it just  
sublimated sex? Her warm touch or her  
kisses send shivers through me like an  
electric shock. No other experience, no other  
pleasure compares with this. What is it? A  
peak-like experience signifying nothing, yet  
touching some deep long-forgotten archaic  
chord in my dying body.

I watched an old fish, washed up on the Mexican seashore, struggle at first to get back into the water and then give up life and simply die, like the bulls at the Mexican bullfight after the descabello. Life—all organic life—a brief mystery and then with a sudden shiver a return to the inorganic and decay. Is that brief kiss an antidote to the premonition of everlasting oblivion?

I watched my daughter talking to the young Mexican men, on the prowl to reproduce. Then I thought about myself struggling like the fish to postpone the inevitable, a kiss or two, a sigh for missed possibilities, and then death in one form or another and it is all over. How quickly! When compared with the age of the universe, what a brief moment of senseless struggle, and then extinguished. A mystery. Science cannot explain this, as it is buried deep in the cells of all organic life. Dwelling on it only makes me more depressed.

*(Stops abruptly, looks straight at the audience and recites:)*

From an unknown Greek poet of Homeric days:

Then he will lie in the deep-rooted earth  
And share no more in the banquet, the lyre  
Or the sweet cry of flutes.

*(Pauses, and then begins to harangue the audience loudly:)*

All those fools at the hotel gathered around the innumerable bars, drinking themselves senseless with tequila already at five in the evening in Mexico, the loud beat of the music, all to escape the struggle, fooling themselves constantly; the fat pot-bellied men lying on the beach baking themselves in the broiling sun—why? Because everybody else does. Crazy. Organic existence just seems to have no meaning at all; nothing.

*[Looks up abruptly to his left and shouts:]*

Stop laughing, I say, stop laughing, stop! Is it love? No, no, you press me relentlessly to destroy myself and she is the instrument of my destruction! (Person 1983) The rage! The rage!

*(Gets control of himself and strides briskly back to behind the podium and speaks in a lecture form:)*

Falling in love begins with the original idealized superego, perhaps generated from internalizing one's idealized parents. This love is projected onto our guiding ideals in adolescence and onto our idealized females or males as in the adolescent crush and in young adult love. As idealized hopes collapse in middle age they are projected again, this time onto a selfobject with whom one wishes to fuse.

*(Walks slowly out from behind the podium and again directly faces the audience as if deep in meditation. Continues slowly and somberly:)*

Renunciation is the cornerstone of ethics, the be-all and the end-all of ethical issues. *(Looks up, as if at a sudden vision above the audience.)* There they are, in *Hannah and her Sisters*, dancing in the hotel room fortified by sips of champagne. An ecstatic state! *(Pauses. Looks again directly at the audience, speaks pensively.)* This must be renounced. It takes quite a person to do so. It's like giving up a spectacular treasure, something one has searched for all one's life. And finally finding and embracing it, one must lose it again. Forever.

*(Looks up suddenly to his left again.)*

I can't give it up! I won't give it up!

*(Paces back and forth. Stops at the right of the stage, the other side from the podium, and faces the audience.)*

To fuse with the idealized loved one provides an unutterably intense moment of pleasure, meets some powerful need; in a lightning flash it restores narcissistic equilibrium to the drained, overburdened, middle-aged psychiatrist ... a breathing space for a little while, postponing the inevitable.

*(Spreads his arms and reaches to the sky. Looks above the audience in a slow invocation:)*

To possess my loved one in every way, penetrating and pouring into her every opening, to get inside her eternally. And she into me, forever.

*(Slowly puts his arms down. Looks and speaks pensively.)*

Or, in the movie, he needed a woman dependent on him to take care of her. Or, perhaps he needed a woman to take care of



him, to smile at him lovingly.

*[Paces back and forth once and stops on the podium side of the stage: faces the audience intently.]*

This produces the most incredibly vivid state of feeling alive again! *(Pauses)* Why this exhaustion of the self? Young adults can compensate for deficient mirroring of their true self in early childhood by establishing hopes and ideals; dedicating one's life for example to being a doctor, a healer, an Albert Schweitzer ... reverence for life, extending a helping hand to the wretched of the earth. If these collapse in middle age as the burdens of life close in, as death approaches, as God is silent, then comes the cynicism, the despair, the fragmentation ... and one is caught up helplessly in the pursuit of relief from the never-ending pain ... and no pain is more excruciating and more unbearable than the crumbling of the self, a psychological cancer-death.

*(Moves toward center stage. Rumples his hair. Faces audience and shouts:)*

Falling in love if it is returned provides the intense mirroring. It is magic! Her kisses, her

warm body make me come to life again! You who are not in hell cannot imagine what it means to come back to life. What it would mean to die again!

*(Falls to his knees and gazes above the heads of the audience as if seeing a vision:)*

But also, but also ... to just gaze upon the beautiful idealized object, 'Maja Clothed' or 'Maja Nude', the immortal beatific visions of Goya, is absolutely breathtaking, inexpressible. I'm permeated with yearning, a yearning so powerful it is all pervasive, all preoccupying, and sweeps everything before it, carrying me on a roller-coaster of passion and despair.

*(Buries his face in his hands. Slowly gets up. An intense look of agony crosses his face. Puts his fists to the side of his head and then reaches out to the audience, moving more to center stage.)*

This is what requires renunciation. This is what ethics demands and forces one to turn away from, even when it is already at hand, yours for the asking. If such love is gratified and returned, the pleasure is so intense it sets up a feedback loop even greater than a drug

high, even greater than 'crack'. Look! If one falls in love and this is reciprocated, it provides for both poles of a self which has been sorely depleted of mirroring and idealization for so many, many years. *[Shouts:]* It hits the jackpot in one stroke!

*(Pauses. Looks sharply to his left. Shouts again:)*

Damn you, damn you!

*(Pauses, struggles and gets control of himself. Looks calmly at the audience and speaks in a dramatic intonation:)*

My office is like Bluebeard's castle (Gluck 1985).

The circle closes again.

The walls which had separated individuals once again grow high between them.

All is in vain.

The man remains eternally unreachable to the woman, and the woman to the man.

*(Pauses and walks quietly behind the podium. Momentarily recovers his professional self.)*

Yes, yes, she made a dramatic recovery. She is happy now. But we are not happy together now. I cannot live without her. What am I to do?

*(Looks abruptly to his left. Shouts:)*

You set it up, you set it up. Damn you! (Hurls plastic drinking cup fiercely to his left so it hits the wall with a crash.)

*(Recovers himself. Looks back to the audience, speaks calmly.)*

Now I am in it. How am I to get out of it? Was it the Xanax that made her better? How many patients who get Xanax get better because they imagine what I have carried out? How many patients who take Xanax get better because they sense in the therapist's imagination what I have carried out? Who can tell?

I have done wrong, I know. It may be that I will lose her. I cannot, I dare not, hold her any more. What will happen to her? What will happen to me?

*(Walks out again and faces the audience in center stage and speaks pensively:)*

Perhaps she will break down again, Xanax or no Xanax. Then she will have to go to another therapist, but she will never trust a psychotherapist again. There is no help for it. ... But I cannot bear the thought of her leaving me. *(Cries.)* No. I cannot live without her. Can't you understand that? It would be back in hell without her. I must have her, always.

*(Regains control, after a pause. Speaks more calmly and professionally. )*

Gartrell and her co-workers (1986; Berman et al. 1987) published the results of their survey of psychiatrist-patient sexual contact, but ended up only with confusion and some material that made for juicy sensational quotes in the local newspapers ... offering more fuel to those who already bum with hatred for psychiatry. They plaintively ask, 'Are these psychiatrists unaware of the clinical and ethical contradictions? Are they sociopaths who have little concern for their patients and simply hope to avoid apprehension? Or are they expressing symptoms of other psychiatric impairment through sexual contacts with multiple patients?' They want, 'further research into the psychodynamics of these offenders'; so

here it is, here are the psychodynamics, here is your further research, here are your 'offenders', presented not in statistics but in literature and drama, for our authors and artists are far ahead of our doctors, as they always have been. Listen to John Updike's (1986) character, Roger the despairing theologian: *(speaks poetically and in an almost trance-like state as he quotes:)*

A spiritual fatigue descended upon me, a recognition that my life from the age of fifty-three on was a matter of care-taking, of supervising my body like some feeble-minded invalid kept alive by tubes and injections in a greedy nursing home, and that indeed it always had been such, that the flares of ambition and desire that had lit my way when I was younger and had given my life the drama of fiction or of a symbol-laden dream had been chemical devices, illusions with which the flesh and its percolating brain had lured me along.

What psychiatrist is going to write that in answer to a superficial survey, even one who has read it before, compellingly presented in Kohut's (1971, 1977, 1984) books? Only 26 per cent even answered them at all, including,

'nineteen uncompleted questionnaires with obscenities or other hostile comments written on them.' ... Who are these nineteen psychiatrists? What are they trying to tell us? At least they are trying—what about the 74 per cent, the silent ones, who never answered at all? Are they trying to tell us what I am trying to tell you here?

*(Looks and speaks to his left:)* Demons! I defy you! I will grapple with you eternally!

*(Speaks to the audience:)* Hegel said this state of 'otherness', of opposition, of conflict, is the driving force for advance to a higher level of philosophical consciousness, a spiritual dialectic, an adventure toward increasingly full and articulated self-consciousness. So I am on the way, in spite of the craziness, in spite of it all. ... Are you?

He said we have to break the hold that natural desires have over us, but that this can only occur in a rationally organized and genuinely free community—what the British philosopher F. H. Bradley called an organic community—for our wants and desires are shaped by our society. And what kind of society do we have? How do we care for the

poor and the sick and the mad? What shapes our wants and desires? What makes crowds of people stand in line all night to buy a cabbage patch doll or watch Prince Charles play polo? No wonder Lacan (Chessick 1992b) said, 'Man is a marionette of his culture' ... and so is every doctor ... and so am I. For I am every man and I am every woman, escaping, forever escaping ... and I am you.

*(Long pause)* And me, what will become of me? I must have her, I cannot live without her. I will not be able to do this again. Perhaps I will find some other way. I must have relief. I cannot live in hell. Like the immortal Yeats, I am obsessed: *(looking just over the heads of the audience, he dramatically recites)*

I went out to the hazel wood,  
Because a fire was in my head,  
And cut and peeled a hazel wand,  
And hooked a berry to a thread;  
And when white moths were on the wing,  
And moth-like stars were flickering out,  
I dropped the berry in a stream  
And caught a little silver trout.

When I had laid it on the floor  
I went to blow the fire aflame,



But something rustled on the floor,  
And some one called me by my name:  
It had become a glimmering girl  
With apple blossom in her hair  
Who called me by my name and ran  
And faded through the brightening air.

Though I am old with wandering  
Through hollow lands and hilly lands,  
I will find out where she has gone,  
And kiss her lips and take her hands;  
And walk among long dappled grass,  
And pluck till time and times are done  
The silver apples of the moon,  
The golden apples of the sun.

(Yeats 1989)<sup>5</sup>

*(Walks off stage.)*

*Dr. Richard Chessick (comes on stage behind podium):* Thank you very much cousin Barry<sup>6</sup> for your interesting and dramatic presentation of a borderline individual. Perhaps we can better empathize with their sufferings, view them more as patients and less as 'offenders,' and recognize

the profound social and therapeutic problems involved in trying to help and to change them.

### *Notes*

Originally published in *Psychoanalytic Psychotherapy* 7: 142-51. Reprinted by permission.

[5](#) *The Song of the Wandering Aengus*, reprinted by permission of Simon and Schuster for US rights and A.P. Watt on behalf of Michael Yeats in England (see also Alt and Alspach 1977).

[6](#) The role of Dr. Barry Chessick in this presentation was originally played by Mr. Barry Chessick, an actor in community theater.

## Nothingness, Meaninglessness, Chaos, and the 'Black Hole'

Whoever fights monsters should see to it that in the process he does not become a monster. And when you look long into an abyss, the abyss also looks into you. (Nietzsche 1968, p. 279)

This chapter re-examines material not uncommonly encountered in the analysis of severely ill patients such as schizophrenics, borderline personality disorders, and mixed as well as narcissistic personality disorders. It deals with the emergence of an unendurable state often described as a sense of nothingness, meaninglessness, chaos, or a 'black hole', a falling

through space in the void. Previous discussions of this in the literature have emphasized the relationship of this material to an infantile catastrophe, a failure in the initial nursing couple with all that this implies for core psychosis or impaired ego functioning, or a faulty sense of self.

### **Introductory Case Material and Preliminary Discussion**

A 54-year-old married woman that I have been working with in analysis for many years was finally able to describe how she feels at her very core. When I first met this patient she was psychotic and unable to function at all. While in analysis previously for four years as a graduate student in the humanities department at a local university, she had broken down and so was unable to complete her PhD thesis. The analyst had the unfortunate habit of falling asleep during her sessions, possibly in part because she was

extremely superficially articulate and talked at great length, often in a rage, about the most trivial offenses. Her analysis went from bad to worse with him until she was in a psychotic state and unable to function. At that point a friend who had completed analysis with me at an earlier date recommended that she come to see me. Her treatment went through many ups and downs; by this time a tremendous number of practical and social difficulties had also accumulated due to her increasing inability to function. Just as she was getting on her feet and returning to her profession she contracted a very serious and extraordinary hematologic disease of unknown etiology which threatened her life. After an almost miraculous recovery from the hematologic disease she married, spending most of the marriage in a rage and quarreling continuously with her husband.

We discussed this rage at great length and

attempted to understand its meaning. Was this a schizophrenic or borderline patient who had a dysregulation of affect? There was no question that she had a dysregulation of her capacity to alleviate tension, for even the smallest frustration or stress would keep her awake tossing and turning much of the night. Or was this rage actually a protection for her, a protection against something even more horrible? Finally the patient told me that she had come to the conclusion that under her rage was a 'black hole'. She described this to be 'a falling through space, no gravity, out in the black, just a void, I can't feel anything—even my own arm'. She continued, 'When you fall through the black hole there is no human being to validate you and there are boundary problems.' As she held up her hands she said:

What are my fingers? ... If you are in a rage, you at least care about something. Even if you lose control of your rage, at least it is

over *something* that you are invested in. Under that I have no compassion, no forgiveness, and no excuses. I have no feelings, no capacity for empathy, and no ability to respond to another's suffering or happiness. Of course I play the superficially polite role and go through the proper responses in order to survive, but under that is a non-existence. I keep asking myself what makes me, me, and you, you. What makes me even exist—I can't even phrase the question right!

I am like a catatonic, rocking, like Whistler's mother in the painting, not responding, not living in the world but living in a world of my own, of my own head, so that nobody else even exists for me. Even to pay attention to my child when she was a baby was the hardest thing for me to do as a mother because I would be constantly distracted and daydreaming. How hard it was to pull myself out of myself. At my center is a passive little teeny nothing, for after all, one cannot control anything if one does not have gravity when one falls through space like a baby. It also feels like I am always under water, cut off, where even sounds are skewed. So

perhaps under this rage is an autism, which I experience like the buzzing of a dial tone on a telephone line.

Then there was a long pause; the patient thought further and said, 'Am I creating a breast I never had with this autism? Does the autism fend off the rage, or the rage fend off the autism? My rage is scary and it makes no sense; explosive tantrums for no reason.'

I felt that the patient, who was very articulate, very intelligent, and very sick, had hit on something quite important. I was immediately reminded of Grotstein's (1990a, 1990b, 1990c, 1991) publications on the 'black hole' as well as Kristeva's (1982) obscure book on abjection. Kristeva writes:

There looms within abjection, one of these violent, dark revolts of being, directed against a threat that seems to emanate from an exorbitant outside or inside, ejected beyond the scope of the possible, the



tolerable, the thinkable. It lies there quite close, but it cannot be assimilated ... a 'something' that I do not recognize as a thing. A weight of meaningless, about which there is nothing insignificant, and which crushes me. On the edge of non-existence and hallucination, of a reality that, if I acknowledge it, annihilates me. (pp. 1-2)

Kristeva then goes on at great length using complex poetic prose to enlarge and elaborate on these metaphors, producing some very difficult writing to decipher indeed.

I prefer Rilke's (1983) poem, 'In Ignorance Before the Heavens of My Life ...':

In ignorance before the heavens of my life,  
I stand amazed. O enormous stars.  
Unfolding and descent. How still.  
As if I weren't there. Do I take part in this?  
Did  
I dispense with their pure influence? Do the  
tides  
in my blood rise and fall in consonance with  
them?  
I'll put away wishes, all forms of relationship,

and accustom my heart to its farthest reaches.

It does best to live among its terrifying stars,  
and not in apparent protection, pacified by  
what's near.

(p. 106)<sup>7</sup>

Yes, this is obscure, produced by a poet who suffered from a severe narcissistic personality disorder. Like Rilke, some patients find this state of deadness or emptiness unbearably terrifying; others find it unpleasantly or unbearably weird, bizarre, and disorienting. But what my patient, and the patients of Grotstein, and Kristeva, and the poet Rilke are all trying to tell us about is the almost impossible to articulate sense of what Grotstein (1990a) calls 'being obsessed with one's despair or futility, and/or not having a "floor"' (p. 30). Grotstein attempts in further publications to connect this sensation with the 'black hole' of physics and with certain neurophysiologic

phenomena, but in my opinion this tends to obscure the issue and digresses into some far-reaching speculations, rather than focusing on the clinical situation.

What is more to the point is his (1990a) statement that 'psychosis consists mainly in the irruption of massive, burgeoning nothingness, meaninglessness, chaos, randomness' (p. 36), but I do not agree with him that it is the 'quintessence of the traumatic state' (p. 36). I do not know what it is! Listening to my patient quoted above, it is not clear whether her chaos, meaninglessness, and nothingness constitute a defense against an unendurable rage, or whether the rage was a defense against the unendurable sensation of falling through the black hole. This 'primary meaninglessness' described by Grotstein in my experience does not necessarily have to be a sense of falling, it can simply be a feeling of deadness,

perhaps an extreme of what Kohut (1971) would call the empty depleted self. Another of my very sick borderline patients put it this way:

There is a heavy feeling inside my head—I want to cry, I want to be held. My mother never wanted to touch me. I feel like a person coming out of anesthesia. I try to stir myself up into a rage about something to distract myself. When I was a child and an adolescent, mother would laugh when I complained that I felt this unbearable dead feeling.

Yet this patient actually collapsed into a suicidal despair only after her mother died when she was an adult. She would often hear her mother laughing scornfully at her during the therapy sessions, and I came to understand this actually distracted her from giving way to the unendurable dead feeling.

Grotstein (1990b) tries to distinguish this sense of deadness from an 'awesome force of

powerlessness, of defect, of nothingness, of "zerness"—expressed, not just as a static emptiness, but as an implosive, centripetal pull into the void' (p. 257). I question whether these archaic phenomena can really be so neatly distinguished; perhaps it is just that various patients have various ways of describing the sense of fragmentation of the self or, alternatively, of articulating the semi-autistic states that existed before consolidation of the rudimentary ego. In these patients there has often been a lack of maternal stimulation, a failure of the nursing couple, as Winnicott (1968) would call it. Good-enough holding, he writes:

...facilitates the formation of a psychosomatic partnership in the infant. This contributes to the sense of 'real' as opposed to 'unreal'. Faulty handling militates against the development of muscle tone, and that which is called 'coordination', and against the capacity of the infant to enjoy the experience

of body functioning, and of BEING, (pp. 18-19)

He continues:

If the environment behaves well, the infant has a chance to maintain a sense of *continuity of being*; perhaps this may go right back to the first stirrings in the womb. When this exists the individual has a stability that can be gained in no other way. (p. 28)

But what in psychodynamic terms is this sense of Being and the continuity of Being, which is apparently a function of good-enough holding in infants?

## **Kleinian and Post-Kleinian Formulations**

Spillius (1990), in her review of Kleinian theory, reminds us that the psychoanalyst Esther Bick thought a sense of catastrophe was the ultimate basic experience. In Bick's view, this sense of catastrophe constitutes both the focus of existence and what everyone uses thought and

thinking to evade. She conceived of this ultimate or central catastrophe as a primary infantile experience of unintegration which continues as a problem even into adult life. Spillius writes:

Bick's idea is that catastrophe is experienced as falling apart, falling endlessly into space, or as one's insides liquefying and pouring out uncontrollably. She thinks the response to this anxiety is a desperate use of all the senses to hold the self together, (p. 158)

In a related comment Folch (1992) points out that for the ego 'to become robust and strong, and to ensure the integration of the drives and their psychic representatives, love and hate, the individual has to be able to introject a containing object which becomes the core of his or her own ego' (p. 215).

So the Kleinians believe that the enormous difficulty of acquiring a stable ego that can hold a pathological person together is the result of faulty

introjective identification. According to Rey (1990) such introjective identification is 'made very difficult by persecutory feelings and a fear of the object created by the projection of destructive, envious, and insatiable impulses which can become incredibly violent' (p. 209). Malcolm (1992) describes a psychotic state which consists of a situation in which 'the internal objects are destroyed and fragmented; the main anxieties are of disintegration' (p. 115). In order to cope with this situation a perversion or an intense hypersexual phantasy may be constructed by the patient as a protection against breaking into pieces.

Grotstein (1990b), in a very dense Heideggerian description, tries to distinguish between (a) nothingness 'the negative matrix or container of chaos (experienced as randomness) and continuous with the quality of emptiness' (pp.



272-3); (b) secondary meaninglessness or abandonment anxiety; and (c) disintegrative nothingness, or the 'black hole'. This latter he views as a traumatic state, a chaotic state of turbulence. Psychosis, he claims, is the psychological transformation of this state. He goes on to maintain, 'The experience of randomness is the traumatic state (the "black hole") and ushers in the psychotic state in those who are especially vulnerable' (p. 274). Later he (1990c) points out that however these phenomena are characterized, 'a virtual disappearance of the self seems to occur and is followed by a pathological infantile autistic response characterized by the survival of some elements of the psyche in an encapsulated or entangled but yet deadened form' (p. 379); here he is following the work of Tustin (1972, 1981, 1986, 1988, 1990).

Tustin calls attention in her work with

psychotic children to what she calls 'the black hole' or 'the deep pit'. She regards this as a way of 'depicting the unknown "not-me", which came with the traumatic infantile experience of bodily separateness from the mother' (1981, p. 76). In her division of 'encapsulators' who have shut out the black hole and the 'confusionals' who are enmeshed with the black hole, she distinguishes between two types of autistic children. She believes the 'encapsulators' are stronger children, having developed this encapsulation to keep the threatening black hole at bay. Both types of child have experienced a premature psychological birth, propelling them into a world of precocious separateness from their mothers, a sort of shocking infantile catastrophe associated with stark terror. Tustin believes that adult patients who are prone to autistic ways of behaving also have, instead of a psychic core which holds them

together, an unmourned sense of loss or 'black hole'. This black hole represents the absence of the mother and is a primitive depressive situation, perhaps even earlier than the paranoid-schizoid position (Tustin 1988).

Grotstein (1990c, pp. 379, 383) says that Tustin, working with autistic children, distinguished between 'void' and 'black hole' experiences (see Tustin 1988). The 'void' is more like an anaclitic depression from the beginning of life, whereas the 'black hole' type of depression is based on the catastrophic loss of an illusion of at first having a 'floor' or 'mother'. Grotstein (1990c) states that the 'black hole' phenomenon was noted by Tustin 'in many of the autistic children she has personally analyzed' (p. 383), and that he is elaborating on her concept of it. It is important to note that Tustin, in writing to Grotstein, describes 'a "black hole" type of depression against which

the autism has been a protection' (quoted in Grotstein 1990c, p. 383). Grotstein views this as connected to the death instinct and, *contra* Klein, as constituting a most archaic aspect of the depressive position antedating the paranoid-schizoid position.

Kernberg (1994) in a 1980 paper summarizes Fairbairn's view that schizoid individuals:

...unconsciously struggle against a true investment of others and regress to and/or are fixated at an essentially receptive, demanding stage of object relations in which they experience themselves as only on the taking side and carefully avoid having to give of themselves. Giving becomes equivalent to being emptied out, a catastrophic reminder of the sense of depletion derived from libidinal investment not responded to. (p. 47)

To me this is more helpful as an explanation of the 'black hole' phenomenon, namely, viewing it as a

defensive withdrawal from threatening object relations. As Kernberg (1994) explains Fairbairn's conception of this, efforts to avoid 'giving', since giving becomes equivalent to being emptied out, a sense of depletion derived from previous libidinal investment not responded to:

...may reinforce the need to repress all affects to avoid affective investment. In order to avoid a sense of loss, the patient may curtail his links with his own artistic products, stifle his creativity, and take active measures to drive away those who potentially threaten him with love. (p. 47)

Is it not possible that these patients are trying to describe for us their sense of impending catastrophic annihilation which oscillates with their overwhelming rage, rather than some kind of primary trauma or actual infantile experience? Although there are always parental defects in the infant-mother and infant-father relationships, these defects are indeed magnified, as Klein

argued, by the child's powerful phantasy investments, projection of these phantasies and terror of them, as well as by very important biological and constitutional problems such as those manifest in dysregulation of affects and defective tension-regulation mechanisms. We are dealing, I believe, with an interacting combination of parental failure *and* the child's contribution, both in phantasy and from innate biological factors, followed by the escalation of these failings into the formation of a closed system of horror. This central system of horror, which the patients are trying to tell us about by invoking such phenomena as 'black holes', chaos, void, meaninglessness, and so on is extremely refractory to therapeutic influence because it is a closed system like a walled off abscess, around which the rest of the personality defensively develops in pre-schizophrenic, borderline, and

other personality disorder patients. To breach this wall carries the danger of reopening the abscess with the flood or miasma of malevolent elements drowning the ego. Note how again one must fall into metaphors to describe this inherently inarticulatable experience. Perhaps Edgar Allan Poe should be credited with the finest writing on the subject; perhaps Hallowe'en is an externalized derivative of it.

When such material begins to appear, after usually a very long time in analysis, it is a great vote of confidence in the therapist on the part of the patient. It is only after a large variety of evasion tactics that the patient becomes ready to face and deal with these extremely archaic and primitive phenomena. I hasten to add that some patients *begin* therapy with complaints of this nature. These are usually manifestations of intellectualized alienation or depression and do

not have the kind of terrifying unendurable affectual charge unless the patient is psychotic. Or they may represent a dissociation in which the ideation is expressed but the affect is repressed, so that only later on will the severity of the patient's psychopathology emerge.

### **More Clinical Material: The Predicament of Mrs. A.**

There is another possible meaning to this 'black hole' phenomenon. Instead of viewing it in the sense of modern physics as some powerful singularity which draws everything around it into it, it can be experienced as an emptiness or void in a much more depressive and passive sense, although still an unbearable or terrifying sensation. This disagrees with Grotstein's or Tustin's attempt to metapsychologically distinguish these states and with Grotstein's effort to compare the 'black hole' psychological



phenomena with the black hole of physics. I have come across a number of patients who have addictive disorders, such as alcoholism or bulimia, and who after substantial analysis begin to experience these things. Here is an example in a letter from Mrs. A., a 56-year-old woman in intensive psychotherapy for several years. Her four-years younger brother, her only sibling, was born with pyloric stenosis, leading to predictable consequences for her. She had a severe narcissistic personality disorder but could not be called schizophrenic; she was a talented musician and a successful professional writer:

When I begin to ruminate about the hole that is in me, all sorts of images start to gather in my head. Images about filling this hole by acting out the emptiness—images about my need to be noticed so I don't feel nonexistent. They seem to be falling together, the more I think about them; they relate to eating and drinking, to performing, to wanting to be

noticed in a room full of people, to my music and where I stand in the orchestra.

I thought first of the powerful images about vomiting which have always haunted me, left over from when my brother, who'd taken my place at home and who was the much-desired son, was vomiting all the time. My memory of sitting in the corner, or crouching or whatever, feeling alone and terrified, still seems very clear; but now it has another dimension: I think that because I had a hole inside me, like a void, I feared that if I vomited, I would be empty and would cease to exist. I clamored for my parents' attention, for permission to take up space, but I think now that I also felt dead if I was in the room and nobody noticed me. Also tied up with my revulsion of vomiting was the fear that my brother would cease to be if he kept throwing things out of his mouth. Thus, I could control my environment if something was always coming out of my mouth to convince me I existed—I talked, I sang, etc.

I never told anybody this, but to this day, I feel it like a disaster. Once years ago I went to a school opera production alone to see my child in 'Hansel and Gretel'—I was sitting

part way into a row and, for some unknown reason, I wondered what would happen if the little girl next to me should throw up. To my horror, when we got outside at intermission, the little girl did vomit, all over the corridor. I felt like a witch.

The things that come out of me increase the hole—the things that go in are an acting out of wanting to fill up the void—hence, as the day draws to a close and the void of night, of powerless sleep and dreams which I cannot control comes closer, I substitute filling the hole with food and drink. I think this is why, although in years past I wasn't fat and I didn't have a problem with alcohol, I now find food and drink so important. I didn't have to watch my weight years ago, being younger and more active; I wasn't tempted by the soothing effect of wine, because the four children who came out of me—the constructive emptying of that hole inside—were not only keeping me very busy so I was exhausted at night, but also filling their needs soothed me. Since I felt as if I didn't exist whenever it was quiet, I loved to point to these constructive people I'd brought into the world, show them off, as if nobody (as

my ever-helpful mother once pointed out) had ever had a baby before. It gave me more attention, and more of a right to take up space; it convinced me more that I was in fact taking up space, when I looked at them, saw my eyes, my long fingers and big feet and all those characteristics that were mine, being reproduced. I was more convinced I was alive and real. I really have never thought of this in this way before: the only time the hole got emptied which was soothing and satisfying was when I had the babies. That gives a very mystical overlay to my powerful desire for children and my maternal instincts, which probably were healthy. I loved watching the two younger ones be born.

The hole suddenly seems even to extend to my place in the orchestra and the choir for the first time, and this time, in the framework of my therapy and not just as part of the mystique of being an artist. Perhaps I was so powerfully attracted to being an alto and playing the viola, always being an inner voice, partly because again, this helped fill the hole. I used to feel more together than I did any other time when I

was performing a symphonic concert, and along with the mystique of music, I wonder now if the hole also may have something to do with it. This maybe needs to be re-opened.

I touched on the spiritual crisis the hole has given me—powerfully attracted to spiritual things, basically a strong believer in God, yet I have this hole which whispers to me that when I die, all will be void—there is no afterlife, it only belonged to Jesus; again, I yearn to fill that hole with faith, but my doubt is very deep. I understand better than ever before where the doubt comes from—it's that damned hole again.

So there it is—my hole. If I don't talk, if I don't hear another respond to me (and especially if he/she doesn't smile), I panic. The void of outer space feels as if it is somewhere inside me. This central terror has always been there, but I believe this is the first time I have been able to come to terms with it and identify it—along, possibly, with the why of this hole. I can even see it at work when my taciturn boss in a telephone conversation with me only sighs or goes 'hrmmn'. It isn't just that I fear I did

something wrong again (that's the conscious response)—it's as if I no longer exist. It's one hell of a metaphysical problem and very hard to touch; but so extreme is the longing to fix it somehow that when you sat down at the end of the last session and looked right at me, which so seldom happens, I was suffused with longing to trust, and I had to look away—I who have wanted so to look at you!

In my view it is best to discuss this patient's material from five different channels of psychoanalytic listening. I will begin with a brief recapitulation of my (1992a) orientation, which contrasts sharply with that of Grotstein.

### **Review of Listening Channels<sup>8</sup>**

What are the five channels (models, perspectives, frameworks) from which we can tune in to the transmission from the patient? Each of these, as is well known, is based on premises that are currently conflicting and irreconcilable. The first model was presented by Freud and

focuses on the Oedipus complex and the emergence in a properly conducted psychoanalysis of the need for drive satisfaction in the transference. This enables us to study the patient's conflict in terms of defenses against the instinctual drives and the resulting compromise formations produced by the ego in dealing with its three harsh masters—the superego, the id, and external reality. Freud's structural theory, placing the Oedipus complex at the focus, was developed for this purpose. At the core of it are the patient's childhood or infantile fantasies which repeat themselves over and over again in the patient's mental life and behavior (Arlow 1985). We carefully listen for the derivatives of these fantasies and look for them to be re-enacted in the transference. I believe this to be the primary model, the starting point for all psychoanalytic listening.

The second channel utilizes the perspective of object-relations theory for its model. The work of Klein and her analysand Bion focuses on the earliest projective and introjective fantasies of the patient as they appear in the object relatedness manifest in the transference and in the process of projective identification as it occurs in the analytic process. Bion (1963, 1967) emphasizes the 'toilet function' of the analyst in which the analyst must receive, metabolize, and give back in acceptable form the unacceptable fantasies and affects and expressions of these coming from the patient. Klein (1975a) developed the concept of projective identification (defined differently by every author), in which the patient attempts to place into the analyst whatever representations he or she wishes to place there, with more focus on preoedipal fantasies and processes. A study of projective identification operating in the



therapeutic process emphasizes the patient's earliest internalized object relations and yields data about how the patient as an infant organized these relations into self and object representations and then projected and reintrojected various aspects of these images. Understanding of these processes clarifies the patient's relationships in the present because all such relationships are perceived and reacted to through the spectacles of these early organized self and object representations. Kernberg (1975, 1976, 1980) has presented the most thorough theoretical elaboration of this material.

A third channel, which focuses on the patient's being-in- the-world, might be labeled the phenomenological point of view. Here an attempt is made to grasp the facts of the patient's life phenomenologically, without other theoretical preconceptions to organize the data. This

approach was elaborated in philosophy by Husserl and then differently by Heidegger, and taken up especially by the pioneer psychoanalysts Boss (1963) and Binswanger (1963), especially in their effort to understand seriously disturbed and psychotic patients. A corollary of this approach began with Feuerbach and Marx, and was elaborated by thinkers such as Fromm, Sartre, and most recently Lacan: society shapes the individual and we can only understand the individual if we understand the society or culture or world in which he or she must continuously live and interact. So to understand an individual we must grasp that lived state of being-in-the-world which is unique for the situation of each person and has shaped that person's psyche and mentation.

The fourth approach is from Kohut's (1971, 1977, 1984), self psychology which focuses on the state of the patient's self as it is empathically

grasped by the analyst. Important originators of this approach were Fairbairn and Winnicott. The latter introduced the notion of the true and the false self that was taken up in detail by R.D. Laing (1960) in his brilliant exposition of schizoid and schizophrenic conditions; the former, like Kohut after him, produced a theory of ego or self that did not depend on postulated biology or 'instinctual' drives.

Wolf (1985), from a self psychological point of view, pointed out in his description of 'regressive listening' the impact of the therapy situation itself on the analyst and his capacity to listen. Although he became quite critical of Kohut, Gedo (1977) sharpened our focus on the archaic transferences, in which the patient forces a response out of the analyst and contaminates the evenly hovering attention stance advocated by Freud. The management of such archaic transferences and

how they affect psychoanalytic listening is one of the most important and central issues in modern psychoanalytic therapy because so many patients present with preoedipal damage and rapidly develop such transferences. Gunther (1982) emphasized the converse of the archaic transference, namely, the narcissistic aspects of the countertransference. He points out that countertransference manifestations appear often after the therapist's narcissistic equilibrium has been upset; they represent an attempt to restore the therapist's equilibrium and he urges us to look for these situations in psychoanalytic listening.

The final approach or channel on which to organize the transmission from the patient might be loosely termed the interactive, which focuses on the countertransference of the therapist or, more generally, on the here-and-now factors in the treatment, emphasizing the analyst's

participation. Many of the numerous and conflicting points of view under this rubric have been developed as a response to our increasing understanding, especially in preoedipally damaged patients, of the patient's need for an experience and not just an explanation in the treatment. Modell (1976) describes the psychoanalytic process in the early phase of the treatment of narcissistic or schizoid patients as providing a 'cocoon', a holding of the patient until the patient is ready for self-exploration. Gill (1982) emphasizes the importance of the therapist's participation in the particular transference manifestations that develop in a given treatment and he also focuses his interpretations on the here-and-now interaction between patient and therapist.

Lipton (1977a, 1977b, 1979, 1983) restudies Freud's cases in order to demonstrate how

significant aspects of the real interaction between the patient and the analyst profoundly affected the data that were presented for psychoanalytic listening. Thus Freud in his actual practice violated some of his own admonitions in his papers on technique. Stone (1981) systematized this under the rubric of the 'physicianly vocation' of the analyst and has demonstrated compellingly the profound impact of this stance on the material produced and the process of the treatment itself.

The conflicting premises behind all these approaches highlight the difference between viewing the patient as suffering from a psychic deficit, with emphasis on experiential repair, and viewing the patient as suffering from psychic conflict that requires explication. My approach differs significantly from that of Gedo and Goldberg (1973) because their principle of 'theoretical complementarity' (p. 4) assumes that

the different frames of reference or models of the mind may operate only as long as no internal contradictions arise among the various parts of the theory. But in my approach, theoretical orientations or models are being utilized that *directly conflict with each other* and cannot be thought of as complementary because the basic premises that underlie them, both their epistemological foundations (Chessick 1980, 1981) as well as their basic assumptions about human nature and its motivations (Chessick 1977b), directly collide. This forces a *radical discontinuity* as we shift from channel to channel in our receiving instrument, rather than, as we would all prefer to do, sliding back and forth between theoretically compatible positions, or at least complementary positions that are consistent with each other.

It may even seem that certain other theoretical

approaches or models should be added to these channels; what I am offering here is what has proven in my thirty-five years of clinical experience to be of the most value, to be the least speculative (experience-distant), and to be forceful of the least number of arbitrary inferences. The most important requirement of a model is that it be suggested by the very data the patient produces rather than superimposed on the data by experience-distant or arbitrary prior conceptions in the mind of the therapist. This is a relative concept because no theory is truly experience-near, since it is impossible to approach data without some prior conceptions. Our only hope is that our conceptions be not too abstract, generalized, and divorced from the specific material, and that they are capable of being validated by a study of how the patient responds to interventions based on them. Even this is



fraught with difficulty, as it is all too human to hear what we wish to hear. Hence the value of consultation and of the publication of the details of therapist-patient exchanges.

The hardest part in using this approach is to be willing to keep discontinuous and conflicting models in one's mind, which offends the natural and very dangerous human tendency for a neat, consistent and holistic theoretical explanation of all material, even if it is wrong. Kant (1781) called this tendency the regulative principle of reasoning, and Freud (1900) based it on the powerful synthesizing function of the ego. My approach requires tolerance and flexibility on the part of the listener as well as a certain maturity. It is sometimes the unfortunate result of a personal psychoanalysis that the individual becomes a strong and rigid adherent of the particular theoretical orientation or style of one's analyst.

Kohut (1984) suggested that the reasons for this are inherent in a psychoanalysis that has incorrectly and prematurely interpreted certain transference manifestations. Since there are no data available at present that convincingly and decisively prove that any of these theoretical orientations are the one and only best orientation, this uncritical adherence would have to be a leftover of a misunderstood or unanalyzed transference, just as emerging from one's psychoanalysis with a sense of nihilism about all analytic theories would be a similar indication for further analytic work.

### **Discussion of the Predicament of Mrs. A.**

Turning now to the material from Mrs. A., it is easy to see that it fits neatly into Freud's concept of the little girl as a defective boy. One way of looking at the patient's 'hole' is that it represents

her vagina and that the hidden desire in the material is to acquire a penis, which in Freud's equation, is represented by a baby. And indeed, she states how she loved to point to her babies and show them off, and so forth. The defense against this hidden penis envy would be manifest in her presenting the material in a preoedipal cast, a regressive defense against a primary oedipal wish to have a baby by the father. Similarly, her alcoholism and excessive eating could be understood as regressive preoedipal acting out to defend herself against forbidden incestuous wishes. Further argument for this point of view comes from the fact that the patient was quite a successful person, certainly not psychotic, and had certain hysterical qualities typical of exhibitionistic artists and performers and of oedipal neuroses. Her relationship with her boss, as described near the end of the material, again

points to the fear that he may discover her guilt-ridden unconscious incestuous wishes. This approach therefore would view the patient's narcissistic personality disorder largely in terms of constituting a defense against an intense unresolved Oedipus complex. The symptoms that cause her to be labeled narcissistic, her exhibitionism, the libidinization of her entire body, and perhaps even her sublimated performances as a musician and a writer could be understood as compromise formations to help defend against her penis envy and provide substitute gratification. This is made more plausible by the fact that she had a brother who suffered from projectile vomiting (pyloric stenosis), the 'much-desired son' and 'who'd taken my place at home', clearly the center of attention of the parents.

The Kleinian point of view, which I stressed more at the beginning of this chapter, would take

quite a different approach, even if one is not willing to go as far as Grotstein. The vomiting problem represents a signifier of introjection and projection and centers around oral receptivity and oral sadism. The patient feels 'like a witch' because she seems to have the magical powers that are implied by these primitive operations. The patient is preoccupied with the impending infantile catastrophe and so has been unable to work through the depressive position. She is thrown back on the paranoid-schizoid position in her ruminations and remains fixated at this narcissistic level. The depressive position, based on the projection of the bad object frustrating mother who is preoccupied with the brother, and then the reintroduction of this bad object leaving her with an unresolvable conflict about the loss of the mother that would occur if she destroyed the introjected bad object, remains an insoluble issue

for the patient, 'one hell of a metaphysical problem'. It is illustrated by her intense ambivalence regarding ocular incorporation of the therapist at the end of the session. The void or black hole in this patient might from this channel of listening be understood as the product of an unsuccessful nursing couple that generated an elaborate terrifying infantile phantasy life. The activities of music and writing and childbearing defend the patient against an interior collapse onto what Bion would call her psychotic core, an implosion in Grotstein's terms.

From the point of view of self psychology the patient is struggling to maintain a cohesive sense of self. She finds soothing to be of central importance and she obtains it from wine and food and vicariously experiencing the satisfaction that she gives to the needs of her children. She maintains her narcissistic supplies by showing off

her children and her artistic and literary performances, but she is condemned to seek a never-ending source of narcissistic supply because her nuclear self is enfeebled and wobbling, on the edge of fragmentation. There is evidence of early disappointment in the idealized parent imago as she mentions her spiritual misgivings and speaks sarcastically of her 'ever-helpful mother'. It is reasonable to suppose that both poles of the bipolar self in this patient have been damaged, but she has developed some compensatory mechanisms to keep going and elicit some joy from life. Yet she is always on the edge of panic unless she is provided with continuous narcissistic supplies. 'If I don't talk, if I don't hear another respond to me (and especially if he/she doesn't smile), I panic.'

The phenomenological approach would concentrate on the intensity of this patient's

communication of her sense of void and lifelong attempts to fill it. Here we might concern ourselves not so much with the details of interpreting her communication from various metapsychological points of view but with her life curve, which reaches its peak in middle age as she has to come to terms with her existential situation in life. We would want much more information about her relationships with significant others such as her husband and friends, and concern ourselves during interpretative work with the kind of impact her intensity and exhibitionism has on her surrounding associates. It is possible that her sense of emptiness is a signifier of alienation and isolation which is brought about by this style of clamoring for attention just as once she clamored for her parents' attention when they were preoccupied with her brother.

The interactional approach would begin with



the question of why this patient presented this written material to the therapist at this time. What was the therapist's contribution to her motivation for bringing it in, and what was the countertransference aspect manifested in this contribution? For example, was the therapist subtly encouraging the patient to exhibit herself so that an exhibitionistic-voyeuristic misalliance was looming up in the treatment in order to evade something that perhaps both the therapist and the patient were afraid of? There are many other possibilities, but it is clear that when a patient brings in written material, this is a form of 'acting-in', an evasive defense that requires the therapist to do self-analysis. It may also be thought of as a response to a deliberate supportive maneuver on the part of a therapist who has concluded that the patient's narcissistic personality is so severe that it cannot be analyzed and who therefore chooses

to attempt to strengthen her compensatory defenses by encouraging sublimated exhibitionism. Certainly the ending of the material, with the therapist performing in a way that the patient has not noticed to be his custom, looking right at the patient 'which so seldom happens', indicates that a subtle nonverbal interaction is going on between these two people, an interaction that could be interpreted in many ways—but there is not a sufficient amount of detailed material presented here to enable one to understand it with conviction.

I maintain that 'listening' to this material from all of these channels gives hints and suggestions as to what direction one might proceed in trying to understand it as well as further material of this nature. I believe it is a mistake to try to pin down specific data such as 'black hole' phrases from the patient's narrative as having a universal definitive

metapsychological meaning or representing a definitive signifier of a specific catastrophe in the nursing couple. Of course this may be true in some patients at some times, but I have tried to illustrate in this chapter that there are many ways of looking at the same material, and one should consider understanding it on all of one's choice of channels although this is uncomfortable, rather than remain rigidly committed to one point of view. What Kohut (1994) called the excessive tendency to dissension among psychoanalysts may be the result of our lack of a definitive method to decide among these approaches, or may be due to the fact that all of these approaches have some validity and that no one approach can ever serve as a completely explanatory system.

## Summary

In the present chapter some clinical material

involving complaints of nothingness, meaninglessness, chaos, and the 'black hole' is presented and discussed. The purpose of the discussion is to illustrate that it is not possible to interpret this material solely as representing the re-emergence of psychosis or early infantile catastrophic states. It is necessary to analyze this material, along with all other material, on at least five channels of therapeutic listening that I have described in previous work on the subject. These channels are the traditional Freudian, the Kleinian, self psychology, the phenomenological, and the interactional channels of listening. They are based on utterly incompatible premises. In this chapter I reviewed them briefly and then tried to illustrate how they may be applied to the same clinical material.

It is hopefully demonstrated that the emergence of this characteristic nothingness,

meaninglessness, chaos, void, and black hole material should not be automatically attributed to any one underlying intrapsychic situation, but can have many meanings in one patient as well as a variety of different meanings in different patients. Because this material is so dramatic when it emerges and is relatively common in the patients we see in our clinical work today, it is very important not to be misled by preconceived notions of what it means; one might even argue that the insistence on certain preconceived interpretations of given material represents an unfortunate form of countertransference.

### Notes

Originally published in the *Journal of the American Academy of Psychoanalysis* 23: 581-601, 1995. Reprinted by permission.

<sup>7</sup> Reprinted by permission of Oberlin College Press.

<sup>8</sup> This review was presented in Chapter 1 but is also appropriate here because the application to a complex clinical example follows.

## **A Failure in Psychoanalytic Psychotherapy of a Schizophrenic Patient**

This case report is being presented because it illustrates some of the frustrating difficulties in the intensive psychotherapy of extensively preoedipally damaged patients. It also depicts the many vicissitudes in the treatment of such patients, demonstrates problems that lead to failure in the treatment, and describes a patient of unusual theoretical interest, especially in the light of Pao's (1979) recent formulations about the schizophrenic process. The entire subject of the intensive psychotherapy of schizophrenia and the general guidelines to follow has been thoroughly

reviewed by McGlashan (1983b) and will not be discussed again here.

## **Case Report**

A moderately attractive white young woman of 22 appeared in my office in June 1979, having been referred by a psychiatrist from the student health service at a local university. Her chief complaint was, 'I'm all screwed up.' She reported that she dropped out of her senior year in college in the fall of 1978, and worked at waitress jobs in one restaurant or another since that time. She had changed jobs repeatedly because 'I am looking for something.' Her main complaint was a sense that everything had gone wrong with her, which she had great difficulty putting into specific terms, although she was obviously intelligent, communicative, and she was an English major. She offered such phrases as 'Everything has gone

wrong' and 'At times I lose my vocabulary'; above all she complained of a remarkable transformation in which she felt that a 'new self' had formed which was markedly different than her 'old self' before the fall of 1978. This new self differed in that she was indifferent to everything and unable to experience feelings; furthermore there was no sense of past or future and no feelings of continuity of the self in time. She was sharply aware that this state, which she described as a new self, was quite different from her previous state, which she regarded as her normal self. She also reported a struggle in which at times she would resist the sense of formation of this new self and at other times felt herself acquiescing and adjusting to the new self.

The patient reported that she saw a psychiatrist in our geographical area once a week for about a year in 1976 for the complaints of



anger and anxiety, and that it did not help. After her 'transformation' in the fall of 1978 she visited several psychiatrists for a few visits and finally went back to the original psychiatrist for a couple of months, but was unable to remain in treatment with any of them. She mentioned in passing that her mother had seen a psychoanalyst for the past twelve years in psychotherapy and remarked, 'That's all she has.' She reported that one of the psychiatrists she saw recently a few times told her she simply needed a boyfriend; another after two or three sessions made some statement about his hobbies which the patient felt 'was not ethical because he should have been talking only about me', and she abruptly left treatment with him. When in 1978 she went back to her first psychiatrist, she noted an unreasonable feeling of great terror of facing him, and she continued to be very anxious, sitting up during the sessions with

him. She mentioned that finally, in desperation, to use her phrase, he suggested placing her on phenothiazines which she accepted but which did not help.

The patient denied any history of drug ingestion or alcoholism and was in good physical condition except that she noted that her hair is falling out and she is getting some treatment from a dermatologist for this.

Her parents were divorced about eight years ago when she was in the eighth grade. Father remarried five years ago and seems happier and freer since that time. She described him as 'childish' and she stated that she talks to him about once a week on the telephone. She also described him as evasive. In the summer of 1978, before she dropped out of school, she went to stay with her father for six weeks. The world seemed

'stale and colorless'; she noted a writing block, could not complete an English paper, and was very nervous.

Her mother suffers from depression and was actually hospitalized for it in April 1978. She was described as 'fragile, vulnerable, and easily enraged'. The rest of the family consists of a brother one year older at another college, and two younger sisters—the first two years younger than the patient and also at college, and the second only 16 years old and living with father. The siblings have no known psychiatric disorder according to the patient.

She reported that her friends are a few women her age that she knows on the campus. She has no boyfriends because 'I have not much energy for it.' She hopes to go back to college, and added that she had started at a different college in the East in her

freshman year, but her father had not paid the tuition after promising to do so, so she transferred to the local university where she could get student loans; she was heavily in debt to the local school at the present time.

The mental status examination revealed an extremely tense person at first, with much blocking. At one point there was a hint of paranoid feeling in which, when I raised my eyebrows at the fact that she had been to several psychiatrists, she claimed that I actually said she was 'fickle' about psychiatrists, and she quickly added that she does feel 'guilty about hopping around'. As she relaxed she became more intact and able to communicate, but her planning seemed vague and her functioning marginal. There was no evidence of depression, delusions, or hallucinations, but there was an unexplained amorphous massive anxiety at the beginning of the diagnostic session. My

impression was that of either a borderline personality disorder or an underlying schizophrenic disorder and I suggested to her that she pick one therapist and stay with her or him. She said that she would think it over and I made a return diagnostic appointment with her.

In the second diagnostic interview the patient seemed a bit calmer and reported 'impulsive desperate behavior since I dropped out of school', which she said was a long story she would hold for later sessions. At this point she maintained that she wanted therapy with me and agreed to the available times twice a week as well as with my suggestion that she would pay for each session individually because of her financial difficulties so that no large bills would pile up. She stated that her father, a businessman, would be willing to help her pay for the treatment. In this session the patient seemed to interact well—in great contrast

to what seemed to be chaos and anxiety that ruled in her life since the fall of the previous year. She continued to complain about the previous therapists; the one she saw for a longer time she insisted was 'desperate' because she could 'sense it' and the therapist who talked about his hobbies she complained 'chattered on the phone and chain-smoked during the sessions'.

Further history was given in subsequent sessions. She was born and raised in our geographical area, in a well-to-do suburb. There were no reported feeding or toilet training difficulties. She was bottle fed and walked at one year. At 2 or 3 she was in the hospital for a few months because the whole family had 'mumps encephalitis'. She has no memory of this hospitalization herself, nor were there any known residua in any of the family members. Her earliest memory was being sick with the mumps at home.

She was told that she fell out of the window at that time. A more specific memory was being locked in a room by an aunt who was yelling.

She often shared a room with her one year older brother and two years younger sister, but by the time she was 6 years old she shared a room only with her sister, and at that age a second sister was born. There was much moving around in her early childhood: 'I lived in three houses up to the age of 6.' She did well in grade school and had friends. There was much fighting in the house and she gave a memory of mother in a rage at father killing the cat by dumping a pot of boiling water on it. Her parents split up, as stated, when she was in eighth grade, and 14 years old.

When the parents split up the patient bought a horse and became a very devoted rider, keeping the horse at a nearby farm. She did less well in

high school, living with her mother, and spent much time with the horse. There were occasional dates but she was 'very self-conscious and unhappy'.

The complaint of being unable to feel seems to have been already experienced in a milder form when the parents were divorced. At the same time the patient developed great interest in singing and playing the piano; she began college as a music major. Her father pressed her to go to the eastern college, because after she graduated from high school she felt unable to summon up the energy to do anything. When he finally filled out the application for her she actually went, but then because he could not or would not pay for the tuition, she switched as stated to the local college. In her junior year she changed to an English major because she did not feel she had sufficient talent in the music field.



Menarche was at about 14 years of age and she was prepared for it by the school—not her mother. She denied any experience with sexuality whatever and was very uncomfortable with the subject of sex. She also denied any homosexual interests and claimed that she was 'too spacy' to interest boys.

After she saw me the first time she dreamed that she went to see two more psychiatrists. One was an elderly woman like her grandmother—her mother's mother whom she doesn't see very much but who visited her as a child and was kindly—and the other was a man like her uncle—her father's brother—'who told me about his hobby of children's toys and a choo-choo train'. In the dream she was rejected as a patient by both psychiatrists. Her associations were about the last psychiatrist she saw who had mentioned his hobby of cooking which she felt made him

'immature and unethical'. Her association to the woman psychiatrist in the dream was 'a different kind of therapy, more mature, but she was silly like a chicken'. I was aware of, but did not interpret the split image of the therapist in this dream—but was more impressed with the male-female split than any affect-laden all-good or all-bad images. In fact I felt the dream was inappropriately bland and remote. To my mild suggestion that this dream might reflect her disappointment in both her parents the patient replied that she did not understand what I was talking about.

During the period of the history taking sessions, the patient's father called me and asked if I would see her once a week instead of twice a week. He was very exasperated with the patient, and reported that I was the eleventh psychotherapist that she was working with. He felt

that she was a hopeless psychotic. I insisted that at least for a while the patient have twice a week intensive psychotherapy.

After several history taking sessions, during which the patient seemed very intact and showed no evidence of overt schizophrenia, I decided to give her a trial of therapy using the couch because the patient had complained so bitterly about the sitting up position with the other psychiatrists. She took very readily to the use of the couch and agreed that it was much less tense for her than the face-to-face situation with her previous therapists. She seemed eagerly motivated for intensive psychotherapy, but also she mentioned another psychiatrist she had seen, a psychoanalyst, who 'insultingly' told her that she was 'crazy'. She began talking about what she called 'the wall' around her feelings to avoid her anger at her 'disinterested' father and at her 'depressed'

mother. Even at this early point I felt that the patient was walling up her feeling not so much to protect herself against anger but to protect herself against her longings, but no interpretation of this was made to her.

In the second month of the treatment I received a requested letter from her major previous therapist, which was quite detailed and well written. The complaints in 1976 had to do with chronic anxiety and anger during her first year of college away from home, and also a 30 pound weight gain. Her interpersonal relations even at that time were very bad and she was alternatively living with her father or with her mother, jumping from one household to the other. In the original treatment as with the present treatment she was constantly giving a vague and diffuse picture of her distress. The therapist wrote, 'What emerged was a portrait of a chronically

unhappy, empty, insecure, and angry young girl.' He felt the feelings preceded the parents' divorce but were accentuated by it. The household had been a tumultuous and chaotic one for many years and the patient experienced neglect and deprivation from both parents. Already in high school she felt 'both ugly and stupid'.

His therapy focused on the patient's tremendous anxiety and rage and attempted to work through her relationships with her parents but there was so much anxiety that the therapy had really no effect. The therapist wrote, 'I believe the transference issue was primarily of her ambivalent maternal relationship and, although wishing for closeness, she was persistently fearful of her own needs and the expectation of re-experiencing disappointment with the therapist.' The patient terminated the therapy after about a year against the therapist's advice.

In March 1979 the therapist was re-contacted; the patient now reported six or eight months of experiencing 'no feelings'—which was consistent with the history she had given me. He felt at this point she was 'moderately disorganized' in her thinking. This seemed to have developed *pari passu* with her mother's deterioration and hospitalization in the spring of 1978, and her perception that the mother was afterwards and now functioning even worse than before. She reported feeling that 'nothing bothers me', detached, isolated and at times appeared to be describing a bizarre depersonalization. She stated, 'I can't get excited about anything. I don't know where I am, I don't feel I am myself, I feel I am floating.' The therapist was unable to find definitive reason or precipitating cause for this new change in the patient, but, as stated, it seems to have come on during the time she was living

with her father in the summer of 1978 before her senior year; during that time she felt isolated and detached and claimed that she had progressively 'lost my sense of myself'.

The therapist diagnosed her as schizophrenic at this point and wanted to try her on Prolixin 2 mgm per day, which led to a great increase in the patient's anxiety and fearfulness about taking medication. She complained that the Prolixin made her feel that she was 'in a fog' and discontinued it and also discontinued her relationship with this therapist. Reading between the lines of the therapist's report one could sense his frustration, for the hard work that he had put into this patient showed very little result; it was my impression that he had done very competent work and also produced an excellent report.

The first six months of the patient's therapy

with me were aimed at the specific goal of getting her back together so that she could resume her school work. During that period she reported more information on the events leading to her 'change of self'. There was an increasing recognition of the deterioration of her mother's condition after her mother's hospitalization for depression in the spring of 1978, and an attempt to move from mother's house (the original parental home) and live with her father and stepmother during the summer of 1978. This turned out to be a very disappointing experience for the patient because she experienced the father and stepmother as cruel to her and not interested in her.

There were two dreams reported during the first six months of therapy. The first was that she was in her father's house which had no ceiling and was open. Her father and stepmother were there



and told her she must take a test to see if she is a lesbian. The tester was the 'fat psychoanalyst' who had told her she was crazy; she told him that he looked like a woman and walked out on him. There was also a huge grasshopper there. In her associations the patient mentioned that her father told her that her mother was a lesbian and she mentioned significantly, 'I feel I will go over the cliff with her.' She also reported that it was hard to get the money from him for the payment for the treatment, although he was grudgingly giving her the required checks.

The second dream was 'I was a bus-boy and kept dropping things and making mistakes. The owner warned me, but this owner was also a music teacher and an ineffectual person. Another man, good looking and effectual, also warned me.' The patient suggested that this dream might represent 'the two aspects of Dr. Chessick'. She

went on to report an expectation that I, like her mother and her music teacher, would suddenly rage at her or fire her. In other words, the patient at this point expressed the fear that I would suddenly get rid of her—in contrast to her actual repeated abrupt desertion of psychiatrists and recent constant moving from one parent's home to the other. She mentioned that she had many flying dreams, in which she flew from one parent's house to the other like a butterfly. She felt this represented a wish to escape from her anger and to be 'above it all'. She claimed that she was looking for 'an unspecified something' that one cannot find in any therapist, and also reported a tendency to see all male therapists as monsters.

I felt that this material indicated the patient was defending very hard against the possible formation of an idealizing transference with me at this time. I did not have time to await further

material or consider interpreting this defense to the patient because the father abruptly ceased to pay for the therapy sessions, claiming he had no money. Her anticipation of this and what it might do to her therapy provided further explanation of the above dreams.

We were now, after about five months, confronted with a financial crisis. The patient and I spent the months of November and December in a colossal effort to mobilize this family and try to get them to help support the treatment. I had a phone conversation with the grandmother, which did no good whatever because the grandmother simply blandly insisted that the father would pay for the therapy. I talked to the mother, who promised faithfully that she would pay for the therapy—but never ever gave the patient any money towards it. The father simply stated that he had financial debts and could not support the treatment at this

time, but vaguely promised the patient that at some future date he would pay for the treatment again. To my rather desperate suggestion that the patient go to work full time and pay for the therapy she responded with outright rage, because the whole aim of the six months had been for her to get back to college. She was already working part time and paying all her own expenses since father was not helping with her college tuition either, although constantly promising to do so. There was here a very real financial crisis in which the patient was quite let down by this family in spite of all their promises.

As a last resort I wrote to a millionaire who sits on the board of directors of a charity clinic for which I was a consulting psychiatrist, and asked if he would possibly support this patient's therapy for a year or two while she finished school. He wrote back a polite form letter stating that it was

not the policy of his financial foundation to support individual treatment. So, by the end of the first six months of therapy, I was confronted with having to see this patient for nothing or to stop the treatment. At this point she reported that she owed money to several of the other therapists she had previously seen, also because the father had promised to pay and then neglected to do so and they had not—like me—requested payment at each session. She further reported that during the course of the six months of treatment with me she was able to study again and had registered to go back to school in the coming quarter, the winter of 1980.

Although I tried very hard to maintain some equilibrium during the month of December 1979, the patient sensed that I was not really prepared to continue a long-term intensive psychotherapy for no financial remuneration and she herself

recognized that there was no point in going on, since she had no money. There seemed to be insight and she mentioned clearly that she recognized I was not at fault for the situation. She said, 'After all, I told you that I could pay for the treatment.' The situation looked dismal but the patient rescued herself at this point by writing a letter herself to the same millionaire. She heard me mention his name, looked him up in the phone book, and wrote to him without telling me. She later gave me a copy of the letter she had written, which was extremely well done, forthright and to the point—which was that she could not have psychotherapy if she continued in college and she could not continue in college and psychotherapy without financial support from somewhere.

The patient called me and informed me in January of 1980 that the millionaire had agreed to pay for two years of intensive psychotherapy for

her on a twice weekly basis. When I remarked happily on what a kind and charitable act this was she snapped, 'He can't buy my friendship.' I feel that the therapy never recovered from this December episode because the patient felt an empathic lapse on my part, due to my preoccupation with the problem of payment for the treatment. Her first dream after resuming treatment was that she was chased by something and frightened. Her associations were that this something was her anger; later she added that perhaps two women—one she admires and one she hates—were chasing her, 'and in the dream I flew, I was a man'. I felt that an ominous increase in splitting as well as an autistic grandiosity and regression with gender confusion were expressed in this dream. I tried to focus on her anger and disappointment over the financial crisis engendered by her parents, without much success,

since she denied being able to feel anything about them.

During the first half of 1980 the patient went back to school and was able to pass her courses with acceptable grades. The therapy however, was now a standoff and was marked by a constant complaining and devaluation of everything I did and everything I said. This was in contrast to a dream in which her mother married and went on vacation with a new kind of wonderful man, and the two of them took the patient along on the vacation. It seemed clear that any therapeutic alliance or further positive transference which had started to form had collapsed in the month of December, and the patient now split the representations in her mind into an imagined good therapist or parent, and projected onto me the bad therapist or parent. At times she was suddenly filled with overwhelming rage at me and I actually



was able to list for her all the accusations which she had made against me in an effort to show her the extreme negative picture that she had about me at the time.

All interpretations involving the projection of all bad self and object representations onto me at this point were flatly rejected. It was notable that whenever a discussion of the patient's disappointment with her mother occurred there was a sharp increase in her devaluation of me. The patient had clearly given up on the development of an idealizing transference and returned once more to attempt some kind of relationship with her deteriorated mother. At the same time she continued in school and graduated from college in the fall of 1980, after making up some incomplete courses in the summer. She never told her parents that the millionaire was supporting her treatment, and for all they knew the treatment was over in

December 1979.

During the entire year of 1980 there was no improvement in the patient's rage at me and she dreamed, 'I dislike you more and more as you turn out to be an ugly fat man like my father.' She repeatedly insisted that I was like her father and was unable to empathize with her or in any way be useful to her; in other words, I was just like the other therapists. She even began wishing that she was back with her original therapist whom she saw as a far greater therapist than I was. She felt that I paid no attention to her and was preoccupied with 'mothers and babies', and she went back to the student health service at the college to complain about me.

I was extremely careful to listen to her complaints and to try very hard to empathize with where she was at. But anything that I said was

invariably labeled as evidence of my utter incompetence and lack of empathy. At times, she simply requested me to be quiet so at least I wouldn't annoy her.

In the fall she went to graduate school but decided that she did not like it. There was increasing evidence of paranoia. For example, although I was extremely careful to express no opinions about which graduate school she should go to or into what field, leaving this entirely to her discretion, she accused me of having many opinions and of trying to force them on her. She also complained that she was becoming increasingly accepting of her 'new self' and less and less inclined to do anything about that.

She began working full time as a waitress during the fall of 1980 and planned to resume her education in 1981. She felt that at best I was an

incompetent idiot and at worst a dangerous persecutor who wanted her to be passive while I 'stuff her' with foolish interpretations. She claimed, 'I need an outlet' and 'I don't understand what therapy is all about.' She repeatedly threatened to leave and warned me that we had no relationship—which was manifestly correct.

She showed a similar pattern when anyone else expressed an interest in her. For example, a young male graduate student engaged her in some conversations and suggested that they get together for dinner. The patient accepted the dinner engagement but spent the dinner acting in a cold and distancing fashion so that he never called her again. Similarly, another graduate student began showing interest in her and sometimes smiled at her; she met his interest with a cold and distant stare. There was considerable discussion of her distancing behavior, which I

again and again tried to interpret as an attempt on her part to avoid any emotional relationship from developing with anybody. Her response to this was to tell me that I was 'nuts'.

The final dream of the treatment occurred in October 1980, and was as follows:

I was trying to get to an appointment with Dr. Chessick. On the way the elevators stuck between floors. A man with a trumpet appeared and showed me an open stairway going up very high, with no walls or ceilings. He led me up the stairway and at the top I found Dr. Chessick with a group of nurses and doctors all dressed in white and eating. Dr. Chessick was casual when I saw him and pleasant, and he said, 'I will only charge you \$5.00 for this session because there is so little time left for it.'

Her associations to the dream were:

You are just like the previous therapist who told me about his hobbies. You are not being professional in the dream. I miss my first therapist who I never complained about and

I was used to. You are just like my father; you ignore my observations. You don't help me. You don't let me explore how I feel. What am I staying here for? You are not interested in the details of my life and the person I am becoming. You give me too much feedback on too little input.

Then there was a long pause and at the end of this session the patient mentioned, 'I am thinking of the story of a man that I read about in a magazine recently who was seeking a wife and owed a very large hotel bill.' This was the last communication the patient ever made to me and I never saw her again after this session. My interpretation of the dream was that it represented the patient's profound longing for a fusion with an idealized parent imago and her bitter disappointment in the longing. The gender identity confusion runs consistently throughout this patient's material.

## Discussion

I found this patient of great theoretical interest, because she illustrates some of Pao's (1979) important conceptions of the formation of a schizophrenic disorder. I believe at the time I first saw this patient she was suffering from what Pao calls sub-acute schizophrenia; a new self was in the process of formation and consolidation. The purpose of this new self as Pao describes it, is to protect the patient from ever again having to experience what he calls, following Mahler, an organismic panic.

I believe that the horse as a transitional soothing and supporting object protected the patient from organismic panic during high school. There is considerable evidence for this from the patient's history. For example, she reported two memories. In one memory the patient's parents were quarrelling bitterly one evening and the patient went out and sat on her horse and felt very

soothed and comforted. In another vivid memory, a young colt accidentally became separated from the mare. The patient noted this and threw her arms around the young colt, weeping bitterly for its distress. We came back to this latter memory repeatedly in the therapy, although the patient denied any identification on her part with the situation of the abandoned colt.

I believe the deterioration of the patient's mother in the spring of 1978 made it impossible for the patient to any longer maintain the pretense that a mirroring selfobject relationship was intact between herself and her mother. Near the end of the therapy, when she was so extremely angry at me, she would call her mother and try to talk to her. She insisted that her mother would listen to her—even though she had before repeatedly mentioned that her mother was often drunk and would insist on spending all conversations in



complaining about herself. It became a delusion on the part of the patient near the end of therapy that she had an interested mother.

I believe that organismic panic was experienced in her mother's house in the summer of 1978, from which she fled to her father's house. The patient was never the same after that. The flight from therapist to therapist beginning in the fall of 1978 represented her recognition that an intrapsychic disaster had taken place, as well as an effort to restore an extremely archaic relationship with an omnipotent and perfect selfobject, so that any sign of empathic failure of any kind in the therapist no matter what the cause—even such a simple item as a casual comment about an interest of his own—produced profound disappointment and rage and her characteristic defense of suddenly leaving; perhaps this was a repetition in reverse of the sudden disappointment

experienced from the potential selfobjects which for her would be another 'falling out of the window', that needed to be avoided at all cost.

I feel that the case was of great interest because it represented a developing schizophrenia temporarily frozen *in statu nascendi*. By approaching the patient in this manner I was able to hold her in therapy for about a year and a half. There was a silent merger transference which I think enabled her to go back to school, but I believe the case floundered on the patient's need for an idealizing transference involving the father. The situation in December, in which both the father and I profoundly disappointed her, produced a fixed identification in her mind of the two of us which I was unable to change by any sort of interpretation. This identification contained a crucial defensive value because it enabled her to distance herself from me and avoid future

disappointment. I believe that the patient gave up on me because she did not want to experience in any way, shape, or form, or for any reason, my giving up on her.

I think that at the back of her mind was also the realization that the support of the treatment by the millionaire would come to an end in another year, which would again confront her with a financial crisis. The patient simply did not want to go through a repetition of the situation we suffered through in the fall of 1979, and the idea of working full time at menial work—which was the only possibility she saw until she finished graduate school—and having to pay out the money for therapy, distressed her greatly. There was partly a reality factor since she was heavily in debt already and under pressure to repay the school.

Pao (1979) writes:

By now the ego functions are relatively stable and the experience of organismic panic has almost subsided. The patient appears relatively comfortable, for his delusional new self assures him of a 'background of safety'. He no longer asks 'Who am I?', for he 'knows' that his 'new' delusional self is his self. (p. 246)

The patient ended up working full time as a waitress and with vague plans of going on in graduate school. As the illness advanced, her indifference became increasingly manifest and behind the facade of emotional detachment the patient reported that she felt empty or dead. Pao continues:

The objectively observable emotional indifference and the subjective experience of feeling empty, dead, or nothing represent one aspect of the schizophrenic's best possible solution. Like everyone else, the schizophrenic must process instinctual-affective and environmental stimuli. In

response to these stimuli he automatically conjures up various wishes, some of which inevitably lead to frustration, rage, murderous fantasies, persecutory fears, and organismic panic. Since organismic panic is an extremely ego-dystonic experience, the patient has to exert an all-out effort to avoid it. In the course of time, he comes to rely on indifference (or feeling empty, dead, or nothing) as the best possible solution. Through this solution, he succeeds in dampening the effect of internal or external stimuli as soon as they are registered. ... Chronicity often plays a significant role in the degree of indifference, as the passage of time permits consolidation of the defensive use of indifference, (p. 309)

I believe that the primary failure in this case was that my effort to reverse the patient's 'new self' formation failed because the patient was unable to form a stable idealizing transference. The patient consolidated into a form of chronic paranoid schizophrenia in spite of my best efforts. The most distressing experience of the therapy for me was

to witness this consolidation under my very eyes while being unable to do anything about it, except protest. Thus, Pao's type II schizophrenia shifted into a type IV schizophrenia, and a tentative re-establishment of self-cohesion by the organization of a pathological new self now became chronic, with an unmodifiable new self.

The extreme ambivalence of this patient made it impossible for her to form a sufficiently long-lasting relationship with the therapist in order to make therapeutic intervention possible. The crucial conflict of wishing to be simultaneously close and distant from other people was manifest both in this patient's history and her relationship in the therapy, and resulted in a life of chronic frustration. The distancing that the patient used seemed very much 'the best possible solution' that she could find to prevent further painful fragmentation experiences. These fragmentation

experiences or 'organismic panics' were rendered inevitable by her narcissistic demand for the absolute perfection of the selfobject, which could not be either modified or interpreted, because the rage was so great whenever these imperfections were experienced that the patient in essence broke off the relationship and dismissed anything that the therapist had to say. Pao calls this 'a desperate struggle against the symbiotic pull' (p. 183).

Another important theoretical point about this patient is that the material points away from 'splitting' as the basic problem. Of course, there is splitting of the self and object representations, in that the good ones are invested in the mother and the bad ones are invested in the therapist, but this splitting occurred primarily as a reaction to inevitable empathic failure on the part of the therapist, in which he cannot live up to the

patient's demands for perfect empathic attunement. The patient then flees from the therapist back to the archaic mother which is, in Pao's terms, the central delusion in this patient's schizophrenia; that is to say, the delusion of having an all-good mother who will listen to her appears as her rock bottom protection against empathic failure. What is missing in this patient is the capacity to stay in the relationship in spite of the disappointments in the wished-for perfection of the therapist. Instead, a fragmentation of the self occurs in which the therapist becomes utterly devalued and the patient retreats into a delusional core fantasy for the purpose of autistic soothing.

It is this vital step that makes the patient essentially untreatable by the method of intensive psychotherapy; thus, it is not the amount of raging that the patient does that represents the limit to the possibility of the treatment, but the patient's



refusal to stay in the relationship and insistence on falling permanently and irreversibly back on an inner world of her own making, which she does very suddenly, quickly discarding the therapist. The patient was aware that by staying in a long-term treatment she would have to experience inevitably from time to time frustrations and failure in therapist empathy. These experiences were apparently so painful for her that she could not allow them to happen; thus, the best possible solution for her was to withdraw from all interpersonal relationships.

The disorder here cannot basically be explained as resulting from the presence side by side of unintegrated all-good and all-bad self and object representations but rather, as Pao does, as a manifestation of 'the best possible solution' to avoid the unbearable experience of fragmentation of the self. Everything is sacrificed in the interest

of maintaining or attaining the minimum level of safety, as Pao writes:

The psychic apparatus is therefore constantly called on to direct its effort to maintaining that precarious feeling of safety. ...Maintenance mechanisms and early defense mechanisms (e.g., denial, projection) will be substituted for the later type of defense mechanisms (e.g., repression), (p. 225)

What Pao calls the preformed delusion, the delusional view about the self and the object world, in this patient is the feeling that she has an all-good mother who will listen to her. It is around this delusion that the patient re-establishes the sense of self after fragmentation due to disappointment. Attempts to get at this preformed delusion, which constituted an essential aspect of my approach, exposed the patient to a recurrence of organismic panic, because they represent the threat of removing the patient's most important

self-soothing mechanism before any other soothing is available in the form of a transference to the therapist with subsequent transmuting internalizations.

Thus, the therapist is trapped; if he accepts the delusional system as it stands, he is accepting the patient as a chronic schizophrenic and will have to deal mainly with her efforts to adapt to a crippling defect. Because of the intensity of the patient's need to form a selfobject transference with a perfect selfobject, the therapy will soon deteriorate and the therapist—as did the first therapist with this patient—will feel a profound sense of frustration. If on the other hand as I did, the therapist attempts to discuss and uncover the basic fallacy of the relationship with the mother, the patient will respond with rage, distancing, and accusations of lack of empathy—for indeed it is a sort of lack of empathy to threaten to take away a

patient's psychosis, when from their point of view it is all they have to protect them from organismic panic.

Pao (1979, p. 236) explains that delusions are extensions of pre-existing fantasies, and contribute immensely to the re-establishment of the badly needed sense of self-continuity. This is especially effective in paranoia, where the delusions enable enough self-cohesion for the patient to mask impairment of cognitive capacities and other ego functions (p. 187). He defines a delusion as a retrospective falsification of the infantile experience. Although my opinion was that the father in her childhood had offered the patient more than the mother because at least in some sense he took responsibility for what happened to the family, the patient consistently insisted that it was the other way around; that it was from her mother she obtained the main

soothing and support that she needed. This was maintained in opposition to overwhelming evidence of the mother's utter lack of empathy and inability to mother this patient, or anybody.

This case also brings up some very important countertransference issues in the treatment of preoedipal disorders. I don't think there is any question that I over-estimated her capacities and state of mental health, probably as a countertransference reaction to her obvious intelligence and verbal skills. In general if a patient has been unsuccessful with ten therapists it is almost impossible to expect that she will be successful with number eleven, but here again I was impressed with the patient's obvious earnestness and sincerity in trying to reverse the formation of the new self, which at the beginning of therapy she recognized as a disaster. My intellectual interests were stimulated by her

because I felt we were seeing this self formation *in statu nascendi*, but on reflection I think that the new self was considerably more consolidated than I was willing to admit at the time.

The most frustrating countertransference issue raised by this case is the issue of payment for treatment. What does the therapist do when a family guarantees the payment of treatment and then after six months refuses to pay any longer? Ordinarily the patient is asked to go to work full time and pay for the treatment at whatever rate is reasonable for their income, and that is what I would have done in this case. Had I insisted on this the patient would have definitely left therapy at once because it would have been asking her to give up hope of finishing college in her senior year. Perhaps there was a manifestation of countertransference here also, because I felt, as did the patient, that the goal of graduation from

college was very important as a self-cohering and self-esteem enhancing accomplishment for her. To ask her to drop out of school for some years and work at a menial job in order to pay even a small fee for two sessions of psychotherapy a week would have represented a tremendous sacrifice that would have made the patient very fragmented and probably made me very guilty. The bottom line of this discussion is that the patient sensed that I was simply not willing to see her for nothing for a long period of time, and it is this for which I was never forgiven, in spite of the colossal efforts we both made in eventually obtaining financial support.

All the therapists I could contact who worked with this patient ended up with a sense of being trapped and frustrated because their best efforts toward her somehow were extremely devalued. The most dramatic example of this was the

desperate effort of her first therapist to give her Prolixin. The patient was inflicting on the therapists what her mother had inflicted on her; that is to say, no matter how hard the therapists reached out to her and how many ways in which they attempted to soothe and to interact with her, she somehow saw to it that situation ended not only in disappointment but in a disappointment in which the therapist somehow felt devalued, guilty, and frustrated. I believe that it is a common experience for the schizophrenic patient painfully to inflict on the therapist the experience and fantasies of revenge that they have in turn received at the hands of the mother. In a previous publication (Chessick 1982b) I have described how inflicting revenge on the deep unconscious of the therapist was a crucial step for a borderline patient, enabling the resumption of development and attainment of mental health. The present



patient was compelled to act out this revenge, destroying her treatment.

Money, for this family, was a critical way in which they each disappointed the other members. The mother was always in debt, unable to manage her finances, and constantly attempting to extract more money out of the father. The mother was also totally corrupt with the patient; for example, she would take insurance checks which were received for the patient's therapy bills and instead of sending these to the therapists she would cash them and spend them on herself, thus leaving the patient with large unpaid therapy bills with the other therapists. The father would promise various sums of money to the mother and to the patient but then either not deliver the money at all or force the patient to repeatedly ask for it; there was an utter unpredictability in his financial behavior. The grandmother—father's mother—

who had adequate money and could have financed the patient's therapy, clung tenaciously to the fiction that her son, the father, was consistent and loving and would gladly provide all the money that the patient needed. Thus, no matter in what direction the patient turned, she met with frustration along with the refusal to accept responsibility for meeting her needs and, as time passed, an increasing set of accusations on the part of various family members that she was to blame for her own difficulties.

One of the most striking features of the case was her tendency to return again and again to telephone conversations and meetings with her mother in the face of overwhelming evidence that the mother did not have the slightest interest in anything about her. Indeed, at every one of these meetings the patient ended up 'lending' money to her mother, which she never saw again. When the

patient would visit the mother at her home, the patient often spent time there cleaning up the house and throwing out empty beer bottles. Any attempt to discuss the reality of this mother was met by the patient with an explosive rage, which seemed to be clinically the projection of all-bad self and object representations onto the therapist in order to preserve the all-good self and object representation of the mother. But it is better explained as a rage secondary to what she experienced as empathic failure in the therapist in which the patient's precious core delusion is challenged, which would then leave her vulnerable to organismic panic.

The abrupt way in which this patient leaves her therapists is of great psychodynamic significance. It is the best communication of the way the patient was in a sense set up by the mother, who pretended to be a suburban middle-

class mother and then repeatedly severely and abruptly disappointed her; this abrupt leaving represents a communication of the extraordinary depth of the patient's pain and disappointment, as well as an attempt to inflict narcissistic wounding on the therapist in retaliation. It is hard to decide whether, if the threat of my leaving the patient for financial reasons had not come up, the patient would still have had to eventually inflict this abrupt leaving on me. As Grotstein (1983) writes:

Often, with schizophrenic patients in analytic treatment, whether classical or Kleinian, a negative therapeutic reaction occurs. The very success of the treatment institutes a progressive disengagement, an increasing crevasse, between the normal and abnormal personalities—to the point where psychotic catastrophe or psychotic acting out becomes imminent. The psychotic personality tends to respond in terms of outrage. In other words, the ignored schizophrenic personality must loudly 'knock on the door' of the normal personality so as to call attention to its panic

at being left behind in the forward surge of its twin's progress.

This patient was neither amenable to interpretation nor to a relationship or supporting form of psychotherapy, which is also what makes the case of great theoretical interest and worthy of presentation and discussion. It is a most poignant situation in which a human being is undergoing a catastrophe of the first magnitude at a young age, and we can only stand by and watch it happen.

### *Note*

Originally published in *Dynamic Psychotherapy* 2: 136-49, 1984. Reprinted by permission.

## Impasse and Failure in Psychoanalytic Treatment

A psychoanalytic treatment can fail for many reasons, and the impasse is only one of them; but it is so singular that it merits preferential attention. Stealthy and silent, the difficulty of detecting and resolving it is intrinsic in its nature, as is studying it and reflecting on it. It is perhaps the worst risk in our hazardous occupation and the most certain threat to our instrument of work. Just one of these cases is sufficient to shake our scientific ideology, because impasse is not simply an internal difficulty of the theory but a real anomaly, which brings into question the psychoanalytic paradigm and threatens with a crisis. And in general it does not present itself to the newly trained analyst but to one who already has sufficient experience to remove more visible obstacles. (Etchegoyen 1991, p. 796)

An impasse in psychoanalytic treatment is an insidious arrest of the psychotherapy process which often results in failure or, worse, transference and countertransference acting out. As Etchegoyen (1991) points out, 'It tends to perpetuate itself: the setting is preserved in its basic constants; its existence is not obvious as incoercible resistance or technical error; it is rooted in the patient's psychopathology; and it involves the analyst's countertransference' (p. 786).

An impasse occurring even in one single case is very serious for the conscientious psychoanalyst because it forces the analyst to review his or her entire choice of profession, theoretical orientation, and the discipline of psychoanalysis itself. It is not the same as blatant failure or interruption of treatment, which usually can be traced to

relatively obvious personal and recognizable faults in both the patient and the analyst. The impasse, on the other hand, involves a very subtle interaction between the analyst and the patient so that it may go on for months or even years before the analyst realizes what has happened. In some cases, the patient who is suffering the impasse not only often does not mention it, but will resolutely deny it if it is suggested by the analyst. Of course that is not always true, since some patients complain of impasse from the very beginning of the treatment and never budge from that position.

Impasse is complex and multi-determined and countertransference is often deeply and subtly involved. From my clinical experience, when the analyst realizes that an impasse has occurred, it may be a shocking and humiliating experience and may require serious self-analytic study. In this chapter, I will discuss failure and impasse and



then offer a case presentation to illustrate the difficult issues entailed.

## **Failure**

In a previous book on clinical studies of failure in psychotherapy (Chessick 1983b), I reviewed the patients encountered in the first fifteen years of my private practice. One category included all patients who dropped out of therapy after at least three initial interviews but without mutual agreement to terminate. However, these patients were not all failures. They included teenage patients who were taken out of treatment after a year or so of twice weekly psychotherapy by their parents. Even though they had made obvious substantial progress, their parents did not approve of their growing health and independence. In the same category also were patients with schizophrenic episodes and some

with depressive episodes who had gained symptomatic remission and good return of previous functioning capacity, but who refused to go further into uncovering psychotherapy. There were some patients who had to leave me before I gave any signs of leaving them; these tended to have a very rigid and brittle ego structure.

A few patients revealed massive chronic fixed paranoid delusions, secretly held for many years and clearly inaccessible to treatment, at least from me; these patients usually terminated treatment after five to fifteen visits. One or two patients with a previous history of hospitalization became psychotic again during treatment and had to return to the hospital.

Certain patients dropped out after one to four months because, in spite of repeated explanations, they expected fast results and therefore were

easily disappointed. Most prominent in this group were oral characters, alcoholics, drug addicts, and patients with hypochondriacal complaints. A few patients realized they could not really afford psychotherapy and admitted they had lied about their financial capacity because they secretly hoped to have an unusual quick treatment. The husbands of several women patients stopped paying for treatment despite having initially agreed to do so, because they had hoped for a quick change in their wives that did not materialize.

Also in this category were the patients who were outright failures. In spite of all my efforts, they either made no improvement or gradually went downhill over a period of 50 to 200 sessions. In order to understand what happened in such cases a patient-by-patient analysis is required; generally these were severe borderline patients,

often with alcoholism or drug addiction and a history of repeated failures in various therapies. A few were homosexuals who had an increasing paranoid development that I could not check. Of those whom I could follow up, a small number reported definite improvement after leaving therapy; a few went on to see another therapist with variable results, and two 'improved' with subsequent group therapy.

Not all drop-outs are failures in treatment and not all successes are terminable. It is not always easy to determine success or failure in psychotherapy nor to recognize the clinical danger periods for failure, impasse, or dropping out. Patients who refuse treatment or unexpectedly fail to return after a diagnostic work-up represent an immediate and obvious failure at the outset. Some have a need to inflict a narcissistic wound on the therapist. Some are simply too frightened to

continue. This failure is at times attributable to the flawed skill of the therapist and/or conscious as well as unconscious factors in both the therapist and patient that reject either an alliance or psychotherapy. Regardless of the humiliation involved, therapists should try to follow up these patients as much as possible in order to learn more about themselves and the patient and the reason for the failure.

Outright failures after the treatment begins, due to a basic defect in the therapist or the patient (or both), represent a tricky and stubborn problem as well as an unfortunate waste of time and money. The best hope for preventing these failures is to train psychotherapists adequately and encourage them to gain insight into themselves. Outright failures usually occur when there is no solid therapeutic alliance or when the therapist does not sufficiently recognize, interpret,

and work through resistances before dealing with psychic content. Elsewhere (Chessick 1991) I discussed in detail the conduct of the therapist and the formation of the therapeutic alliance. It goes without saying that in order to develop a reasonable working alliance the therapist must first present himself or herself in a reasonable and realistic fashion. This will automatically rule out a whole variety of bizarre procedures that are presently being foisted upon the public in the name of therapy.

Greenson (1967) presents the technical aspects of dealing with resistance, beginning of course with the importance of recognizing the resistance. The resistance is to be demonstrated to the patient by allowing it to become manifest through waiting for several instances; at times it is necessary, says Greenson, to intervene in such a way as to increase the resistance in order to help it

become demonstrable. Next the motives and modes of resistance must be clarified. What specific painful affect is making the patient resistant? What particular instinctual impulse is causing the painful affect at this time? What precise mode and method does the patient use to express his or her resistance? The interpretation of the resistance should explore what fantasies or memories are producing the affects and impulses behind it and pursue the history and unconscious purposes of these affects, impulses, or events in and outside the analysis, including the past. The mode of resistance is to be interpreted, including similar modes of activity that represent resistance and acting out in and outside the psychoanalysis. Finally, the history and unconscious purposes of this activity in the patient's past and present need to be traced and worked through, and the resistance is hopefully to be dissipated by

repetitions and elaborations of the above procedures.

In a previous publication (Chessick 1984) I described a dramatic failure in the psychoanalytic psychotherapy of a remarkable schizophrenic patient. I believe that the primary failure in this case occurred because my effort to reverse the patient's psychotic so-called 'new self' formation failed, due to the fact that the patient was unable to form a stable idealizing transference. The patient's psyche consolidated into a form of chronic paranoid schizophrenia in spite of my best efforts. The most distressing experience of the therapy for me was to witness this consolidation under my very eyes while being unable effectively to do anything about it.

The extreme ambivalence of this patient made it impossible for her to form a sufficiently long-



lasting relationship with me in order to make therapeutic intervention possible. The crucial conflict of wishing to be simultaneously close and distant from other people was manifest both in this patient's history and her relationship in the therapy, and resulted in a life of chronic frustration. Pao (1979) calls this 'a desperate struggle against the symbiotic pull' (p. 183). The distancing that the patient used seemed very much 'the best possible solution' that she could find to prevent further painful fragmentation experiences. These fragmentation experiences or 'organismic panics' were rendered inevitable by her narcissistic demand for the absolute perfection of the selfobject, which could neither be modified nor interpreted, because the rage was so great whenever these imperfections were experienced that the patient in essence broke off the relationship and dismissed anything that the

therapist had to say.

What was missing in this patient was the capacity to stay in the relationship in spite of minor disappointments in the wished-for perfection of the therapist. Instead, a regressive process occurred in which the therapist became utterly devalued and the patient retreated into a delusional core fantasy for the purpose of autistic soothing. It is this vital step that made the patient essentially untreatable by the method of intensive psychotherapy. It is not the amount of raging that the patient does that represents the limit to the possibility of the treatment, but the patient's refusal to stay in the relationship and insistence on falling permanently and irreversibly back on an inner world of his or her own making, which in this case she did very suddenly, quickly discarding the therapist. The patient was aware that by staying in a long-term treatment she would have

to experience inevitably from time to time frustrations and failure in therapist empathy. These experiences were so painful for her that she could not allow them to happen; thus, the best possible solution for her was to withdraw from all interpersonal relationships.

All the therapists I could contact who had worked with this patient ended up with a sense of being trapped and frustrated because their best efforts toward her somehow were extremely devalued. She refused even to cooperate with psychopharmacological psychiatrists. The patient was inflicting on the therapists what her mother had inflicted on her; that is to say, no matter how hard the therapists reached out to her and how many ways in which they attempted to soothe and to interact with her, she somehow saw to it that the situation ended not only in disappointment but in a disappointment in which the therapist

somehow felt devalued, guilty, and frustrated. I believe that it is a common experience for the schizophrenic or borderline patient painfully to inflict on the therapist both the experience and consequent fantasies of revenge that they have in turn received at the hands of the mother. In a previous publication (Chessick 1982b) I described how inflicting painful revenge on the deep unconscious of the therapist (myself in that case) was a crucial step for a borderline patient, enabling the resumption of development and attainment of mental health. The schizophrenic patient described above was also compelled to act out her revenge, destroying her treatment, a not uncommon behavior in such patients.

## **Impasse**

In the present chapter, which is based on an additional twenty-five years of experience in

psychoanalytic practice, now reaching a total of almost forty years, I wish to deal with a more subtle kind of failure, the stalemate or impasse. Maguire (1990) asks whether stalemate invariably reduces itself to issues of self-analysis or reanalysis, or if it involves the need for better conceptual and technical tools. Must the analyst invariably assume the burden for the analysand's intransigence, and should priority be given to countertransferential issues? In at least one category of therapeutic stalemate the answer is no; Maguire argues that there are stalemates or impasses which occur 'as an inescapable fate of those analyses in which the analysand's intuitive perception of the analytic task ahead generates such incalculable tensions, and consequently such intractable resistances, as to preclude the regressive mobilization of the transference neurosis' (p. 64).

Maguire distinguishes between negative reactions in therapy that are founded on resistance, those which represent the negative therapeutic reaction, and therapeutic stalemate. Impasse or stalemate is insidious and often recognized only retrospectively:

The first portent of stalemate may be the analysand's initial failure to engage the therapeutic process affectively. Alternatively, stalemate may be heralded by the analysand's gradual and insidious withdrawal of affective investment from the process once engaged, what I like to refer to as the devitalization of the analytic compact and situation, (p. 66)

There are certain additional presumptive signs of a developing impasse, as for example when the frame of the treatment becomes a problem, involving such behavior as persistent tardiness or absences that remain inaccessible to interpretation or, on the contrary, an excessive

compliance with the frame that Maguire calls a 'slavish devotion'. The patient may lapse into progressively longer periods of silence or engage in a highly intellectualized process with an endless recycling of old issues. The patient may regress:

...to a fixed state of hostile dependency, challenging the analyst's competence and good will by evincing a defensive demandingness that preempts further engagement. Using depressive affect as a weapon for purposes of vengeful distancing, the analysand oscillates between unremitting recriminations about the process and a general state of lethargy, (p. 67)

Maguire hopes that if there is an early recognition on the part of the analyst of the development of an impasse before the whole credibility of the procedure becomes irreparably damaged, 'and an acceptance by the analyst of the analysand's negative perception of the process as both psychologically and realistically valid' (p. 68), and

if there is some minimal good feeling on the part of the patient that is left which could be mobilized, there is still the possibility of a favorable outcome to the impasse.

He presents a patient who was unable to enter regressively into a transference neurosis because she intuitively anticipated an experience in a transference neurosis from which she would not be able to recover. Kohut (1977) mentions this type of danger that certain patients intuitively recognize if certain aspects of the mirror transference are activated, an activation which would expose the patient to the danger of permanent psychological disruption through the re-experiencing of primordial rage and greed. In such patients, for example as in Kohut's case of Mr. U., behind the more apparent layers of frustration:

...there hovered always a nameless preverbal depression, apathy, sense of deadness, and



diffuse rage that related to the primordial trauma of his life. Such primal states, however, can neither be recalled through verbalized memories, as can traumata occurring after speech has developed, nor expressed through psychosomatic symptoms, (p. 25)

These patients intuitively sense that psychoanalysis, if leading them to become engaged in a transference neurosis, would be what Kohut calls 'a regressive voyage from which there is no return' (p. 25). I tried to depict this situation of nameless underlying dread in another presentation (Chessick 1996d), and Grotstein (1990a, 1990b, 1990c, 1991) has paid a great deal of attention to these very early unendurable archaic states, which patients must avoid at all costs. As in the case of Maguire's patient, such patients still may be able to make use of the analyst in a circumspect and distancing manner; perhaps this happened with the patient to be

presented in the second part of this chapter.

Etchegoyen (1991) throws additional light on the problem of impasse by utilizing Bion's (1963) idea of 'reversible perspective'. Bion introduced this concept to denote a drastic attempt on the part of the patient to destabilize the analytic situation through a remarkable reversal of the processes of thought. The patient silently, either consciously or unconsciously, experiences the entire psychoanalysis from a different set of premises than those held by the therapist. The analytic contract is actually violated, although the patient appears on the surface to be cooperating with the treatment. Etchegoyen (1991) explains that in this situation the patient

...is continuously reinterpreting the analyst's interpretations so that they can blend with his own premises, which is also a way of saying that the analyst's premises have to be silently rejected—silently, because between

analyst and analysand there is manifest accord and latent discord, of which the analyst usually becomes aware only when he realizes that the process is completely stagnant, (p. 759)

The clinical example Etchegoyen offers is that of a homeopathic physician who ostensibly came seeking psychoanalytic treatment for anxiety and crises of depersonalization as well as hoping for a modification of the psychological factors contributing to his bronchial asthma. Actually, the patient was guided by professional rivalry and simply wanted to reassure himself that the method of homeopathic medicine was superior to the method of psychoanalysis!

Reversible perspective is often operative in patients who are chronically late. In those situations, as Etchegoyen, explains:

to interpret at the level of defense mechanisms is not enough. Because as one interprets lateness or silence in terms of

fear, frustration, revenge, envy, Oedipus complex, castration anxiety, omnipotent control or whatever, one has not reached the level at which the conflict is rooted, (p. 766)

The reversion of perspective needs to be suspected when everything seems to be going well in the treatment but no change is taking place in the analysand. This is not an infrequent occurrence in training analyses, where the analyst thinks he or she is helping the patient to resolve neurotic difficulties but the patient, a candidate analyst, is simply intending to use the training analysis as a source of borrowed knowledge and accreditation. This is an example of reversible perspective that often appears in narcissistic personality disorders; a common and extreme type of such patient enters analysis secretly not in order to be cured of neurotic difficulties but to demonstrate to the analyst that he or she does not need analysis at all. The very premise that the

patient is the patient and the analyst is the analyst constitutes a painful narcissistic blow for some people; this is especially a difficulty in the analysis of mental health professionals and in patients with narcissistic or borderline personality disorders.

One sometimes sees a similar situation when analyzing colleagues in the mental health profession who attempt to use the analysis to 'teach' the analyst that the analyst's theoretical orientation is incorrect and to persuade the analyst to adopt the analysand's theoretical orientation. Other variations of this from my own clinical practice are, for example, the patient who spent many hours trying to convince me that her difficulties were caused by various chemicals in the air that she breathed, or mental health professionals who enter psychoanalysis because they have been involved in unethical behavior and wish to strengthen their case when it comes up in

front of the licensure committee by being able to state that they are seeking treatment for their difficulty. In certain of these latter cases the patient's sole aim is to impress the licensure committee; they secretly believe that they have no mental health problem. The patient who was convinced her difficulties were due to the chemicals in the air was a brilliant woman who actually accumulated a large library of volumes purchased in local bookstores and written by so-called 'experts' and even physicians practicing outside the mainstream of American medicine. She did this so effectively that she convinced her whole family that she was correct and sent them all off seeking a bizarre variety of antidotes to the supposed chemical dangers, utterly obsessing and preoccupying them with finding a completely chemical-free environment in which to live and work—a task that of course never succeeded.

Gedo and Gehrie (1993) present seven common pitfalls that often lead to an unsatisfactory course of many psychoanalyses. These involve errors in the diagnosis, errors in the nosology and strategy of treatment, commitment to a favored clinical theory, failure to agree on rational goals for the treatment, the problem of a cultural gap, countertransference issues, an unfortunate neglect of careful scrutiny and analysis of superego contents, and the issue of whether to concentrate on the transference in the here-and-now versus reconstruction of the past.

Referring to this latter issue, they explain that a common difficulty occurs when there is confusion in the mind of the therapist about the way in which vital unresolved issues are relived within the psychoanalytic situation:

Instead of relating the relevant vicissitudes of the patient-analyst relationship, (the

candidates] tended to summarize a series of reconstructions about the childhood past. What is worse, often they did not specify whether those conclusions were reached on the basis of the unrolling of a sequence of transference reactions or whether they were the kinds of 'dynamic formulations' demanded of participants in psychoanalytic training programs, that is essentially speculative, (p. 8)

It has also been my supervisory experience that this is a common confusion displayed by students in the mental health profession.

Gedo suggests meeting adaptive distortions that have occurred in the patient which interfere with our attempts to provide ordinary developmental assistance in a confronting fashion with an effort to correct them. He also warns that conversely the envy of patients' superior abilities and creativity may lead to a depreciating attitude on the part of the analyst that in turn leads to an impasse. The crucial test in studying our



interventions is to observe the effect of each intervention. The correct interpretation of a defense leads to psychic or behavioral alteration; interpretations based on an over-estimation of the patient's resources leads to rage and/or disappointment in analysis and carries the danger of an impasse. Gedo emphasizes the necessity for the analyst to transform enactments into verbal statements, in a sense teaching the patient a new language, and he insists that we must not impose a technique on the patient but instead devise a technique that the patient can use. For example, 'Correct interpretations are experienced as assaultive if they put the analysand in the position of unacceptable passivity—in terms, for example, of causing excessive anxiety or even pleasurable overstimulation' (p. 212). This is a very important point.

Not all patients share the analyst's sense of

impasse. Renik (Coen 1994) describes a patient who was quite content with her relation to the analyst and considered him as supplying a missing vital part, in an almost quasi-delusion. In psychoanalyses where the patient in this fashion is using the analyst as a fetish, claims Renik, 'such analyses must lead to impasse' (p. 1227).

More generally, the pressure on the analyst to abandon his or her ordinary role, coming either from new psychoanalytic theories or from the patient, has become more intense recently as the literature pays more attention to developmental processes. According to Spence (Coen 1994), analysts are especially tempted to take the role of a nurturant mother and to imagine that psychoanalysis is a process for correcting development. In discussing the various cases of impasse reported by members of a panel on impasses at the American Psychoanalytic

Association, Spence pointed out that each analyst was forced by his patient into playing some role other than that of the interpreting analyst: 'Once the analyst could recognize and interpret this false role, the impasse was interrupted ... for the impasse to be resolved, the analyst must indeed get out of such false roles and return to the position of interpreting analyst' (p. 1231).

Chused (Rosenblum 1994) points out that there are some resistances that simply do not yield to interpretations:

As a result, we change our technique with different patients. Whatever the deviation each of us adopts, to the extent it deviates from what we consider our standard analytic technique, it reflects an internal decision that the patient needed something different in order to do the work of analysis, (p. 1259)

This leads to an unresolved issue in the study of impasse. Many more traditional psychoanalysts

claim that deviations in technique are often the cause of impasses in psychoanalysis, while a more adventurous group of psychoanalysts maintains that impasses can be avoided or resolved by the willingness on the part of the analyst to consider the point of view of other theories, and to provide interventions that are not called for by the particular theory to which the analyst usually is committed.

## **II**

### **Case Presentation**

In the second half of this chapter I wish to present a patient who is probably the most difficult one for me to understand and deal with in my current clinical practice. She is a brilliant patient whom I have been seeing three times weekly for the past twelve years. During that entire time the patient has protested almost at every session that the treatment is worthless and

it does her no good whatsoever. She claims she has no idea why she keeps coming, she doesn't believe in psychiatrists or psychiatry, and she is a hopeless case that no one could help anyway. At the same time she has attended reliably and consistently over all these years. The only exception to her claim that the whole treatment is of no value and that she has no relationship with me occurred when I was hospitalized for major surgery which caused me to have to interrupt my practice for about six weeks during the eleventh year of her treatment. At that point the patient suddenly felt a tremendous upsurge of love and concern for me and a tremendous longing to see me. Upon my return to my practice this soon dissipated, at which point she relapsed to her usual continual complaints about the treatment.

This patient had an arrangement with her hospital employer that she would decide each year

how much money her medical expenses would be for the coming year and request a deduction of that amount of money from her salary in advance, which was advantageous to her for tax purposes. This meant that the patient had to commit herself every December to a full year of treatment for the following year (otherwise she would lose the money). Every December she underwent an obsessional discussion with herself about whether it made any sense to commit herself for another year, but it was always with the implication that there was no real question if she was going to do it.

Dr. A., an extremely intelligent 35-year-old, moderately attractive, highly respected oncologist, was referred to me by a social worker who was finishing her analysis with me. Dr. A. was known on the ward where the social worker also worked as being rather eccentric in her behavior; for

example she would pick her nose during rounds and she dressed in old or ragged clothes with some neglect of her personal appearance. Dr. A. decided about three years before meeting with me that she wanted to have children. She was convinced that she would never get married and was living with her eccentric chain-smoking elderly mother; she had no social life or social relationships whatsoever, and her existence consisted simply of working long hours with much night call, and reading popular novels which she bought at the supermarket. By the time she came to see me at the urging of her colleagues, she was obsessed with the idea of having children and was starting an artificial insemination program. She never had any sexual relations and denied having much sexual interest although occasionally she masturbated.

The patient's mother was born in the United

States and was described as an 'energetic loner who was very undemonstrative physically'. She worked with the patient's father in a small business. The father died of a cerebrovascular accident about six years before I saw the patient and for about two years before that he had a serious illness, a metastatic melanoma. While her father was sick the patient was in a fellowship in oncology and developed such severe anorexia that her weight went down to 89 pounds. She was abruptly asked by the head of the department to leave the fellowship. This did not alarm the patient. She went home and saw a therapist for a few months at which time she began eating modestly again so that her weight went up to its current level of 130 pounds. The patient always struggles with her weight and cannot stand the thought of any body fat showing ever since she was a teenager and was teased for being a little



overweight. Although she is slim, she wears a tight girdle at all times. She flatly denied any connection of any of her difficulties to her father's death. Three years prior to seeing me she gave up even occasionally going to singles clubs and gave up any hope to find a marital partner. She could not remember the name of the therapist that she saw in her home town for the episode of anorexia or describe what they discussed.

When I first saw her she claimed that she was reasonably comfortable and happy except for 'ups and downs with the baby problem', although she conceded that two months ago she was quite depressed and found it an effort to do things, but was able to work and lost no weight. She had one sister who was four and a half years younger and who had a long history of sociopathic behavior, drug ingestion, and possibly some psychotic episodes. This sister was being supported in

another city on money from the patient's mother. The patient claimed that as a child she had several girlfriends but she has no friends at the present time except her mother. She claimed that she was her father's favorite and that her mother favored neither child. There was no family history of mental illness. The patient was in good physical health and never used drugs or alcohol.

Her mother's first baby was a boy, born dead thirteen months before the patient was born. The patient's first year of life was disturbed by severe eczema and colic. She reported that her mother was sure that she would die: 'I scratched ridges on myself and cried all night.' During her second year of life mother had her first miscarriage. The patient continued to be a feeding and sleeping problem. By the time she was 2 years old she talked in long sentences and gave no difficulties with toilet training. It was soon apparent that she

was a very intelligent person. In the fourth year of the patient's life her mother suffered another miscarriage and hired a part-time maid who had some unclear role in the patient's upbringing. When the patient was 4 years and 6 months her sister was born. Her earliest memory is of mother bringing the sister home from the hospital: 'I touched her and held her and loved her as soft and cute and cuddly.' This is especially significant because the patient has repeatedly said that the only pleasure she gets in life is from holding the cute and cuddly little babies of her own; as soon as the child reaches about the age of 3 and doesn't want to be held and cuddled all that much any more, the patient ceases to have such intense pleasure in the child and begins planning another pregnancy or, lately, an adoption.

Kindergarten at the age of 5 years and 6 months was marred by surgery for appendicitis.

The patient remembered that already in first grade she had trouble with the other children on the playground. Her mother had a third miscarriage. The patient at that time had one friend and visited her house every week or so. She also developed recurrent 'boils' on the legs and was treated at home. By the time the patient was 7 or 8 years old the maid had left the employ of the family.

At the age of 10 the patient discovered that the maid had died and developed her first asthma attack. Also, mother decided that the patient was too old for birthday parties and these were stopped. Between the ages of 10 and 11 the patient's school work was so good that she left the other children far behind. This stimulated a lot of sadistic behavior from the other children. The patient was transferred to a small private school where she continued to be very unpopular and

ceased to have any friends. In junior high school her father broke his arm and the patient had her second major asthma attack. By the time she was 15 years old her mother's behavior became very unpredictable and difficult and the patient became very busy in school but was always 'out of sync' with the other girls. Her life consisted of school work and volunteer work. Around that time also, her younger sister began taking drugs and acting very oddly, to the point where the patient had to point out to her parents that her sister was psychotic. By the time she was in college she was working thirty to forty hours a week as well as doing her college work. School and work took up all of her time. She had no social life and claims she did not miss it as she was too busy.

At the time her father got sick her mother went to work and the patient began dieting. From about the age of 21 when she began medical school to

the time I saw her the patient dated men occasionally, but nothing ever developed and she always had a reason why this or that man was unsatisfactory. This is in spite of the fact that the patient was basically a very decent, ethical (she was chairperson of the ethics committee in her hospital), pleasant, and reasonably attractive apparently successful woman physician. By the time she was an intern at around the age of 25 she had a serious eating problem and her weight was down to about 110 pounds. It remained around that during her residency and only during her fellowship when her father died did her weight become alarmingly low.

She summed up her current state as consisting of a drive to have babies, an inability to form meaningful relationships with anybody, a serious eating problem, and a sense of discontent in life. She stated, 'I have very poor judgment about how I

look', and went on to insist that I call her by her first name because in her group of doctors everyone went by their first name. I cannot ever remember when this patient has called me by name, either by my first name or last name in twelve years.

The patient also had considerable difficulty in driving a car (although she commuted from a long distance) because she was very frightened of falling asleep at the wheel. When very depressed she felt the impulse to drive her car into a concrete abutment. If anyone shouted or cursed at her in traffic she became absolutely devastated psychologically and severely depressed and agitated.

Once or twice, when she was extremely agitated and upset over some automobile incident, the patient accepted a small amount of

tranquilizers from me. She has absolutely refused to take any other medication including antidepressants because as an oncologist she has seen a number of patients who had taken various medications that were not known to cause cancer and which later were found to have a carcinogenic effect.

Her reported dreams during the initial interviews were: (a) she was down at the seashore with her mother, father, and sister and it was very pleasant. To this she associated that she wants her family back together, (b) It was the first day of college or some kind of examination and she lost her schedule. To this she associated that she often has dreams in which she is not prepared for a course or examination for one reason or the other. She interpreted this dream as being anxious over getting to her first appointment with me on time. I wondered to myself if she was warning me she



was not prepared to undergo analysis.

From the very beginning of the treatment, three times weekly using the couch, the patient was very anxious and worried about the therapy and even wondered if she should have a female therapist. She admitted the latter was her mother's idea. She recognized that her parents had never been able to understand a child's needs. As a child she had to keep her rage to herself because due to the family business, which was operated out of her home, the children had always to be very quiet. She recognized that she turned this anger on herself and was starving for someone to share her life with, but 'something keeps me from finding it—I am very moral and would never think of stealing it'. Her first dream on the couch was, 'I am home but only as a visitor. My father is still alive but sick. I put milk in his cornflakes and go to get him some bananas, and I also make breakfast

for my mother and I. He seems very confused and makes a silly grin, yet he never smiled when he was sick.' Her associations were that this was a very sad dream and she wishes he was alive. Father was an impotent person who just got sick and cried when he got angry. Mother on the other hand could often get out of control and have violent rages. Later on the patient actually told me that mother was a transformed person when she went into a rage; the hatred in the mother's face was terrifying and it was like she was another person. Mother's tantrums go on even to this day, and the patient also is subject to temper tantrums at home, usually in response to her mother. She very carefully forbids herself to have tantrums in my office; she occasionally will walk out instead.

During the first year of therapy artificial insemination was successful and the patient became pregnant. She was delighted to carry the

pregnancy and very happy when the baby arrived. Around the end of the first year she reported her first masturbation fantasy which she then remembered she also had as a child. During the masturbation she imagined she was being punished for a minor infraction, spanked with a belt or a paddle on her bare buttocks. This led to an orgasm and then the fantasy continued that she would be held and told that she was a good girl and OK. She went on to report that she never had any memories of her parents holding or caressing her and she was unable ever to ask them for a hug even as a child. That night she dreamed that her mother claimed to be so angry she would not eat. Her sister in the dream received a craniotomy and the patient was telling father that the sister needs to eat. She went on to associate that her mother blew up at everything when the patient was an adolescent and was always very critical even when

the patient was a child: 'Joy in my house stopped about the middle of my childhood.' The patient reported that between the time of her sister's birth when she was 4 years 6 months and the age of 6 she socially withdrew and became an outsider. Her father was 'too busy' to see what was going on and her mother as usual was critical.

The patient stated that her new baby did very well until a few days before my vacation. He then began screaming while I was gone, starting a few days before I left, and then stopped screaming a few days before my return which the patient reported she was counting the days for. It seemed like a reasonable therapeutic alliance was beginning to form and the patient was talking about significant issues.

In the second year of therapy the patient began dating a man and it looked like there were real

possibilities, but again it fizzled out. She dreamed that she was downstairs with her mother and there were horrible water bugs. Her mother would not get rid of them. The patient was stuck on a couch and was terrified of the bugs. It was a nightmare in which mother did nothing. The couch was where her father used to lie down when he was feeling sick. I wondered to myself whether this was another warning about the analytic process and couch.

As time passed the patient became increasingly annoyed with the fact that I took vacations or went to meetings of any kind and began complaining more and more about the structure of the therapy. She resented the fact that the sessions were over in forty-five minutes because that meant she had to interrupt whatever she was talking about and wait until the next session. This increased gradually to the point where she began talking less

and less because she did not want to get started with any topic and be interrupted by the end of the session. I felt that the regressive process in the therapy was becoming intolerable to her and generating a situation where she could not go on much longer. She explained that the reason for being skinny is to never be told that she is greedy and fat. She must never eat more than others, always less. Her mother constantly told her she is argumentative and disagreeable and as a child eats too much and she deserves no love.

At that point she watched a movie on television on nuclear destruction which ended with a mother and her baby left as the only survivors and doomed to die of radiation. This brought the patient to the verge of panic and left her feeling very depressed and demoralized. She felt great anger at me because I could not give her any immediate relief from the depression and there

was a sharp shift from a very primitive anxiety to a depressive picture with anger at herself and me. Interpretations of any of this were denied and responded to with silence. Discussion of antidepressant medication which occurred several times during this therapy, and which came primarily because of my anxiety over her not taking it and the conviction that she probably could benefit from it, always led to simply flat refusal to take anything. She complained of a washed out, tired depletion but denied any suicidal ideation and continued to function.

When I would return from vacation it often took her two or three weeks before she was willing to talk to me at all and I found myself becoming increasingly active with her. She was full of rage at everybody and everything and began complaining by the third year of the therapy that every session makes her depressed and upset no

matter what I say or do or don't do. She complained she was not getting anywhere, the therapy takes too long, and she has no reason to believe it will ever help her. She regarded me as an intruder into her isolated life and from that point on was constantly trying to decide whether she should go on with the treatment. I suggested to her that depriving herself of relationships was like depriving herself of food, out of fear of her own strong needs and ambivalent feelings toward any object of possible gratification. Her masturbation fantasy shifted to the point where I was doing the spanking.

Near the end of the third year of the treatment, because of the increased emotional distancing, the dreams, and the long uncomfortable silences, I felt that this patient should no longer use the couch and began, I hoped temporarily, working with her in a sitting up position on the couch. This allowed



her to take occasional glances at me, although for the most part she looked straight ahead of herself and at times assumed some strange postural manifestations such as holding her fingers in her mouth, and so forth. Her body posture was one of 'keep out', with arms and legs tightly folded.

We worked slowly and meticulously on her exquisite sensitivity to any criticism and worked through a number of issues involving changes of authorities at the hospital and her rage over this as well as her fears and anxieties about losing her academic position. During the next few years the patient had two more children by artificial insemination and was doing quite a reasonable job of bringing them up. She also bought a home and supervised some difficult construction on the home to make it more livable for herself, her children, and her mother. In sharp contrast to this improvement the therapy sessions remained at

the same level. There was one dream where she insisted that she would not eat for anyone but the maid, but I was never able to get more information about her relationship with this maid except that, in contrast to the parents, the maid was nice and took the children to the zoo. In contrast to the maid, by the time the patient was 3 or 4 years of age mother was unapproachable and spaced out in front of the television set. Even today mother spends her entire day in the patient's house where she lives playing solitaire or looking over her investments; she never goes anywhere and has no friends or relationships. The patient's greatest terror is of ending up like her mother. She insisted that by the time her children would grow up, if there was no change or improvement in her situation she would commit suicide rather than end up in this fashion, which did indeed seem likely to happen.

She remembered that her father would stop eating and leave the table when he was upset and angry, which would disrupt everybody's eating. The patient as a child then began to do this also and mother would say, 'I suppose you will punish me by not eating.' The patient seemed quite loaded with guilt about her mother. She complained that before she started therapy she thought she loved her mother but now she does not.

As the therapy progressed I began to feel more and more like the patient was re-enacting a drama between herself and her mother, one in which I was given the role of the patient and she was taking the role of the mother. My continual efforts to relate to the patient were always met by the same straight-arm response. I am sure this was the experience of all who attempted any but the most superficial relationship to her. The patient

had learned that she could never go to her mother for comfort and she was determined, I believe unconsciously, to never give me any comfort or satisfaction with what I was doing. Only babies were to be given gratification, no adults. By the fourth year of therapy she began having dreams of being assaulted or attacked by various men, sometimes in the company of her mother and sometimes not. I questioned whether she was beginning to feel my efforts to be an assault on her defensive structures and I experimented with being more passive in the treatment, but it made no difference to the dream material. In fact, nothing I did seemed to make much difference to the consistent distancing and complaining of this patient and to her obvious chronic depression which always threatened to flare up and become something acute. The only genuine emotional gratification she seemed to get from life was in

cuddling her babies.

When I suggested that there was a malignancy in her that wanted to keep her cachexic and give her nothing, she did not deny this interpretation but was totally pessimistic that anything could ever be done about it and felt controlled by it. She remembered during her anorexic episode that she would only allow herself the piece of lettuce in any sandwich. By the fifth year of therapy, with such interpretations at least not being rejected, I felt that we were approaching some crucial material. Then she fell and fractured some bones of her foot and again was in a dreadful mood. My vacations became absolutely unacceptable to her and she continued to rage at me because of this and also because she felt I was encouraging her to develop social relationships which just exposed her to more humiliation and disappointment. There was an additional masturbation fantasy in which 'you

and Robin Hood master me', and she remembered that from the age of about 7 and 8 she would play at being Robin Hood's servant. She also remembered a great many fears as a child at home, including the fears that there were some rooms in her home she could not go into because something unknown in them was too terrifying.

With the appearance of her babies on the scene the patient stopped efforts at any kind of social life entirely. In the sixth year of therapy the patient decided to have a third child and after much concern about pregnancy and a normal fetus it was carried through successfully. She stated, 'If it wasn't for the children I'd have an uncontrollable need to abuse myself. The only time I ever feel close to you is when I am upset and the only time I was ever ecstatically happy was when my babies were born.' She continued, 'I was told by others when I started with you that I needed fixing. I am

not fixed, I am chronically unhappy.' She conceded that I must have an important function for her because she cannot stand my vacations, but she could never explain the function I serve.

From time to time the patient would bring me a cake that she baked. At first I attempted to analyze this, but it caused her such severe narcissistic wounding and rage that I stopped and simply accepted the cake and thanked her. It was as if bringing this food was the only way the patient could ever express any kind of positive relationship to me. In the seventh year of the treatment I decided that she should sit up permanently due to the long silences in the treatment and the apparent impasse. There was considerable discussion about the goals of the treatment, goals which made sense to her but were always met by the insistence that her case was hopeless. She also felt that she had been

abusing me and could not understand why I was willing to continue working with her.

She became quite exhausted and depressed, having to undergo certain gynecologic procedures following the third childbirth. She has complained for the last five years that she has nothing to look forward to, finds it very hard to get up in the morning, and only wishes to sleep. She is convinced she will never feel better and she doubts she will ever be helped by anything.

She began to become increasingly depressed in the seventh year of treatment to the point where I had to confront her about it and insist that if she feels she cannot go on with her life she will tell me. She agreed to do this although she became very angry and frustrated at having to agree to any contract with me. I was quite concerned at this point that the patient might have to be



hospitalized, but the problem was more a kind of a borderline tantrum than a depressive suicidal episode and the patient was not impulsive, although she was prone to minor automobile accidents. I told her to call me any time she needed me, but never in the entire time she has been in treatment has she ever called me on the telephone.

At this point she dreamed that she was having another gynecologic procedure but when she went to her car two men attacked her. She tried to fight with one except that he grabbed her buttocks and she gave up the fight. Her father was on the roof shooting people with a machine gun and then he closed the vents of a Howard Johnson restaurant and killed all the people in there. He then came after the patient. Her associations to this were that she has a prejudice against all the mentally ill because they bring it on themselves. She stated that psychiatrists can't do anything and some are

unethical and not good and get people in trouble. She was very angry at having to agree to the contract and felt that she was alone and had no place to go and could not trust anybody. She did, however, agree that she would observe the contract and, although she complained endlessly about it, it seemed to form an excellent barrier to any further impulses to self-destructive behavior. She repeated her discussion of the fear of the dark and empty rooms in her house and remembered in grade school that there could be no expressions of feelings or concern because her parents would always either put her down or disregard what she had to say.

In the eighth year of therapy she remembered getting baths from her father at the age of about 5. She received a letter from her sister accusing father of abusing the sister sexually when she was a child. The patient denied any memories of this

having been done to her. She disliked and rarely communicated with her sister. Not long after this she fractured her ankle. While I was on vacation she dreamed that her mother was at her bedside trying to kill her and she remembered that as a teenager she was afraid that her mother or father was poisoning her food, but she told nobody about this. She continued to be miserable, fussing over every decision, silent in the therapy sessions, withdrawn from me and claiming that she had been so for many months and that this by itself depressed her. Interpretations that perhaps she needed to cause me to feel how her father or mother made her feel only upset her and were dismissed as having no meaning to her. She did remark that by not responding to others she drives them away. She repeatedly said, 'You can't win.'

My countertransference fantasy to this often

repeated statement was to imagine the scene from Chapter 9 of Kafka's *The Trial*. Joseph K., awaiting trial on charges that never become clear, goes into an apparently deserted cathedral where he is told a baffling parable by a priest: a stranger from the country spends his whole life trying to enter into a legal building, but each time is kept out by a gatekeeper who tells him he cannot let him in yet. Finally, as the man lies dying, the gatekeeper tells him the gate was meant for him alone. That is to say, in some peculiar sense this psychic struggle between us was the nucleus of our relationship; the apparent impasse constituted the transference and my tenacity had an important therapeutic function.

Near the end of this eighth year she stated, 'We are back at square one. No more children and nothing to look forward to.' She dreamed that she was in a car and her mother was driving. A snake

seemed to come in but it turned out to be a knife in the car stabbing the patient in the leg. It ended in a collision with a car coming alongside of her. At this point I went thoroughly over the patient's case and notes again, having reviewed them several times before also in the hope of coming up with useful ideas. In spite of the hints of sexual abuse from father in the material, the patient had absolutely no memories of it, in marked contrast to her sister's claims. I concluded the patient felt basic despair because she could not have more babies, since cuddling them is the only thing that gives her a high of excitement. She no longer had the wish to go out or be among adults and proposed to just stay at home and read and be isolated like her mother. She had no hope of any of this changing and argued that since she has come to therapy this long without change, it proves she cannot change. I tried to discuss with her Bion's

notion of attacks on linking and tried to find some way of getting herself to allow herself to relate to me or somebody. Although she came in regularly, she kept insisting that in a couple of years she will have nothing to enjoy or look forward to because babies are all that excite her and she is doomed to end up in despair.

As we moved along for the next three years, the patient's dreams became increasingly ominous in that there were assaults by rapists and killers and dangerous things happening throughout the dream material. She dreamed her mother was trying to smother her and of strangers trying to poison her. At the same time the patient denied any meaning to any of these dreams and was unable to make sense of them at all. She even questioned the idea that dreams have any meaning, preferring to think of them as a sort of excrescence of leftover daytime brain functioning,

a theory not much different, I mused, from that of Aristotle. She came a few minutes late to many sessions. Since I could not help her with the baby problem she could not understand why she was coming to the therapy altogether. The masturbation fantasies gradually disappeared and the patient insisted that when she masturbated there was no fantasy any more. It seemed that something that had flickered between us had never been allowed to flower and had faded out, just as in all her other chances at human relationships.

The patient now claimed that the fantasy sequence involving masturbation was as follows: as a child she had the fantasy that Robin Hood was her brother and that he was punishing her for some infraction. However, this was not a sexual or sexually arousing fantasy. She remembers that she did masturbate as a child but does not remember

the fantasy involved. As a high school girl she repeatedly had the fantasy that she was being given medical procedures that were rather painful. These were not sexual fantasies and she did not masturbate to them; the purpose of the fantasies as a child and adolescent, she said, were to demonstrate her goodness and bravery. The patient claimed that she did not masturbate from adolescence until the time after she began the treatment with me, when she began to masturbate to fantasies of being made to scrub the floor or to pull down her own pants and be spanked by me. There was the additional masturbation fantasy, mentioned above, in which she was 'mastered' by Robin Hood and me together, thus fusing the childhood and adult fantasies during adult masturbation. But by the time she volunteered this information, she insisted that she no longer used any fantasies when she masturbated.



I repeatedly reviewed this case but was unable to find any kind of leverage to reverse what appeared to be a gradual withdrawal from me even to the small extent that she had related to me in the past. She did note the connection between the fact that she cannot experience any feelings for me unless she's upset and in pain, with the fact that spanking and domination had been crucial in her masturbation fantasies, but she could not associate to this any further. She denied any childhood jealousy of her sister. Most of the sessions she was not greatly upset or in any psychic pain and she felt depressingly uninvolved in our relationship.

I had to do a good deal of supportive work during the eleventh year of therapy because the patient was sued for malpractice. Actually, she had done a very conscientious job and was furiously insulted and extremely frightened about this

lawsuit, which was clearly an attempt to extort money from herself and the hospital. This lawsuit is still unresolved and the patient dreads having to appear in court. She is very anxious, anticipating verbal attack by attorneys; even the prospect of a deposition greatly upsets her.

As stated at the beginning of this case report, the only time the patient really showed some powerful affect for me was when I became seriously sick during this eleventh year of her treatment. Actually this was the only time I had ever interrupted her treatment for anything except vacations and meetings. While I was ill and we were separated she kept at my request a diary which turned out to be sixty pages and very emotional and moving, and she conceded that she feels much closer to me when there is pain and trouble for either of us. Interpretations about how volatile and sensitive she is, and how afraid of

narcissistic injury she is if she is criticized in any way, were accepted as correct but of course were not explanations of why her feelings for me only appeared when I was quite sick.

After I resumed work the patient in a couple of months returned to her previous stance and continued to have rather fierce dreams. Repeated discussions of the therapy and the therapeutic plan left her uncertain because she was so convinced that she was a hopeless case. My approach was and still is to offer to work with her as long as she will let me attempt to help her understand herself and explore why she is so isolated and chronically depressed. I neither strongly encourage her to continue the treatment, nor do I encourage her to stop. I did from time to time suggest that she might want to get a consultation and that I was not the only psychoanalyst in the world, but she repeatedly

said she would never go to any other psychiatrist, nor would she even consider reducing the frequency of the sessions.

At one recent point the patient, after some upsetting incident at work, began falling asleep while driving and this worried us both. After she felt a little better she claimed that she was quite detached and stated, 'In all the years I've been coming here I have not become any happier and I have achieved no understanding of what is wrong.' She said, 'My brief therapy fixed my eating disorder so I could live with it. I want facts and not your theories.' She was also furious at that time because she had received a parking ticket which she considered to be a black mark against herself. She complained that it was unprofitable for her to share her thoughts with me and insisted that she could keep me out forever. She told me that I had informed her of nothing in the twelve years she

was coming that she did not know already; at the same time it was not clear to her why she was speaking this way or behaving this way.

When she was shouted at because of a minor auto accident she claimed:

I am more devastated if a stranger yells at me; actually it fixes faster if I am upset with you rather than a stranger. But my mother has a way of yelling that is truly frightening. She really hates me when she gets angry and would tear me apart if she could. I react the same way, I get very angry. The way she talks, looks, carries herself, is different than the way most people seem when they are angry. When I feel this way it is most unpleasant since the hatred is so intense. I throw myself on the ground and scream when I have this hatred. Yet mother denies she ever yells; she also says I cannot yell back because that is wrong and inappropriate.

She continued:

What has been happening here for years

needs to be fixed. Thirty per cent of the time I care. I cannot pin down the problem. For brief moments I respond to you, for example, when you get annoyed at me for coming late. I cannot define my emotional response. When I go back to the real world of hospital work, this time I spend with you becomes like a novel. I have brief thoughts of wanting to bake something for you.

Around Christmas of 1994 the patient dreamed a spectacular nightmare which upset her for days, the first time this ever happened. The dream opened with her needing colleagues to make rounds with her on the hospital ward but she could not find anybody. In the next scene she noticed that she forgot to pick up her child, but she knew where the child was and was not concerned. She then was driving to pick up the child but she got lost. The third section of the dream was the terrible nightmare. She was a passenger on the *Titanic*.

The ship was in trouble and we were herded

to the lower deck, waiting for it to go down. I sit next to Jack, a doctor in our division. He holds me and then he stops for some unexplained reason. Then I attempt to hold him but he does not respond. The ship tips, Jack runs up the gangway ahead of me and I lose him as we go upstairs. I see one of my children sitting on the deck and he says, 'Why are you so upset?' There are no lifeboats and I know we are certain to go down. This dream ruined my weekend. It left me very sad and hopeless and lonely.

It was similar, I pointed out, to the movie that upset her so much (as described above) where a mother and baby were doomed to die. She connected this dream to my impending holiday vacation.

Since the time when I was ill I have also asked the patient to continue writing a diary when I am on vacation. She has been able to do this, and in contrast to the long quiet periods where she has little to say when she is with me, her writing is

sometimes more eloquent, or there are days when she writes nothing. The content basically consists of more affectual expressions of the same problems that she talks about in the therapy. I feel I am in the presence of a powerful defensive structure which the patient must maintain in order to be able to function and raise her children. I am not, in contrast to some of her intruder dreams, strongly countertransferentially motivated to break into this structure because I feel it might be calamitous for her. Sometimes I think it protects her from a psychosis. So I have to let her use me in whatever tangential way she can to maintain her psychic economy. At the same time the patient feels an appropriate increasing despair at the fact that she is unable to respond directly to our relationship, nor does she have any reasonable hope that she will end up differently than her mother.



At the current time she is deciding whether or not to adopt a girl baby; she probably will do so in the near future. The possibility it may not work out is leading her at last to think about other avenues of gratification such as volunteer work to fill the projected emptiness of her future. How this will all turn out remains to my mind uncertain but not hopeless.

In spite of all this frustration I continue to have a strong positive feeling about this woman; she is a beautiful person in the grip of a tragedy. I have never had the feeling of total hopelessness about her case that she insists upon. Had her father abused her?

### **Addendum**

Up to the compilation of the present book, I am still treating this patient three times weekly as I have been doing for the past seventeen years. Very

slowly she is developing a silent merger transference that holds her in the treatment and enables her to continue to function. She did adopt a fourth child, and her children are all doing very well; she functions in an outstanding fashion as a mother and as a physician. The greatest area of constriction in her life is in her social relationships and she has made very little progress in that area. She continues to be a lonely individual and I believe I am the only adult with whom she has a current sense of closeness and bonding. It is extremely difficult for her to admit the power of this bond, but it is clear when I leave for vacations or, if for other reasons the treatment has to be briefly interrupted, that the patient becomes quite depressed. I am hoping that eventually there will be sufficient internalization so that it will be possible for her to withstand my inevitable death without developing a severe depression, and she

will be able to function competently for the remainder of her life.

*Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 24: 193-216. Reprinted by permission.

## OCD, OCPD: Acronyms Do Not Make A Disease

Obsessive Compulsive Disorder (OCD) is usually chronic and waxes and wanes in severity. There is evidence that the first peak of it occurs by the age of 15 in at least one-third of the patients, that boys have an earlier onset than girls, and a second peak occurs in the third decade of life. The onset of the disorder is apparently rare after the age of 40. It is not necessary here to review the *DSM-IV* (American Psychiatric Association 1994) criteria for Obsessive Compulsive Disorder (OCD), except to remind the reader that *DSM-IV* distinguishes it from Obsessive Compulsive Personality Disorder (OCPD), as showing quite

different clinical manifestations. Obsessive Compulsive Personality Disorder (OCPD), says *DSM-IV*, 'is not characterized by the presence of obsessions or compulsions and instead involves a pervasive pattern of preoccupation with orderliness, perfectionism, and control and must begin by early adulthood' (p. 422). Kaplan et al. (1994) point out that:

...unlike patients with the other personality disorders, obsessive-compulsive personality disorder patients often know that they are suffering, and they seek treatment on their own. Free association and non-directive therapy are highly valued by the overtrained, oversocialized obsessive compulsive personality disorder patient. However, the treatment is often long and complex, and countertransference problems are common, (p. 746)

Focusing on Obsessive Compulsive Disorder (OCD), there is evidence for biological substrate changes in this disorder to the extent that some

psychiatrists are convinced it is a brain disorder. Nobody can argue with this, since all mental disorders are at some level a brain disorder. A portion of these Obsessive Compulsive Disorders have a rapid onset while others develop insidiously. The fact that PET studies show changes in the brain metabolism of patients with Obsessive Compulsive Disorder (OCD) does not conclusively prove that these changes are the cause of the disorder in the way, for example, that abnormal electrical discharges from a brain focus may lead to seizures. More likely we are dealing with a 'complemental series' as suggested already by Freud (1916, p. 347), who, the reader will remember, began his career as a trained neurologist. In each of these cases of OCD, and perhaps also in cases of OCPD, there is a mixture of psychodynamic and biological etiologic factors. In some cases the former predominate and in

others the latter predominate. The success of certain drugs such as clomipramine or perhaps fluoxetine in alleviating this condition proves nothing about its etiology any more than the success of aspirin in alleviating rheumatoid arthritis leads us to any understanding of that disorder.

Although most traditional authors have stressed the origin of obsessional indecision as connected with the drives and struggles of the anal phase of psychosexual development, Druss (1976) points out that there are many patients who cannot resolve their indecision, which has in its origin an oral component. He traces this to the fact that deciding on any choice requires one to renounce an oral fantasy that one may have everything, since each choice that a person makes requires the renunciation of an infinite number of potential options. The general trend today is away

from attaching obsessive compulsive symptomatology to some sort of fixation at the 'anal phase' of development, and away from the use of drive and libido theory for formulations of the meaning of obsessive compulsive symptoms.

For example, Mallinger (1984) stresses the obsessional patient's 'defensive belief that he can and should maintain complete control of everything that happens to him, and his underlying terror' (p. 163). Mallinger considers this to be a nuclear defensive myth about attaining total control which the obsessional is driven to confirm; the symptoms occur whenever the myth fails. The deep fears underlying this obsessive pursuit of control have to do with annihilation anxiety and powerlessness. Again we seem to be in the realm of the preoedipal and into the oral and even preverbal phase of development. Similarly, Munich (1986), in reporting the development of



transitory symptom formation in the analysis of an obsessional character, states that, 'the material points toward including conflicts around separation and loss in the etiological mechanism of transitory symptom formation' (p. 534). His case study also militates against the idea that OCPD is a brain disorder and shows that the development of obsessional symptoms can be understood dynamically both in their appearance and their disappearance. Kulish (1988) stresses precocious ego development as leading to early disappointment in parental objects in the genesis of obsessive compulsive neurosis. She presents an illustrative case in which the patient's superior intelligence and precocious ego development engendered an early capacity to perceive the parent's flaws. Kulish believes this inevitably interferes with or influences the processes of identification and development of the superego.

Esman (1989) points out that the understanding of obsessive compulsive disorder 'remains not only unmastered, but appears increasingly complex theoretically and at least equally frustrating therapeutically. Despite its inherent fascination, little has appeared in the psychoanalytic literature in recent years that has substantially advanced our understanding of this once-prototypic neurosis' (p. 319). He maintains that little of importance has been added to Freud's original definition of the basic conflicts and defensive structure in the obsessive compulsive neurosis. Freud's (1909) contribution in the 'Rat Man' case was carried further in his (1913) 'The disposition to obsessional neurosis'. Here he formulated the concept of the pregenital organization of the libido and he correlated obsessional neurosis, in which there is a conflict in an effort to prevent regression to the anal stage,

with the obsessional character in which this regression has occurred smoothly and is ego syntonic. Libidinal development is regressed and ego development is precocious which in the obsessional neurosis encourages repression and the development of obsessional defenses. In 1926 Freud referred to the 'severe' and 'unkind' character of the superego as a consequence of the regression from the more mature superego that is found in the genital organization. I have discussed the case of the 'Rat Man' in a previous publication (Chessick 1992a).

The traditional psychoanalytic point of view is that OCD develops out of OCPD through the process of regression and secondary defense formation. Esman (1989) goes on to summarize the classical psychoanalytic literature on this subject, which I will not repeat here. However, Esman points out that:

The finding that a substantial proportion of patients with obsessive-compulsive disorder do not show the classical obsessional or 'anal' character premorbidly, and the common clinical observation that obsessional characters typically develop depressive rather than obsessional-neurotic symptoms, leaves one to wonder whether the similarities between the neurosis and the character style reflect the limits of human reactive possibility, rather than a common etiology, (p. 331)

He regards Obsessive Compulsive Disorder (OCD) no longer as a paradigmatically psychogenic illness, but now as a multiply determined condition 'with components of neural biology, learning and conditioning and conflictual elements synergistically involved' (p. 320).

Meares (1994) also agrees that Obsessive Compulsive Disorder remains a mystery, and concedes that since Freud's time psychoanalytic interest in it has waned. This has to do with the

gloomy view of the prognosis, compounded by the possibility that there is a neurophysiological basis for it, that discourages treatment based on psychoanalytic principles. Meares offers a treatment approach which does not focus on the obsessions but rather on 'the nebulous sense of a core reality and an immature conception of personal boundedness' (p. 98). To my mind this again points to a failure in the earliest pregenital experiences.

The ego of the patient who develops OCD has always labored badly, whether from psychogenic, constitutional, or neurophysiological factors or a combination of these, and under stress there is a tendency to regression and primitive forms of thinking and wishing. These protect the patient in a magical fashion from a fear of annihilation and a dissolution of ego boundaries, from a sense of nothingness, meaninglessness, chaos, and even

perhaps the 'black hole' phenomenon (see Chessick 1996d). If these protective devices are integrated into the personality we have the appearance of OCPD; if they are conflictual and defended against, we have further symptom formation and the appearance of OCD. Regardless of the complex etiology of this disorder, there is no apparent reason why psychoanalytic or intensive psychoanalytic psychotherapy should not be applied in order to strengthen the ego and modify the superego, allowing the patient to develop more appropriate and adaptive compromise formations. There is also no reason why the patient should not have a trial of psychopharmacologic agents which have been known to alleviate symptomatology in these disorders, as well as any behavioral therapy that may be available at the same time. I believe that the gloomy prognosis for the psychoanalytic

treatment of OCPD and OCD has come about from ill-advised efforts to uncover assumed fixation points at the 'anal-sadistic' stage of development, on the assumption that when these infantile impulses have been released and worked through in the treatment, the symptomatology will disappear. Although, this may have happened in the case of the 'Rat Man', subsequent experience with OCPD and OCD has not confirmed this single-factor approach.

The point of this chapter is to maintain that OCD and OCPD are far more complex conditions than are generally realized, and that they are not to be placed in the category of simple unifactorial diseases. There is a tendency in the psychiatric literature to consider them—especially OCD—as simple unifactorial brain disorders, which I strongly disagree with. The main impetus for this attitude comes from the wish to demonstrate that

the disorders treated in psychiatry are organic in origin and therefore are medical disorders in the same category as the disorders treated in other branches of medical practice. This is an issue involving economics and prestige, but it ignores the reality of the situation. Even the prevalent use of acronyms such as OCD or OCPD tends to lend a certain definitive context to these disorders, ignoring the fact that they commonly tend to blend in with a variety of coexisting difficulties. Looking at them as definitive 'diseases' runs the risk of ignoring what may be the central issue that the patient is facing, which is that the patient's ego is laboring badly and reaching in a regressive direction in an attempt to produce compromise formations that will satisfy its three harsh masters (the superego, the id, and external reality). To illustrate my contentions about these conditions, I now wish to present a patient that I have followed



in psychoanalytic psychotherapy twice weekly for thirty years, the longest lasting treatment case in my career as a psychoanalytic psychotherapist.

## **Case Presentation**

Mrs. A., a reasonably attractive, slim, 25-year-old, married, Catholic social worker consulted me for therapeutic help with the chief complaint that she could not get along with people, especially her in-laws. She had been married for two and a half years to a man 38 years old whom she described as a quiet chemical engineer. The patient had suffered a miscarriage nine months before consulting me, but did not show great concern about that.

She was the third of five children born to a blue-collar Catholic family. Her oldest brother was living as a hermit in the woods of a western state. The second child, a woman, was a nun living in the

Far East and extremely eccentric. The two younger brothers had received psychotherapy and at the time held laboring jobs. They tended to migrate from state to state and one of them, not long after my patient's treatment began, decided not to work any more and was living on welfare.

She realized soon after her marriage that she had made a mistake and had married a man who was really a perpetual bachelor. Their sexual relations had deteriorated to almost nothing because he was not interested. He was most attached to his mother and his sister, an attachment which made the patient extremely jealous and angry. He was also very attached to his brother who lived in another city, and they frequently got together to play golf and other sports. This brother took a paternal role in the husband's family and was very authoritarian. The patient hated him and hated her husband's sister.

Her father was 63 years old and had broken down with a paranoid schizophrenic episode when she was 6 years old. He was also accused of abusing some preschool children and was hospitalized at the time. Her mother was 57 years old and was described as aggressive, dominant, and very cold to her father. Mother, she said, works long hours and has no friends. There was perpetual fighting in the home between the parents for as long as the patient could remember. She recalled as a child dreaming of trying to cross the street near her house but being frightened of snakes in the street and having fears that she would wake up and fall down the stairs.

The patient was born in the geographic area where I have my practice. Her earliest memory was of having to walk through a cornfield which had snakes in it and having rocks thrown at her by the other children. She was a very good athlete but

reported that her mother disapproved of athletic girls. She had a few friends and began occasional dating in high school. At the age of 21, after an average school record, she graduated college and went on vacation, where she met her future husband.

Soon after the beginning of the first interview she began crying and showing very strange facial mannerisms, which I first thought were tics but then realized were some kind of bizarre stereotyped grimaces over which she had no control. She was oriented and her associations were intact. I had to proceed very slowly in taking a history and give the patient plenty of time because there was so much crying and grimacing in the session which gave the impression of a bizarre and confusing mental state. I offered to see her twice weekly in a face-to-face psychotherapy and she accepted it.

She soon brought in her first dream of the treatment. I was with her and her husband in church and there was some sort of psychotherapy session to be had. We moved to the back of the church, but other doctors and their patients were there. So the patient suggested her car for privacy, but I say it is unethical. She sits with her arms around her husband. Her associations to the dream were as follows: psychotherapy is an irritating invasion of privacy. Her husband objects to it as it will make her more independent. He fondles her breasts but is not interested in sex with her, and both her husband and herself expect super-performance from her at all times. What struck me most about the dream was the ambivalence. Although there was a hint of the seductive in it, I was pleased that I had entered into the dream as a significant figure; on the other hand we have been warned by some traditional

psychoanalysts that the appearance of the therapist undisguised in the patient's first dream is a harbinger of deep trouble in a psychoanalysis. Since this was a psychotherapy, I felt that my appearance in the dream represented a weakness of her ego functioning rather than the announcement of a significant countertransference problem or major error on my part. The reader of this chapter will have to decide.

The patient had some pleasant memories of her maternal grandfather during her childhood but none of anyone else. The paternal grandfather died around the time the patient was 6 and the paternal grandmother died before the patient was born. The patient preferred the maternal grandparents. In the first couple of months of therapy things went very slowly. The patient was extremely sensitive and very frightened. She was

in a constant rage at her sister-in-law and brother-in-law which had a certain weirdness about it, since they really had very little to do with her day-to-day life. She reported that she had been a bed-wetter up to the eighth grade and then again as a sophomore in high school when her parents were bitterly fighting. The onset of menses was at 13. Long before that she had a fear of snakes in her bed and of the dark. Her parents would fight mostly about sex, with her father constantly badgering her mother for sexual relations and her mother perpetually refusing.

The patient remained irritable and almost paranoid about any interpretation or even my questions in attempting to get a history. The initial transference was maternal in that all questions and interpretations were experienced as criticizing and probing, a kind of transference resistance.

During the first year of therapy the patient began expressing her disappointment in her husband and slowly manifested her depression and chronic sensation that her life was cold and empty. When I went on my first Christmas vacation during the therapy she was furiously enraged. She seemed unable to form a comfortable relationship with me; analysis of her rage at my leaving on vacation involved her father's unpredictability in his comings and goings. By the first year of therapy I felt I knew her enough to be convinced that she was on the edge of schizophrenia and suffering from transient paranoid features.

Because of her great sensitivity and her husband's obtuseness there was much quarreling with him, after which she would get furiously angry and consider suicide. I felt there was a suicide risk to this patient but that hospitalization



would certainly not remove it. The central problem was her intense ambivalence toward everyone, including me.

The patient gradually in the second year of the therapy began developing a therapeutic alliance and accepting the therapeutic process. Along with this, the full extent of her anger at her husband began to appear. She was able to say that she was 'fond' of me and began talking more frankly about her sexual problem in the marriage. She turned more to masturbation and at that point she seemed to be shifting from the edge of schizophrenia to more of a neurotic character disorder with hysterical and narcissistic features. At other times she could be quite paranoid and voice fears that I would 'touch' her.

Her husband reached a point where he could not achieve an erection and their sexual life ceased

soon after she became pregnant for the second time. Her reaction to the pregnancy was to become very depressed and silent. She had many hypochondriacal fears involving the pregnancy and at times she noted that whenever dependent loving wishes welled up in her she became withdrawn and picked a quarrel. Much of the pregnancy was spent with her being in a stubborn withdrawal from everybody. The therapy became very stormy and she seemed to present a rigid defensive angry posture oscillating with positive feelings. In 1969 she gave birth to a boy.

After a short interruption she returned to psychotherapy in a state of great rage at me. Interpretation of this as a defense against missing me worked very effectively and she settled back into the psychotherapy. But she showed little affect and manifested some bizarre preoccupations with the baby, including the

unwelcome recurrent obsessional thoughts that she would kill it. There was much tension with her husband, but in spite of all this she was able to function at a superficial level. In a few months it became apparent that her child had a hearing problem, which was eventually diagnosed as congenital deafness.

This introduced a new aspect of the patient's behavior. After a period of depression, which was certainly appropriate to the situation, and complaining about her husband's lack of support, the patient became preoccupied with the deaf. She educated herself to the point where she became an expert on hearing problems, deafness, sign language, hearing aids, and so forth. There were innumerable visits to specialists and pediatricians which preoccupied the patient. She did a really first-class job of helping her son as much as possible in dealing with his defective hearing.

In the third year of psychotherapy the patient's husband struck her while in a fury during one of their quarrels. She was quite afraid of his wrath. She developed a great rage and a phobia of knives as well as the obsessive fears of hurting her son. She only wanted her husband to die. A lot of this year of therapy was spent in helping her to express and deal with her depression and rage, but she refused to consider divorce and actually at this point the two of them bought a home in the suburbs.

The fourth year of therapy dealt with the patient's intense self-hatred. An interpretation that her hatred for her mother generated by the punishments mother inflicted on her had been projected and turned on herself did little except to temporarily relieve the self-hatred. But every time she was disappointed in her husband, the rage and self-hatred would return, and she oscillated back

and forth between rage and guilt and some spontaneous feeling. Over and over again she would be compelled to say to herself, sometimes out loud, 'I hate myself, I hate myself ...'.

As the therapy moved along she was more able to express her desire for affection. She significantly said, 'My body craves nourishment or my mind craves nourishment', a statement that had important implications for later developments in her treatment. At this point, however, as she was able to talk about her craving for nourishment and affection, there was more improvement in her general condition although there was still a great deal of fear and anxiety and discomfort in all interpersonal relations. She was less bizarre and paranoid at that point and began showing some new obsessions with possible diseases caused by her contraceptive device, an IUD.

At the beginning of the fifth year of psychotherapy there was no longer any overt bizarre psychotic symptomatology, although at night she had fantasies of intruders and of the ghost of her father coming through the door at her. During that year she was marginally getting along with much rumination about and preoccupation over her son's health. There was guilt over her wish for pleasure, and although she masturbated there was some guilt over that gratification also. Near the end of the fifth year of therapy she began a compulsive preoccupation with cleaning the house, especially while her husband was home. When she did become enraged at him, as happened on many occasions, she would become depressed, paranoid, and have serious suicidal and homicidal impulses that she barely controlled.

In the therapy she became angry, demanding, manipulating, and controlling, and by the time the

sixth year of therapy appeared we began discussing the goals of treatment and whether it was worthwhile for her to continue. She felt that she was suffering from obsessive ruminations, paranoid sensitivity, and a lack of support in raising her child, and wanted to continue in spite of the difficulties in the treatment. Her husband continued to resent the treatment and considered it a waste of money. The patient began showing an increased hypochondriasis, with innumerable complaints about her body and her health. This was around the same time she was considering reducing the treatment to one session weekly, which seemed cost-effective at this point.

By the seventh year of treatment she had reduced the sessions to once weekly. The same constellation of problems persisted. She began much crying and many self-accusations, using the psychotherapy as a confessional and a punishment

for not living up to her mother's expectations of her. She became increasingly concerned about what other people would think of her, and because of the marked increase in paranoid symptomatology I began her on Stelazine, 1 mg twice daily, which she felt was very helpful, reducing the tension and agony that she had been experiencing.

By the ninth year of treatment she spontaneously stopped the Stelazine and began working in a personnel office. It seemed that her superego was holding her together and I was functioning as a substitute parent, a good father in contrast to her real father. But around the Christmas season I noticed that she became frantic with obsessive symptomatology in trying to decide what to get for whom. I viewed her at this point as a borderline patient who had stabilized, using psychotherapy as a crutch and for ventilation. She



was truly all alone in life besides me, although I did not pressure her to continue coming.

She was not able to stay off the Stelazine for more than a few months without developing paranoid concerns of being gossiped about by her co-workers. There was great rage at her mother and I thought this had been displaced to her husband and his family. When the rage spilled over, even with the help of psychotherapy and medication the patient experienced prolonged obsessional rumination, hypochondriasis, and paranoia. She continued perpetually on the edge of psychosis, especially on holidays such as Mother's Day.

Because of her depressive symptomatology I considered beginning her on imipramine (this was in 1975), and prescribed 25 mg q.i.d. to begin with, and gradually increased the dose. I increased the

Stelazine to 1 mg q.i.d. The patient was less distressed and showed less rumination and more relaxation. Unfortunately she gained 15 pounds on imipramine and I had to cut the dose. She was unable to take this drug at all because of the weight gain and remained only on Stelazine 1 mg t.i.d.

I felt that after nine and a half years I had been able by this once or twice weekly supportive psychotherapy to maintain her in remission and from sliding over into overt psychosis. However, this maintenance was dependent on at least one weekly session to discharge her innumerable complaints and prevent fragmentation. Although her overall personality could be pleasant if she wanted it to be, one only needed to look at the expressions on her face to see the tense, obsessed, and anxious expressions which had replaced the bizarre grimaces seen at the beginning of the

treatment. I have a remarkable photograph of her that she gave me at this point, but in order to protect her anonymity I feel it would be wrong to publish it.

We began attempting to have her come only every two weeks for a session. This resulted in an increase of obsessional concerns about her son's health and her dragging him around to every kind and sort of physician and specialist. She admitted that she had been sexually stimulating her son, putting him to bed with her and fondling his genitals. It was clear she could not be maintained on a once every two weeks basis. I firmly insisted that she come weekly and continue the Stelazine. She agreed to resume the weekly sessions and was now taking 2 mg of Stelazine daily.

At this point her young son threatened suicide and I referred them to a child psychiatrist who

was not impressed by the threat and ended up in an argument with my patient. The patient came in after this consultation in an orgy of self-recrimination and wailing. She claimed that her husband detested her. But she was not suicidal, now at 35 years old. I was attempting to mobilize her and support her at work, getting her mind off her obsessions about her son.

In the eleventh year she began slipping again, finding herself overeating and again taking her son into bed with her. She struck herself in the face with a tennis racket and lost her temper with her son. At my urging, she was trying to find gratification outside of the house but could not give up her obsessive hope of squeezing it out of her mother, her husband, and her son. Her husband seemed sick of her and was totally unsympathetic even when she was hurt with the tennis racket. I insisted that she should have a

complete physical examination and became somewhat concerned about the side effects of Stelazine, which had begun to be described more in the psychiatric literature at that time. I was hoping to institute a program of drug holidays because of this. In the middle of the eleventh year of treatment I did institute such a program and again began considering tapering off the sessions, but the patient was very adamant about continuing at least once weekly. She said, 'The thought of you not caring brings tears to my eyes, it is very painful.' She continued, 'I am slow to make decisions and act, slow to grasp things, I need much information to digest, and evaluate, I do not know how to communicate.'

After twelve years of therapy I attempted to shift her to Tranxene to avoid long-term Stelazine effects. Her husband retired from work and became essentially a recluse. With support and

urging she was now going out to build a career and friends of her own, although due to her great interpersonal anxiety this was not easy. She did find a good job, for which she had to dress up, and began attending concerts, plays, and so forth, with some new friends. I was very hopeful. With her new job she also asked if she could come twice weekly, since now it would not be a financial hardship. I left this up to her and she decided to do so. For the first time she began a major new job in the downtown metropolitan area of Chicago. She held this job successfully from 1979 to the present time (1995).

In the fourteenth year of therapy at the age of 39 she had her first sexual affair. It was not successful. Although the man tried three times, he was unable to ejaculate. It ended with his masturbating her to an orgasm.

Because of the job I had to begin seeing this patient at 7:00 a.m. She came faithfully twice weekly at 7:00 a.m. throughout the years from 1980 to the present time, regardless of the terrible Chicago weather and a one-hour commute to my office. Although she had some difficulty in adjusting to the new job, it seemed that she was doing well in spite of her continual ruminations about her son's and her health and her fleeting paranoid thoughts.

She was promoted at work and given her own office in the fifteenth year of psychotherapy. She dreamed that she was at home and late for an appointment with me because she had to wait for somebody. She called me and I was furious and told her never to come back. In the second scene of the dream she was walking at night, supporting somebody, but they died. She could not understand how to explain this to the authorities.

There were no associations to this dream, but shortly afterwards she began treatment with a diet physician in New Jersey. She revealed that she was beginning to think her difficulty was due to the food she ate and pollutants in the air. If she could remove these pollutants and eat the proper foods she was convinced her paranoia and obsessive ruminations would disappear. She became enraged because I did not support this idea, especially since it involved her having to take expensive plane trips and pay an expensive 'consultant' in New Jersey. She found a new boyfriend and had an affair that lasted about three or four months. It broke up when she discovered that this man had two other women that he was also sleeping with at the same time.

By the sixteenth year of therapy the patient was slowly and definitively building her own life in work and recreation and in lifestyle. This was



interrupted by rages when her husband disappointed her or she had disappointments in her affairs. Much time was lost due to her ruminations which also had a paranoid flavor. She would ruminate for hours about whether or not she had done or said the right thing at work to one of her co-workers or superiors and she kept extensive detailed records of all her thoughts, deeds, food that she ate, and possible exposure to pollutants. At the same time she carried a heavy responsibility at work, which seemed to be correlated with an increase in hypochondriacal fears.

She visited an internist and began crying in his office. They considered antidepressants and she tried it out again with him but again gave it up. At times her paranoia became acute. For example, her boss offered her two tickets to the Chicago Bears football game. She saw this as a 'plot' by him

and the other people in the office to see what her husband looked like. She felt everybody in the office was gossiping about her and was in an agony about this. She took the 'plot' seriously, began ruminating about it, and became obsessed with whether or not she should accept or refuse the tickets. She was afraid if she refused them the boss would be enraged and perhaps fire her, but she was also afraid to accept them and use them. She began experimenting with B vitamins for 'stress'. Two obsessional thoughts kept coming into her mind in spite of all her efforts to keep them out. These were, 'He loves me, he wants to marry me', and 'I hate myself.' In associations to these obsessional thoughts, she claimed that her mother did not love her because mother thought she was so awful, and she remembered 'horrible memories' of an unspecified type at the age of 4 years and 6 months when her younger brother

was brought home.

In the seventeenth year of treatment at the age of 42 she went on a vacation to Mexico by herself for the first time and enjoyed it. But she continued very angry and complaining and started to exclaim that she would have to solve her own problems, find 'alternative medicine' ways of treatment, and that she could no longer rely on traditional medical 'experts'. I did not oppose this and attempted to leave the solutions to her, as I felt it was a support for the development of her autonomy, and that she should take her life in her own hands. Her husband continued to do nothing, but she would not consider divorce. She began to complain, 'My memory is failing, my life is worse, and I have the same complaints as always. I am sure something is organically wrong with me and the various psychopharmacologic medications obscure my physiologic problems, I do realize that

psychotherapy has enabled me to function.'

At this point she complained that she was struggling with two moods. These were (a) intense rage and temper tantrums and (b) the obsessive and compulsive symptoms with associated paranoia. She had many obsessive thoughts about putting out her son's eyes with scissors when he would refuse to obey her on some minor matter. There was much self-torment. At times she had the fantasy that she was being poisoned with botulism due to eating canned foods. As her son began high school and withdrawing from her she began to have incestuous dreams about her brothers.

By eighteen years of psychotherapy it appeared that her son was doing reasonably well and moving emotionally away from her. She was much preoccupied with her obsessional and paranoid thoughts at work and continued to rage

at everybody and everything. She began complaining that the psychotherapy was not of much help any more, but she did recognize all this turmoil in her psyche as related to her son's withdrawing from her emotionally. At this point a local well-known hospital center opened a psychopharmacology clinic and I suggested she visit it to see if anything could be done about the fluctuation between her raging moods and her obsessive and paranoid moods, because a number of 'new generation' drugs had been introduced on the market.

She was referred at this hospital to a psychopharmacologist-psychiatrist who diagnosed her as having a biological depression and proposed to try her on various tricyclic drugs and MAO inhibitors. He would handle her medications, and he criticized me severely for the use of the Stelazine and for wasting her time and

money with psychotherapy. She began seeing him on a regular basis along with seeing me at her usual sessions. She suffered from many paranoid concerns, ideas of reference, and severe compulsions. We agreed that from this point on he would take all responsibility for her medication. He began her on various psychopharmacologic agents but there was no change at all. She had some delusions, for example, that 'bad guys' were hiding in the basement and would come out at night and chop her head off as well as the head of her husband and son. At times she obsessively feared the devil would possess her or the Virgin Mary would appear. She stated regarding his drugs that, 'One per cent of the time I am elated, 10 per cent I am normal, and 90 per cent I am paranoid and obsessional. I know it but I cannot control it. The only effect of the drugs from him are sedation.' The psychopharmacologist next put

her on clomipramine. This seemed to reduce her tension, but produced anticholinergic side effects. She was quite depressed about these, but the psychopharmacologist wanted her to stay on a high dose for a couple weeks more to see if the drug would begin to help. She stated, 'I cannot keep the paranoid thoughts out of my head. Nobody understands or cares about me, I am empty and impoverished.'

The psychopharmacologist after a few months decided that the dose of clomipramine must be raised, and now diagnosed her as having 'an atypical depression'. She began having fantasies, as she waited for her son in order to pick him up after high school, that her 'enemies' went by in a car and threw his bloody head up on the porch. I did not believe that the clomipramine was producing this, and was more inclined to think it had to do with her anger at the side effects. I

believe she had a sealed-over psychosis, which was protected from emerging by the obsessional and paranoid ruminations, and that the psychotherapy helped keep it sealed over and enabled her to function.

On the dose of clomipramine of 200 mg per day she became somewhat less compulsive but gained 20 pounds in weight. She developed some anemia, but the psychopharmacologist was not concerned. He placed her on lithium in addition to the clomipramine. The obsessive symptomatology seemed to be a bit less, but she showed more of a tense depression and some delusional fantasies. The psychopharmacologist stopped the lithium and planned to slowly withdraw the clomipramine because the only obvious effect of these drugs was to quieten her down. She began doing a great deal of sleeping and eating. The psychopharmacologist told her she had a compulsion to sleep as a part of



her obsessive-compulsive neurosis, but to me it seemed more like a regressive withdrawal and a bizarre demand for love and attention. She did not get anxious when she was prevented from sleeping, as one might expect if the sleep was compulsive. In retrospect I think that the sleeping and eating were drug-induced effects also.

By the time the patient had tapered off the clomipramine, she had been in psychotherapy for about twenty years. She complained of some withdrawal symptoms of nausea and hot and cold flashes. During the twenty-first year of psychotherapy she began an active sexual affair again and enjoyed herself. However, when both her husband and son ignored her wedding anniversary, even after she made a nice dinner and reminded them of it, she was so angry that she got a supply of clomipramine and began herself on it. She started to take 50 mg at bedtime. She noted

that her new lover was getting sick of her ruminations and paranoia and withdrawing from her. She then had a traumatic experience; she discovered that her lover apparently arranged to have his best male friend watch them have sexual intercourse, without her knowledge. This ended the affair.

At the end of the twenty-first year of therapy, when her son went off to college, she had a brief unconsummated affair with another man. She had the fantasy that she was a bag lady who urinated on herself. She frequently talked to herself, and slept with no sheets on the mattress. She kept all this a secret from everybody except me. She noticed that she would involuntarily urinate when she masturbated, and raised her clomipramine dose to 150 mg at bedtime. There were no basic changes in her symptoms on this dose of the drug. She had many fantasies and ruminations about her

son's romances, at times obsessively imagining him to be a homosexual although there was no evidence for this.

During the twenty-second year of psychotherapy she raised her own clomipramine to 200 mg at bedtime and noted that she weighs 150 pounds although she should weigh about 125 pounds. She experienced some fleeting olfactory delusions; for example, she would sniff her panties and decide there was a 'sexual' odor in them. At the same time she was able to continue functioning effectively at work although on the weekends she did little. She began reducing her clomipramine dose at my urging. While I was on vacation she had a very unpleasant sexual affair with an impotent man. She was eating voraciously. I urged her to see the psychopharmacologist because she had been taking clomipramine on and off for about four years and had not seen him for

about one and a half years. At that point clomipramine was not approved by the FDA and she had to go to Canada to keep getting her supply of it. She saw the psychopharmacologist, who persuaded her to taper off the clomipramine and urged her to begin on a new drug, fluoxetine. At the same time she developed trouble with her back and began seeing numerous doctors, getting prescriptions and exercises, and so on. As she tapered off the clomipramine she began spending many hours fussing with her back. She became fully preoccupied with her back and I had to work hard to prevent her from getting surgical intervention. On her son's twentieth birthday she reported that she was very depressed and hated herself, regretting that he was no longer a teenager. She began a diet program at a local university and began to lose weight. She came off the clomipramine and noticed only that she was

more irritable. She was considering taking the fluoxetine.

In the twenty-fourth year of therapy she had brought her weight back to its proper level and was off all medication. She was under great pressure at work, with no support from her husband, and now her mother was quite dependent on her and placed in a nursing home. Her life situation was essentially where it was before her son was born. When off the drugs she was plagued by tension and obsessive thoughts, depression, and numerous hypochondriacal complaints and fantasies of having all kinds of diseases. She was finally persuaded by the psychopharmacologist to begin on fluoxetine, 20 mg daily. On her fiftieth birthday, she complained bitterly that she was angry at everybody, and the psychopharmacologist doubled her dose of fluoxetine. She continued to have paranoid

thoughts, including that she had a body odor so that people were pulling away from her. Her mother died, and she was of course depressed about this. The psychopharmacologist in response increased her fluoxetine to three 20 mg capsules daily. She began overeating again.

In the twenty-fifth year of therapy she and her husband sold their house and moved into a condominium. The psychopharmacologist tried various combinations of fluoxetine and clomipramine, but all this produced were upsetting side effects. Finally the psychopharmacologist stopped the fluoxetine and the patient began feeling much better. However, on even small doses of clomipramine she began to be sleepy and began overeating again. She stopped this drug and remained essentially off psychopharmacologic agents from that time on.

When her son graduated from college and went off to India for a prolonged trip, she began developing innumerable migrating pains and physical complaints. Complete examinations by internists revealed no pathology. She was increasingly furious at her husband, her son, and myself for not finding a solution to all her ailments. She became preoccupied with fantasies about her son having AIDS, and what she would do to care for him, and so forth.

Then she decided that maybe her problem was her diet, and she went to get a 'hair analysis' to see if she needed vitamins. She began some kind of special diet and stated, 'My body is getting too much of something I cannot handle from the environment or from my diet.' She became completely absorbed in this and obsessed with keeping records. She decided that she could not stand any fragrance on any person; that it would

instantly nauseate her and give her headaches. This caused her considerable difficulties at work, as there were many employees who worked under her and who wore various perfumes, after-shave lotions, and so forth. She decided that all her body tension and inability to relax was due to environmental chemicals. She convinced herself that she was allergic to every sort of odor and fragrance and this was the cause of her innumerable physical complaints. She found some sort of 'doctor' who would help her undergo extensive 'allergy' tests. Although I was concerned with this self-preoccupation, and it sounded suspiciously like a developing paranoid delusional system now that her son had left for India, and I was worried that she would end up a lonely eccentric, I felt that my role was mainly to listen, support, and steer her away from any dangerous treatments like back surgery.



In the twenty-seventh year of psychotherapy she began raging at the traditional medical profession doctors who do not consider seriously her complaints. She stated that for her, psychotherapy was a place to express her anger and to help control her compulsion to tell others about her symptoms; she said, 'I guess you think I have regressed.' She agreed that the psychotherapy had helped her raise her son and kept her going at work in spite of all her complaints. She stated that every system in her body caused her pain and trouble, and fragrances made it impossible for her to concentrate and dizzy: 'I have chemical sensitivity and a yeast syndrome.' She went to a variety of doctors trying to discuss this with them and stated, 'I don't want a teaching hospital, I want a country practice doctor who likes to solve problems ... I dislike and distrust all these other doctors I have seen.' She

continued, 'I have this poison in my body that travels around to different parts of my body and causes swelling and pain, for example my brain swells and tries to burst, and the same is true of my gut.' Any suggestions that any of this might be psychogenic was met with great rage and she stated, 'All I have to do is find the right doctor.' She called many osteopaths, nature doctors, and so forth, but rejected most of them over the phone.

She taught me not to interfere with or to criticize these efforts of hers, which clearly allowed her to keep hope alive that she could improve her condition. She was convinced that her system was too weak to fight infection and that toxic wastes were passing from her parents to her. By mastering my own countertransference annoyance with this, I was able to allow her to continue to come and express her opinions without interference. This produced an attempt on

her part to move away from her husband. She purchased her own apartment and began an intensive program of making it odor free and chemical free. She stated, 'I can't even read, because the pages of books and newspapers off-gas to me and get to me. When I open a file drawer at work I am overwhelmed with the fumes that come out and hit me.' At the same time she was able to continue successfully at work and stated, 'I feel stronger but I am not ready to go it alone without supportive psychotherapy.'

By the twenty-seventh year of psychotherapy, although I repeatedly raised the issue of whether she had enough, she insisted she could not go it alone and needed me to ventilate her rage and fears. Nobody else would listen to her weird complaints about odors, fumes, and fragrances, and her endless bickering with her husband. She stated, 'I come here to dump my anger, to keep

myself from shooting myself, a sounding board, perhaps to keep me from suicide or murder.' There were long discussions of smells and fragrances which I listened to quietly. She reported, 'I am full of self-hate and paranoia and difficulty in doing things, but at work I am calm, accessible, pleasant, and forcing myself to plod along. Nobody is interested in me. My mother is dead and my son does not even answer my letters.' She continued, 'The medical community is like my husband. The American Medical Association has power over health care and persecutes people who attempt to help themselves by alternative medicine. If I can get and keep myself well, I will be making a real contribution to health care costs in the USA.' She remained and still remains obsessed with fragrances, odors, nutrition, her immune system, alternative medication such as the South American evergreen

tree which can cure cancer, a conspiracy of the American Medical Association and pharmaceutical companies to prevent natural research, and so on. Still, without any medication, she continues to function on her job and to endlessly repair and fix up her apartment. She found a suburban doctor who sold her various vitamin supplements and gave her shots which were supposed to help her with her immune system and reduce her sense of stomach bloating and sensitivity to fragrances. She began visiting him while also seeing me, in a manner parallel to her earlier visits to the psychopharmacologist.

For the past couple of years I have seen her twice weekly during which time she has been fixing up this apartment over and over again, perpetually fighting with maintenance workers and various electricians, contractors, handymen, and so forth. She is convinced that she is

'chemically sensitive' and that is the cause of her tension, rage, and paranoia, as well as possible electromagnetic radiation from her computer and other sources.

Her son returned from India and began living with her husband, doing essentially nothing. This was a great disappointment to her, but the husband seemed content to now live as a bachelor along with their son. Moving into her apartment, she developed endless ruminations about chemicals in all sorts of the products that she uses at home and at work, and claimed that even ironing makes her sick. She stated, 'I can't finish sentences, my body is being poisoned by what I am breathing, absorbing, and injecting through my skin. I want you to agree with me.' I do not respond to these complaints at all.

After cutting her finger by accident in her

kitchen, which required a few stitches, she dreamed, 'I am in a dirty place, there is an alley outside, my finger tip is cut off, and I am looking for it amongst scraps of food.' Her associations were to her worry over her co-workers and her apartment, and her great longing for love. She stated 'I want a protector and a mate.' The patient now faces having to adjust to living in her new apartment which is never satisfactory to her, or to sell the apartment and move somewhere else. She will be involved in the inevitable wrangle with her husband over finances now that they have separated.

## Discussion

What I hope to demonstrate by this case presentation is the complex interrelationship between Obsessive Compulsive Disorder symptoms, the so-called Obsessive Compulsive

Personality Disorder, depression, paranoia, borderline states, and actual schizophrenia. Would it not be better to view all this as a continual variation in ego functioning as the ego attempts to deal with the vicissitudes of life and perhaps various biological factors, rather than to isolate out any one of these sets of symptoms as a specific 'brain disorder' or 'disease'? With the overwhelming tendency against long-term psychotherapy that has developed in our country fueled by insurance companies, a patient like this in my opinion would be a terrible victim. No psychopharmacologic agents or other forms of short-term treatment made any substantial difference in her state; the best that could be done for her was to keep her functioning as a useful citizen and allow her the dignity of being self-supporting and autonomous in the face of her loneliness, emptiness, and unhappiness. This



would be denied to her if she were dependent on managed care and denied to her if she were diagnosed as having some kind of 'disease' that simply required psychopharmacologic intervention and very occasional visits.

I hope this case speaks for itself; I have left out many of the details of her various obsessions and ruminations for fear of boring the reader. For example, the patient had many rituals and compulsions involving counting telephone poles when she drove in her car, reciting slogans and numbers over and over to herself, compulsions to leave certain work unfinished at work even to her own detriment, and so forth. In these patients the ego is struggling primarily with narcissistic rage; when the narcissistic rage becomes overwhelming it has to have recourse to archaic devices such as obsessive compulsive symptoms, paranoid projections, depression, and so forth, all well

described in the psychoanalytic literature of the past. The classical psychodynamics of Obsessive Compulsive Disorder as described by Freud (1909) were present in this patient: isolation, undoing, and reaction formation. In addition there are other commonly described psychodynamic features present, such as ambivalence, magic thinking, and so forth.

Melanie Klein's (1975a, 1975b) concepts may also be of value in understanding this patient. Obsessive mechanisms are explained by Klein as a desperate effort to repair the object over and over again during the depressive phase. This is one of the defenses used by the child against the wish to destroy the internalized good object, an attempt to control magically the object it fears it has destroyed and to reassure itself that it has not irreparably damaged the love object.

The infantile fantasy of having injured or destroyed the parents is inevitably activated by adult loss, claims Klein. So the outcome of the mourning process depends on the degree of successful resolution of the infantile depressive position which is reactivated by adult loss. The depressed patient, in Klein's theory, has been unable to overcome the anxiety over the wish to damage the internalized love object, has repressed aggressiveness and turned it on themselves. A dramatic clinical example of this is presented by Finell (Finell and McDougall 1985). The obsessive symptomatology is an attempt at reparation in these situations according to Klein, or, as Freud said, an attempt at self-cure.

The unresolved guilt in this situation explains why some depressed patients become impossibly attached to their objects and cannot separate from them, no matter how bad they are. Constant

contact is necessary as reassurance that destruction of the object has not taken place. Therefore all difficulties in separation from an external object originate in aggression toward that object and are motivated by either persecutory or depressive anxiety. The easiest path of escape from the depressive position is regression to the paranoid position, and therefore one sees in many patients an oscillation between paranoia and depression, in which the target of their aggressiveness shifts between the object and the self, and a corresponding shift between persecutory hypochondriasis and obsessive-compulsive phenomena with depression.

I believe that only by an open-minded approach to such a patient, allowing her to unfold her own story over many years of time in a protected environment, could we afford her a sufficient psychotherapeutic 'holding'

environment that would enable her to function. The only alternative would be, as she herself recognizes in her material, her becoming a bag lady dependent on welfare and perhaps living on the streets. Would this be more cost-effective and better for our society than allowing such a patient to have long-term psychotherapy?

#### *Note*

A paper accepted in 1995 to appear in *Psychoanalytic Inquiry* (in press). Reprinted by permission.

## Contingency and the Unformulated Countertransference

One of the factors making psychoanalysis so complicated to study, even though I believe it is crucial to whether or not the psychoanalytic process is successful or ends up in stalemate or failure, is what I call the unformulated countertransference. Any well-analyzed psychoanalyst is aware of his or her countertransference and the fluctuations and vicissitudes of it as the analytic process moves along, but I am suggesting that at the same time certain unformulated vaguely felt or even unfelt or unconscious countertransference phenomena

develop. For example, Tower (1956) described the chronic countertransference structure. She writes, 'The treatment situation between patient and analyst at its deepest and nonverbal levels probably follows the prototype of the mother-child symbiosis ... and involves active libidinal exchanges between the two through unconscious nonverbal channels of communication' (p. 253). To put it another way, Tower conceives of certain basic emotional attitudes toward the patient as being generated into a consistent pattern or structure over the months and even the years of working with the patient. This is called the countertransference structure. It interacts with the transference or the transference neurosis of the patient at various unconscious levels and is vital to the outcome of the treatment. In plain language, Tower states:

I simply do not believe that any two people,

regardless of circumstance, may closet themselves in a room, day after day, month after month, and year after year, without something happening to each of them with respect to the other. ... It is probably far more important that the minor change in the other, namely the therapist, be that which is specifically important and necessary to the one for whom we hope to achieve the major change, (p. 234)

Until recently other authors such as Menninger (1958) have implied a similar point of view, but rather than deeply exploring the subject, they backed away from it. Whitaker and Malone (1953) pointed out that all psychotherapy involves a therapist and a patient who have what they call both therapist and patient vectors in them that work on the level of the apparent as well as the unconscious relationship between patient and therapist. Therapist vectors are responses to the needs of the immature child part of the other person. Most often the responses of the therapist



are therapist vector responses to the patient. At times, however, the patient responds with therapist vector responses to the (we hope) relatively small residual child part of the therapist. Patient vectors are demands for a feeling response from the other person, much as a hungry child demands that his or her parents serve as archaic selfobjects.

It follows that patients will get well only if the patient vectors of the therapist do not make excessive demands on the patient's therapist vectors. Assuming that the therapist had an adequate psychoanalysis of his or her own, thus reducing his or her patient vectors to a minimum, Whitaker and Malone then make a rather startling point. They insist that it is vital for successful therapy that the therapist bring in his or her patient vectors along with his or her therapist vectors. This they call a total participation with the

patient. The therapist thus expands the frontiers of his or her own emotional growth during the therapy. If the therapist refuses to participate totally in this fashion, it is experienced by the patient as a severe rejection, or, in self psychology terms, a massive empathic failure of the selfobject, and the therapy is not successful. In a more extreme view Boesky (1990) states, 'If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis would not proceed to a successful conclusion' (p. 573). In discussing the unformulated countertransference it is clear that it becomes an extremely important issue if we agree that for a psychoanalysis to be successful, some sort of unplanned and spontaneous participation on the part of the analyst is necessary and unavoidable.

Sometimes the underlying countertransference structure only becomes apparent when the analyst

recognizes that he or she is engaging in some kind of enactment with the patient that is either somewhat inappropriate or represents a minor boundary crossing or even a boundary violation (Gabbard and Lester 1995). The well-trained psychoanalyst, alert to the vicissitudes of inevitable enactments and boundary crossings, can use these experiences as clues to a self-analytic investigation of the hidden countertransference structure, and even use this to attain better understanding of the patient, once he or she has corrected the situation.

But there is another situation that sometimes brings into sharp focus a hitherto marginalized unformulated countertransference, and that is what, following Sartre (1956), I have labeled contingency. Over the long years of psychoanalysis there may occasionally occur realistic situations that either are or threaten to be catastrophic in

nature for the patient (or the analyst), forcing the psychoanalyst to make certain choices and actions whether he or she wishes to maintain neutrality and the classical psychoanalytic stance or not. It is these choices and actions by the psychoanalyst that may even suddenly and dramatically reveal the existence of an unformulated countertransference. I propose to offer an extraordinary case presentation that illustrates this kind of contingent situation, one that crucially tests what sort of a person the psychoanalyst really is and what his or her real motives are for practicing psychoanalysis and being a physician.

### **Case Presentation**

Ms. A. was on the couch in full-scale at first three and then four times weekly psychoanalysis with me for sixteen years, from the age of 41 to the age of 57, until her tragic death in 1997. When I

first met her she was a single woman, a professor of sociology and an author of articles for some of the major national news magazines. She had amassed a considerable fortune in royalties and was continuing to get an annual income from these royalties that enabled her to afford treatment.

Her first psychotherapy was at the age of 18 for a brief period in college during her freshman year due to 'a confused state'. She married a graduate student, Mr. B., at the age of 22, but became depressed and sought therapy in the first year of her marriage on a once weekly basis with an Israeli therapist who abruptly and without notice returned to his country in the middle of the patient's treatment. During the following year she fell in love with a married professor, Mr. C., at the same university where she was now also a graduate student. She began an affair with him,

and he left his wife and children. Each obtained a divorce and they married in 1968, when she was 28 years old. Her first husband after their divorce went back to graduate school, completed his studies, and subsequently found a prestigious job and remarried.

The patient completed all her graduate school courses in sociology except for her dissertation and was attempting to become pregnant in this second marriage. In 1973 however, at the age of 33, she applied to the local psychoanalytic institute because she was unable to write her dissertation and was very frustrated because she could not become pregnant. She was referred by the psychoanalytic institute to one of their prestigious psychoanalysts where she received treatment on the couch two or three times weekly for about four years. However, this prestigious psychoanalyst was in great demand in Washington

and New York and had to cancel many of her appointments. He often mixed her appointments up with those of other patients or did not appear at all, so at times she came to an empty office. He would spend time on the telephone with various administrative matters during her sessions and frequently fell asleep during the sessions, even at times snoring loudly. She noted that he especially tended to sleep when she told him her dreams.

During this psychotherapy the patient's husband became ill and eventually died of leukemia, and her father also died. In addition to that she required the removal of an ovary for endometriosis, the condition that she discovered was permanently preventing her from becoming pregnant. The patient became essentially psychotic on this analyst's couch, flooded with florid sexual fantasies that she could barely control and with various hypochondriacal

preoccupations that even bordered on the delusional. She was unable to make any progress on her dissertation and her life became increasingly chaotic. She began an affair with a writer in Boston who was both homosexual and heterosexual, because he had a child and she wanted to imagine that this was her child. She began traveling back and forth from Chicago to Boston frequently and her behavior became more and more chaotic and unfocused. The psychoanalyst did not change his technique during any of this time and continued essentially attempting to analyze what he thought were her oedipal strivings that had emerged in the transference. Finally, she could stand his sleeping no longer and one day when he was asleep she tiptoed out of his office and never saw him again.

She seemed to make a spontaneous recovery after stopping this therapy, pulled herself



together, and finished her dissertation. Unfortunately the man in Boston transmitted genital herpes to her which made her feel sexually undesirable and caused her a great deal of physical discomfort. Having finished her dissertation, she took a position as a professor at a prestigious university in the Chicago area.

She sought further psychoanalysis and was referred to me by a colleague because of my reputation for dealing with borderline and other difficult conditions and for performing second psychoanalyses in situations where the first one had been incomplete or failed. At the time I first saw her she was uncertain about what to do about the man in Boston, very uncomfortable due to her genital herpes, and considering the possibility of adopting a child as a single parent. There was some concern about her platelet count and one of her internists told her that she was 'preleukemic'.

The patient's first dream was, 'I'm covered with leeches and the fire department comes to rescue me.' She continued, 'Of course you will be the fire department.'

She had one brother, a psychologist, who was five years younger. He was married and had two children but the brother and his family wanted very little to do with her, probably because they thought she was bizarre or possibly crazy. Her father had been a drinker, a very skeptical man who was tall, husky, and domineering. He was a bright sarcastic stockbroker but he blamed everybody else for his poor performance in the stock market. Family dinner was a nightmare because he would get very sarcastic and attack her mother, whom the patient defended. The patient took care of her mother, whom she described as an extremely anxious, nervous, incompetent, continually talking person. The mother currently

lived in another city and eventually developed Alzheimer's disease. During treatment with me the patient had to place her mother in a nursing home and took the responsibility for her mother's care.

At the beginning of treatment the patient, an intelligent academic, was obviously under much pressure to talk and very emotional, but her tears were appropriate to the losses she described. She was not particularly attractive and was rather carelessly groomed, sometimes even dirty. She conducted herself appropriately and was clearly lonely and in need of support. She mentioned that she had some good female friends but complained of a lot of unresolved problems and troublesome angry feelings. She seemed quite dramatic and expressed again and again a wish for a magical rescue. My initial impression of her was that she might be a borderline patient who very possibly had a deep psychotic core and was in immediate

danger of fragmentation due to her conflict about the man in Boston and her low self-esteem and loneliness.

There was no history of schizophrenia, bipolar disorder, or depression in her family and the patient denied the use of alcohol or drugs. Her only surgery was an appendectomy at the age of 9 and her physical examinations to the date of my meeting with her had all been normal, except for the puzzling low platelet count.

The patient reported that her brother had asthma by the time he was 3 years old (when the patient was 8) and the brother was always mother's favorite. She was very, very angry at doctors, especially the previous psychoanalyst and the Israeli psychotherapist. It was not yet clear whether her chaos was a reaction to the deaths of her husband and father, or to the previous

therapies, or represented either regression from an oedipal neurosis or a manifestation of a poorly defended psychotic core in a borderline patient. She seemed intelligent and cooperative and I decided to take a neutral stance, start her in psychoanalysis, and watch carefully for developments. At the same time I pointed out to her that she obviously could not come four times a week for therapy and continue the trips to Boston. She seemed very relieved to have a reason to not go to Boston, and soon stopped going entirely.

The patient was born and raised in a small city until she went to college. She knew nothing about her toilet training but was sure her mother could not have possibly have stood her dirt. She was 'sick a lot' as a child and walked and talked early. There were no specific other childhood problems. In grammar school she did not get along with the other children; she loved the teachers but talked

too much and the children teased her. Menarche was at 12 and she remained a virgin until she married. In high school she did not get along and she was unhappy, although she did well with men and had dates. She was refused admission to a sorority when she went to college. She had trouble achieving orgasms with both her husbands and she noted that she slept with a previous high school boyfriend right after she began the therapy with the psychoanalyst.

She claimed that her happiest time was during her marriage to Mr. C., who was fifteen years older than she was: 'He was big daddy.' However he died a slow horrible death from leukemia about five years into her marriage. She stated that she 'went crazy' the year he died and could not stand being alone, which accounts for her affair with the man in Boston. By the time I met her she was a respected professor with a number of publications

and a circle of professional friends, mostly women. She was also very active in her local church and well thought of in the community.

The first years of her psychoanalysis with me were marked by her gradually coming to at least consciously accept the fact that I was not the fire department and that she would have to deal with her problems like an independent adult. At times her behavior bordered on the psychotic; for example, at one point she bought fourteen shirts and in one or two instances she actually stole things from stores that she did not even really need. Gradually she settled into the routine of the analysis and no further parameters in Eissler's (1953) sense of the word (also see Chessick 1993a) were necessary to introduce into the treatment at that time. She began dating a few men on and off but they turned out to be very disappointing and psychologically limited

bachelors with whom she could not form a very satisfactory relationship.

The initial task of her analysis was to facilitate her own development of structure in her life and so to put an end to the chaos. Along with gathering much data about her life history and by focusing a lot on her reality situation this was in place within the first couple of years. By the third year of analysis she was functioning better, received a promotion, and began idealizing me and modeling herself on some of what she considered to be my consistent and calm way of life.

In the fourth year of therapy she successfully brought about the adoption of a 7-month-old baby boy and showed considerable maternal ability. At that point she also had to send her mother to the nursing home. Her attachment to me by this time was very solid, but that of an archaic selfobject



transference; I did not have the feeling that we had a real object relationship or that she had any real trust in me. I began slowly confronting her with this. She dreamed, 'I went to the dentist to fix what was under my capped teeth. He took the whole thing off and there was sheer ugliness underneath. He fixed it up better than it was.' The patient associated that she was beginning to catch on that she had a childhood defect that would not go away but had to be compensated for. This referred to our frequent discussions of her damaged self-soothing system, the consequence of repeated childhood situations where her mother would make her more anxious by reacting hysterically and nervously when she went to her mother with her childhood hurts and anxieties.

She calmed down a great deal in the treatment and was taking appropriate care of her baby. She did continue to date a series of unsatisfying men

and had sexual relations from time to time, especially when she became aware of her boredom and emptiness. At one point she was sleeping with two different men.

In the fifth year of analysis it was noted that her platelet count was only about 25,000 (the normal count is at least 150,000). She was about 45 years old at the time and her internist suggested starting her on Prednisone but she was afraid. We began watching her physical status carefully because the internists were becoming genuinely alarmed at this chronically low platelet count. Meanwhile the archaic transference deepened and the patient began experiencing some sexual yearning for me which she fought off because of her painful memories of what happened with her previous psychoanalyst. By this time her child was 3 years old and she continued to gradually add structure to her life.

During that year she fell on the ice just before she came into my office. I gave her Bufferin (note the enactment) and advised her to go to the emergency room at the local hospital if she was not feeling better. She did go, and there it was discovered that all her blood parameters were now low. A discussion began as to whether she should have a bone marrow test, of which she was very afraid because when her late husband had had a bone marrow test he hemorrhaged, enduring great pain and suffering.

In this fifth year of analysis, in a state of anxious uncertainty about her health, she began obsessing over whether to adopt a second baby and complained that thoughts were flying out of her head and she could not keep them in. She broke up with another one of her unsatisfactory boyfriends. She reported the following dream:

Someone came to fix my dining room ceiling.

There was a hole in the ceiling so that he could stand on a ladder and look into the space between one floor and another and tell what was going wrong. When he looked, then I got a chance to stand on the ladder and look also. My first reaction was surprise at what I saw. The method by which the plumbing was constructed was ridiculous and bound to cause leaks. The way the system worked was that all around the edge of the dining room was a trough made out of concrete—kind of like a horse trough. In effect it was there as a catch basin for all the ongoing leaks from everybody's problems upstairs. It was not clear to me how the system functioned beyond that, how the water drained out of the trough. But what I could easily see which explained my flood was that the water in the trough had gotten too full, spilled over onto my ceiling, and thus caused a flood. The impression the water gave was scary—sort of like a potential flood always going around the outside of my ceiling, always ready to overspill its boundaries; it even gave the impression of an on-going storm, as if the wind were also up there in the ceiling blowing the water in the trough around. The

overall impression was one of near chaos, a barely contained storm circling around and around in this trough that was always ready to spill over and cause problems.

But then there was one curious exception to this system. In the middle of the room's ceiling—near the point of the leak oddly enough—was another trough. It was not, however, part of the circular system going around the room, but self-contained. Supposedly, it was under the leaky bathtub which had caused problems, and yet it was clear from visual inspection that that container had not been the cause of the flood. It was under control and working just fine.

Analysis of this dream and her associations to it suggested that it was what Kohut (1977) called a 'self state dream'. It represented the patient's development of a gradually solidifying area of ego strength which she needed in order to confront what might be called her psychotic core that threatened to overwhelm her during periods of

heavy stress. The reference to me as a 'fixer' was obvious. Perhaps a more classical interpretation would have involved the metaphor of plumbing, flooding, troughs of water and so forth, hiding urethral erotism, but there were no associations that fit this listening channel (Chessick 1992a). I did not try to interpret this dream in any depth, but concentrated on the hopeful aspects of it, mirroring the progress.

By the sixth year of the analysis we began considering whether or not the patient could try life now without further treatment. But she complained of weakness and it turned out that her blood count was even lower than before. A bone marrow test was scheduled as well as blood transfusions. The bone marrow slides revealed a severe nonspecific myelodysplasia.

By the end of the seventh year of analysis she

was on various unsuccessful medications for her low blood count and I recommended that she obtain a second opinion from a board certified hematologist, which she agreed to do. By this time she had seen three doctors who were allegedly experts on hematology. None of them could agree about what was wrong or give any explanation for it, but they were all quite worried. She was of course very angry and asked the question 'Why me?' The doctors began quarreling over how vigorously to treat her blood problem and when to give her transfusions. I stayed out of this except to advise her to try to settle on one qualified hematologist. She finally ended up with a quite good internist. Beside the very low platelet count, her hemoglobin now hovered around 7 grams and he began her on various combinations of steroids.

During this seventh year of analysis she began remembering how her father exhibited himself

undressed in her room when she was a child, but this important material was overshadowed as she developed increasingly obsessive defenses, ruminating about various issues in response to her appropriately increasing fear of her medical condition. She actually did extremely well in getting medical opinions and deciding on the most competent doctor. She began requiring occasional transfusions on an on-going basis. Clearly there was less and less ego energy available for in-depth psychoanalytic explorations of her oedipal conflicts and fantasies because of the developing medical crisis.

By the eighth year of analysis the patient was beginning to bleed from her gums and endure bruises and arthralgias. She made her will and designed her trusts, leaving the majority of her estate to her adopted child. She suffered from insomnia and anger, and we spent many hours



dealing with her reality situation. By this time her hemoglobin had dropped to as low as 4 grams and she had to be of course transfused repeatedly. She began competently keeping track of the transfusions and the vicissitudes of her hemoglobin. By the end of the eighth year of analysis it became clear that her central problem was medical, and it was a very serious one. Finally, the combination of steroids stabilized her hemoglobin at 7 grams, but her platelet count hovered at about 10,000. Various physicians could not believe that she was still alive with such a low platelet count for such a long time.

In the ninth year of analysis she received a call from Mr. B., her first husband who, as stated, had remarried. His current wife had recently died and he had heard that the patient's second husband had died. He courted her for about six months and remarried the patient in spite of her precarious

physical condition and her severe genital herpes. The patient's blood count began to remain steady at about 8.5 grams. The patient spent the final years in analysis complaining about her new husband, and many sessions were taken up diffusing her anger at him and allowing the marriage to continue. But it seemed that her medical condition was now stable and her hemoglobin was now rising even up to 10 grams.

In the tenth year of analysis her hemoglobin was up to 12 grams and she had completely combined her household with that of her new husband and made a number of excellent financial decisions. But she complained, 'If I don't have rage at one pole I have depression at the other pole.' She began slowly working out a decent life with her husband. The marriage improved. She also took on the care of an elderly relative and successfully moved this cantankerous person to a

nursing home where she could visit him and handle his affairs.

In the eleventh year of analysis the patient was found to have developed significant osteoporosis, and additional unpleasant medications and exercises were recommended. This produced another crisis, in addition to the fact that she became clearly concerned that perhaps she did not really love her husband. She began wondering whether psychoanalysis would ever end and we agreed that it certainly had not reduced her real problems. But she was now dealing with these real problems in a much less self-destructive way; however, there seemed to be a certain exhaustion factor that developed in the therapy along with a lot of appropriate resentment at her reality situation. So we began again discussing the possibility of termination. It seemed clear that due to her complex reality problems it would not be

possible to make further in-depth exploration. I was never able to ascertain for sure whether I was primarily dealing with preoedipal pathology or material representing a regression from a severe oedipal conflict. Although she complained bitterly about her husband, he did genuinely seem to care for her and I suspect they did have some good moments together. The problem was that she constantly compared him with her previous husband who was an idealized father-figure for her.

Although we had planned to terminate, by the start of the thirteenth year of analysis the patient's platelet count began falling even more, reaching 8,000, and at one point a count of none at all (!), and she had to begin once more on steroids and receive platelet transfusions. She dreamed, 'A woman was in handcuffs. I called 911, although it was not clear why, and I awoke with anxiety.' Her

associations were that she was the woman in handcuffs 'afraid of letting my rage loose like O. J. Simpson and executing my husband with my tongue'. On her 55th birthday we decided to reduce the frequency of her treatment, but then she was given experimentally large doses of steroids for her lack of platelets which caused her great agitation and emotional lability although it did not raise the platelet count. In spite of all this uproar and her endless complaints about her husband she was able to talk about some of the deeper roots of her rage, recalling many disappointing experiences with her parents, and she began to consider changing her untrusting and cynical stance towards life, modeling herself even more on what she imagined and decided was my mature attitude and conduct. She reached out increasingly toward her religion and it helped her, but it seemed that at this point she could not

function without the holding atmosphere of the psychoanalytic situation. In this sense I was becoming the fire department after all.

In the fifteenth year of analysis the patient appeared to be doing better than ever before. She had learned not to rise to her husband's provocation and was getting along pretty well with her now early adolescent son. The psychological prognosis looked good and the long patient years of work with her seemed to really be paying off. We began focusing on her wish to transform her current husband into her previous husband who she maintained was a good selfobject for her, caring and soothing. I suspected that I had been assigned this role now, vital to her functioning under all this stress. At this point she was taking a series of unpleasant drugs for her osteoporosis and her low platelet count, but now her hemoglobin began falling again and she was

quite frightened. The steroids were increased in dosage and she became appropriately very anxious and worried about what to do. A number of procedures were suggested by the various doctors. Sadly, even her young son began to express fears that his mother might die.

The patient went down hill during that final year and began developing stubbornly antibiotic-resistant staphylococcal infections. She went for two weeks to the National Institutes of Health for an experimental drug therapy which did not help. She began bleeding from various parts of her body and required many transfusions. She began having panic attacks characterized by vomiting and it was necessary for me at the request of her internist to prescribe Compazine suppositories for her on an emergency basis. Some hematologists frown on giving any suppositories to patients with myelodysplasia and I insisted that her internist

subsequently examine her for other possible causes of the vomiting but nothing was found. The patient was clearly seriously physically ill and was temporarily admitted to the hospital for a complete work-up and transfusions. The possibility of a bone marrow transplant seemed to be what frightened her the most, as she had read a great deal about myelodysplasia and the special dangers of a bone marrow transplant in adults. Nevertheless it seemed necessary that she would have to have it as a last resort. She began developing a depressive episode with a comorbid anxiety disorder. There was not much crying and no suicidal ideation but she was clearly immersed in gloom; her bond to me was very strong and was all that was keeping her going.

She had to be rehospitalized due to vomiting and another infection and I began calling her daily on the telephone. Her blood count got very low



and she was repeatedly transfused. It was very sad, as she was in the hospital when her son had his first date. The situation was becoming tragic. The patient had to go daily to the hospital once she was discharged, in order to get blood counts and check-ups and infusions of medication. Her hemoglobin rapidly dropped shortly after each transfusion and they could not stabilize it. She began having severe pain in the left leg and it was not possible to discover the cause. Her internist gave her narcotics for the leg pain which also made her unable to eat and depressed. I started her on Prozac and she began to plan for a bone marrow transplant in two weeks.

I continued this psychoanalysis to the last day of the patient's life and she was eager to cooperate. I insisted that she come to my office four times a week even in spite of the fact that she had a stint inserted in one of her major veins and

was carrying bottles and catheters and the whole paraphernalia of someone who was getting steady infusion of various medications for a serious illness. When she was in the hospital near the end, I went to visit her and sat in her hospital room, closing the door and asking the nurses not to disturb us for an hour, and we continued with her analytic sessions. I discovered that the doctors had been talking out in the hall about her gloomy prognosis and that she had heard all these things and was very upset. I asked them to stop doing that. I urged the staff to give her reassurance and pointed out how frightened she was and that she tended to exaggerate everything she overheard. I found an effective sleeping medication for her to use during her hospitalization. I offered to various doctors on her case to feel free to call me if they had any questions about her. They never did, but they were more careful about what they said in

front of her or near her. I contacted her every day while she was in the hospital either by visiting her on my days off, or by telephone.

When the patient was released from the hospital she required daily attendance by visiting nurses to clean out her stints and catheters, etc.. She continued zealously to come to her psychoanalytic sessions, which she felt were all that was holding her together. A bone marrow transplant was scheduled at a major university center. A few days before she was to have gone in for the bone marrow transplant, while receiving a blood transfusion at the local hospital, she suddenly had a cerebral vascular hemorrhage and died. Her husband called me to inform me of this, and I experienced it as a stunning shock.

## Discussion

I was rather surprised at my very strong

reaction after this patient's death. I had seen her three or four times a week for sixteen years and watched her develop from an essentially psychotic state into a relatively well-functioning individual, only to be cut down cruelly by a vicious disease that nobody could get under control. It was a truly dramatic and tragic situation. During that time, however, I had not felt powerful personal affects about her, either positive or negative, although as a physician I was compassionate with her plight. My conscious countertransference ranged from one of a certain bemusement and looking forward to working with her on the one hand, to irritation with her incessant complaining on the other. I never had any conscious erotic feelings towards her nor did I consider her particularly attractive or desirable as a woman. I respected her education and admired the battle she put up to attain her mental health. Later I respected her even more for

the tremendous struggle she put up to try to conquer an inevitably fatal illness.

Near the end the patient wanted to leave me a great deal of her money because she claimed that I was the person closest to her in her life and, next to her son, the person that she loved the most. I pointed out that it was unethical of me to accept money and we agreed that she would leave the money to Northwestern University in my honor, to be used for cancer research. She died in a state of expressing genuine love and gratitude and with a feeling that I had psychologically held her to the very end. I was proud of that and considered that I had done the best possible job under the circumstances, and felt that at this point, in the shadow of death, she had developed the capacity for genuine object relatedness.

After she died I was confronted with the

question of whether to attend her funeral. I had never met her son or her current husband except when once or twice over the years she proudly brought her son to my waiting room just to say hello. The child was very defensive and clearly was frightened of psychiatrists and wanted nothing to do with them. I decided only to go to the visitation and leave my name, but not to go to the funeral. It was a closed coffin and I went there alone and said a silent goodbye. To my surprise, afterwards I found myself undergoing a standard mourning process, where I dreamed about the patient still being alive; during the day I found myself expectantly looking forward to her coming to her sessions when her usual appointment times came around. I felt a curious gap in my life when the patient no longer appeared in my office at her regular times and I found it almost uncanny and discomfoting, something akin to a phantom limb

phenomenon. Apparently she had made a deeper inroad into my unconscious than I thought.

At first I believed this was because she had a certain resemblance to my mother and that in this sense I was reliving the death of my mother many years ago, which was also a tragic affair. Melanie Klein (1975a) correctly said that every loss revives the depressive position and requires it to be worked through again. I do not know if the loss of this patient constituted a narcissistic blow because it revived the loss of my original selfobject, my mother, or if there was a deep unconscious and unformulated countertransference structure, an object-related ambivalent bond that I had developed with her which was now abruptly fractured and led to the standard mourning process as Freud (1917) described it, or both. Even writing this chapter is clearly related to working through this experience

and an attempt to sort it out. Many years ago I reported a case illustrating the profound effects on the therapist's unconscious produced by the intensive psychotherapy of a borderline patient (Chessick 1982b).

Perhaps the most surprising aspect of the period after the patient's death occurred when I received notice from the executor of her estate that she had left certain properties to me. These, the notice said, consisted of four early edition books and her stamp collection. The patient knew that I was a bibliophile and an avid stamp collector. I wrote the chairperson of the ethics committee of the Illinois Psychiatric Society and asked if the committee would consider it proper for me to accept these tokens. The ethics committee chairman saw no objection to my accepting this bequest, providing there was no objection from the patient's husband or son. I



received written permission from them to accept the bequest.

I was very surprised when I opened the box. The four 'early editions' were valueless and the stamp collection was that of a child, which the patient probably had not looked at for forty-five years; in other words she had left me some worthless trivia and empty remains of her childhood. I could not help the feeling that the patient's final words to me were 'shit on you', maybe in her disappointment that I was not able to pull her through a lethal disease, maybe as her last words to the whole human race, which as a sociologist she had complained about incessantly over the years in my office, or perhaps as a displacement from the transference. Was this my projection? What was it the patient was trying to communicate? Was she consciously aware of the lack of value of such gifts or did she think they

were valuable? Was she punishing me for refusing the gift of money? Or, at a much deeper level, was she trying to tell me that at her infantile psychic core there was an archaic 'black hole' (Chessick 1996d), a depreciated emptiness? That out of the unformulated countertransference I had refused to concede the hopelessness of both her mental and physical conditions and supported her denial, thus preventing her utter psychic collapse?

Even my rumination about these things indicates I have not finished my self-analytic exploration of the unconscious unformulated countertransference, which clearly involved some kind of unformulated symbiosis that I developed with this patient, and which I firmly believe was central to the curative process in her psychoanalytic treatment. She needed a 'fire department', and perhaps I had become one out of an intuitive response to the realistic vicissitudes of

her life. Clearly my early assigned role as selfobject to my neurotic mother was a factor in producing this 'intuitive' response. Was the previous analyst's inappropriate behavior his defensive response to this patient's great need? Where was his 'physicianly vocation' (Stone 1961)? What are the roots of this physicianly vocation in the psychoanalyst and how crucial is it to psychoanalytic cure? Should Freud, violating his own precepts, have fed the 'Rat Man' or collected money for the 'Wolf Man'? As Hamlet said, 'There are more things in heaven and earth, Horatio, than are dreamt of in our philosophy.'

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 27: 135-49, 1999. Reprinted by permission.

## Self-Analysis: A Fool for a Patient?

Derivative as it is from fragments of self-analysis, everything in this paper must be regarded by the reader as data ... the manifest content of a dream that had already undergone secondary revision in writing ... everything is data, the form and sequence of the presentation, the formulations, the omissions and elisions that the reader will immediately detect, and indeed even the motivation to write the paper in the first place. (Engel 1975)

An unfortunate tradition that seems to begin with the unpleasant *ad hominem* squabbles marring Freud's 'Wednesday evening society'

(Nunberg and Federn 1962, 1967), has caused an extremely important matter for both psychoanalytic therapists and their patients to be somewhat neglected in the psychoanalytic literature: continuing self-analysis after one's training psychoanalysis. In spite of this tradition, which has made psychoanalysts understandably reluctant to reveal personal data, publications have slowly accumulated on the subject, and the issue of self-analysis after one's training psychoanalysis is turning out to be much more complicated than was originally thought. In the first part of this chapter I will review the history of this subject and some of the increasing controversy it is starting to generate; in the second part of the chapter I will present some personal material—which is the only kind of clinical material a discussion of self-analysis, by definition, can adduce for consideration. I hope to throw

some light on the issues involved in self-analysis after one's training psychoanalysis, and stimulate a reconsideration of this entire subject. Throughout the present chapter I refer to self-analysis after the successful termination of training psychoanalysis, *not* to the hopelessly impossible 'self-analysis', sold to the general public by various popular authors, or to Horney's (1942) *Self-Analysis*, which is mainly a presentation of her psychoanalytic theory (Rubins 1978).

## I

Freud's self-analysis through his letters to Fliess and as manifested in *The Interpretation of Dreams* was heralded correctly as a gigantic breakthrough in methodology, an act of personal courage, daring, and devotion to truth. As early as 1910 he recommended self-analysis for anyone

who wished to do analytic work. Fleming (1971) has traced the development of the training analysis from this original recommendation and identified the many changes over time in the theory and practice of training analysis. She added that one major objective of training analysis is to encourage a life-long process of self-analysis through 'introspection, empathy, and interpretation' (p. 44). The hope is that since no formal psychoanalysis is perfect and truly complete, self-analysis will go on after termination. As Beiser (1984) explains:

Problems will arise in the course of life post-analytically that may be solved by applying analytic techniques to dreams, daydreams, symptoms, and unusual affects and thoughts to determine the unconscious attitudes and conflicts that impinge on these problems. This is true for all post-analytic patients. In the case of analysts, there is an additional large literature devoted to countertransference, and the place of self-

analysis in resolving distorted feelings and attitudes aroused by patients, (p. 3)

She remarks, however, that most authors do not describe the actual process of self-analysis.

Freud expected spontaneous self-analysis to occur after the termination of training analysis (Tyson 1986), but later Freud (1937) in his famous paper 'Analysis terminable and interminable' became rather pessimistic about the psychoanalytic process, and recommended periodic formal reanalysis for psychoanalysts every five years. This recommendation, although it is based on a formidable argument by Freud, is largely ignored for practical and other reasons, and has been replaced by general agreement that those practicing psychoanalytic therapy will feel a professional obligation to engage in self-analysis whenever they become aware of the interference of countertransference difficulties. This vague



expectation is seldom documented or spelled out in the literature; it is just assumed that everyone who has finished a training psychoanalysis successfully, which implies achieving a sense of professional psychoanalytic identity and personal integrity, will somehow carry out this function as a normal part of everyday psychoanalytic work.

Until recently the difficulties involved in self-analysis have tended to be glossed over, and, with the exception of a few brave souls, very few authors have presented data for study. One of the earliest warnings came from Wheelis (1956) who cautions that, training analysis notwithstanding, analysts also employ defensive mechanisms and are personally affected by the nature of analytic work. For example, the problem of intimacy, writes Wheelis:

... may be aggravated by the life-work that was meant to solve it, and on this problem

some analysts founder. They withdraw from hatred, insulate themselves from their patients, and thereby preclude a therapeutic interaction. Or they yield to what appears as love and enter upon a personal relationship with a patient, a development which not only precludes therapy but also violates the moral commitment of an analyst, (p. 184)

The successful practice of psychoanalytic therapy depends on what Wheelis calls 'the capacity for insight':

... the ability to look into obscure aspects of one's personality, to recognize disguised motivations, to integrate what is discovered with various elements of conscious experience, and to utilize one's findings in such a way as to bring about a change in feeling, action, and reaction, (p. 172)

All authors have assumed with Freud that a successful training psychoanalysis will develop this capacity, but there has been little study of what factors might arise in the on-going life of the psychoanalytic practitioner that may damage it,

blunt it, or remove it altogether. From my clinical experience in the treatment of various previously analyzed mental health practitioners and their family members, it seems clear to me that major breaches of ethics such as mentioned by Wheelis above take place at those points where the therapist's capacity for insight—regardless of how excellent it may be under ordinary circumstances—has been at least temporarily grossly blocked. This occurs either due to extraordinary external circumstances or to the gradual accumulation of unanalyzed narcissistic difficulties in the aging therapist who, in his or her training psychoanalysis, tended to focus more on traditional oedipal problems and less on pregenital and narcissistic issues—as was especially the case in psychoanalyses carried out many years ago.

To my knowledge the first paper that

attempted to focus on the problems of self-analysis in detail is by Kramer (1959). She reminds us that Freud (1937) described how various instinctual conflicts can become intensified in certain periods of life for either biological reasons such as the aging process, or owing to changing external circumstances which may become adverse for gratification—today after Kohut we would add situations which may repeatedly inflict narcissistic wounds on the individual. Indeed this is what made Freud argue correctly that analysis was interminable, and led to his suggestion that analysts be reanalyzed every five years. Kramer used the excuse that it is difficult for an analyst 'who has professional as well as personal contacts with his colleagues, to find a suitable analyst' (p. 18) as a reason to avoid reanalysis every five years—but of course if a person is really motivated to have a reanalysis he

or she can find a suitable analyst.

She concentrated on the other alternative, the so-called continuing self-analysis, and tried to compare and review the forces operating in self-analysis with those in a formal psychoanalysis, singling out (a) the positive transference, (b) the re-experience of old conflicts in the transference situation, and (c) the function of the analyst as interpreter. She claimed that transference feelings in self-analysis, whereas during analysis they are focused on the analyst, 'are now directed towards other objects' (p. 18). She emphasized the importance in self-analysis of the identification with one's psychoanalyst as interpreter, so that the same procedure is followed as during one's formal psychoanalysis 'with the important difference of being patient and analyst at the same time' (p. 19). For example, in attempting to interpret a dream or a countertransference

reaction, the self-analyst uses free association, tries to interpret defenses, and so on, just as if a formal psychoanalysis was taking place. Kramer is not impressed by the efficacy of this procedure because:

... it is evident that these methods can only be effective for conflicts that do not arouse too much anxiety, and will fail against too strong resistances. I feel certain that every analyst who has tried to continue analyzing himself has had the experience of encountering insurmountable resistances. At such times, dreams are forgotten and associations remain fruitless. Interpretations are tentative, they prove to be wrong or sterile intellectual speculations. Any insight that might occur is apt to be about a minor matter and does not lead to a resolution of the conflict, (p. 19)

Freud (Tyson 1986) recognized this difficulty as early as 1897, and Fleming (1971) agreed that 'the experience of resistance is more intense in self-analysis than with an external analyst present' (p.

30), but she added 'We know it can be overcome with persistent effort and in time' (p. 31); however, she presented no data to support her contention.

On the basis of the fact that 'one often has to admit defeat' (1959, p. 19) Kramer tried to draw the distinction between methodical active efforts at self-analysis and an 'autoanalytic ego function' which involves 'seemingly spontaneous experiences' (p. 19), in which material that was previously impervious to active attempts at self-analysis spontaneously, forcefully, and convincingly broke through into her conscious mind. She left open the question whether active self-analytic efforts stimulate this autoanalytic ego function, but it seems to me that this experience is also common during the process of one's formal psychoanalysis and clearly is stimulated by the unresolved issues that are being

concentrated on in the psychoanalytic process. Similarly, unresolved issues in one's active self-analysis could be worked and re-worked preconsciously or unconsciously until the solution sometimes surprisingly and spontaneously occurs; anyone who has done creative work in any area of human endeavor has a similar experience from time to time.

To my knowledge no other author has attempted to maintain Kramer's distinction between active self-analysis and the autoanalytic ego function because the two occur together. Her most important contribution, besides presenting the first detailed clinical material, was to contend that, upon losing the analyst as an object at the termination of one's analysis, a replacement takes place through identification; the analyst and his demand to analyze are set up in the ego ideal. Thus the positive transference as an incentive to



face inner conflicts, Kramer said, comes from the demand of the superego and attempt to seek its approval by living up to the ego ideal.

Myerson (1960) utilized a framework similar to that of Kramer and described an autobiographical episode which he attempted to analyze by a method he considered a step-by-step repeat of the analytic process, but he conceded that discoveries in self-analysis may 'serve to cover deeper and more threatening meanings' (p. 155). For him, as for Kramer, the analytic ego ideal formed from an identification with one's analyst comes to function as a 'permanent part of the post- analytic personality' (p. 150).

A different approach to the study of self-analysis was presented by Ticho (1967), who carried out discussions with an unspecified number of practicing analysts, all of whom had a

personal psychoanalysis that was terminated not less than four to five years before they were questioned. Her paper, although formally presented, consists essentially of Ticho's 'impressions', which because of the dearth of material on the subject, are very interesting. Ticho believed that self-analysis depends on the development of a new skill that evolves during one's formal psychoanalysis, a skill based on the formal psychoanalytic functions of 'free association, objective and respectful listening, and interpretation' (p. 309), but the final organization of these functions into a unified whole is achieved by each analysand on his or her own.

Ticho claimed that the post-analytic phase 'usually starts with a disappointment reaction' (p. 309), and whether the former analysand begins to develop the skill of self-analysis or turns away from self-analysis 'depends on the final outcome of

this phase. When self-analysis progresses, this skill becomes relatively autonomous, and stable' (p. 310). Ticho rejected Kramer's distinction between active self-analysis and the autoanalytic ego function because, as in formal psychoanalysis, it depends on whether controlled or free associations are used, so that both are different aspects of the same process. She found that in the beginning of self-analysis 'the analyst's words are exactly remembered; while if self-analysis progresses, the analyst fades more and more out of the picture' (p. 313), which for Ticho means that the analysand is becoming less dependent on the fantasied presence of the analyst.

Freud's concern about the danger of incompleteness of self-analysis was again raised by Ticho, who reminds us of Freud's warning that in self-analysis alone 'one is too soon satisfied with a part explanation, behind which resistance

may easily be keeping back something that is more important perhaps' (Freud 1935, p. 234). There seem to be a number of self-analytic activities that attempt to get around this problem, such as taking notes of dreams, countertransference phenomena, or other manifestations from the unconscious, together with insight gained at that time, allowing the individual to review the material repeatedly and 'observe their own repression at work' (Ticho 1967, p. 314); thus 'often it is only after months, or even years, that they can see a common trend in all these manifestations' (1967, p. 314). This study of one's own written material over months or even years of time is one way of substituting for the interpreting psychoanalyst's confronting the patient with certain themes that repeatedly appear in the material of free associations.

Certain other important self-analytic activities are described by Ticho. For example, besides

studying reactions to disappointment, not discussed at length by Ticho but surely linked to episodes of narcissistic wounding, there is the continuous self-investigation of countertransference phenomena, particularly those which occur in response to a specific conflict of a patient. Ticho claims, 'in such instances it is the patient who verbalizes the unconscious material, and the analyst, by observing his reaction to it, gains the psychic distance required for self-interpretation' (p. 314). Certainly the meticulous attention to one's countertransference forms a continuing motivation for examination of one's own conflicts and defenses; powerful impetus to the therapist's self-analysis arises in the clinical consulting room out of difficult countertransference problems.

Another point Ticho made, which I did not take seriously until reviewing my own self-analysis, is

that the increase of knowledge gained by reading the psychoanalytic literature or even from continually experiencing art, music, and literature also facilitates self-analysis. Ticho suggested this is not necessarily from intellectual understanding leading directly to effective insight but that somehow, 'there is no doubt that it may broaden one's understanding of unconscious material pushing towards consciousness' (p. 314). Just as an increase of knowledge may substitute for the interpreting psychoanalyst, the works of creative artists, when studied and experienced, the appreciation of the artist's message and the form he or she finds for its communication, and even a study of the way one attends to, or listens to a work of art can certainly throw valuable light on one's own conflicts and defenses.

Although all the analysts Ticho interviewed indicated they believed the focus of their main

neurotic conflict to be the Oedipus complex, what arose in their self-analysis and caused the most difficulty was preoedipal material, which was hard to recall from their psychoanalysis and hard to work through in self-analysis. Ticho pointed this out also in the data of Kramer's (1959) self-analysis.

Ticho attributed this difficulty in self-analysis to the formal psychoanalytic setting having gratified pregenital strivings, such as by the regularity of hours and the reclining position on the couch, etc. But she did not present a convincing argument that explains why, as I also agree, pregenital strivings tend to preoccupy one's self-analysis regardless of whether or not the Oedipus complex—as is usually the case—was the focus of one's training analysis. This is true even though, of course, the various pregenital manifestations of the Oedipus complex and

regressive defenses against it are properly worked through in the training analysis. Here Ticho fell back on the disappointment factor, leaning on the remark of one analyst who had hoped that his training analysis would provide a formula to contain all answers and be the solution of all life's ills—but there is little recognition of the unanalyzed narcissistic factors that lie behind such a hope.

For Ticho, the tension between the ego and the ego-ideal is probably the driving force for self-analysis, although any kind of tension between intrapsychic structures could serve as a potential source of motivation. Ticho left it open whether or not the material that appears as 'new insights' in self-analysis represents actually the resurfacing of insights that were repressed after one's formal psychoanalysis, although she emphasized that the working through of repetitive patterns with



deeper and more extensive understanding could be valuable, even in dealing with 'the post-analytic disappointment reaction' which Ticho reported 'is more common than is generally admitted' (p. 316). She warned of the danger of self-analysis deteriorating into 'obsessive rumination, self-preoccupation, self-accusation, intellectualization, self-admiration, or self-indulgence' (p. 318), which represents a regressive defensive use of self-analysis—as a response for example to a severe conflict situation. She concluded that if there is a permanent impairment of the self-analytic skill, it represents for the practicing therapist an indication for reanalysis; such loss of self-analytic skill or what Wheelis (1956) above called the capacity for insight often appears clinically as a loss of interest in analytic work and in the analytic literature.

Ross and Kapp (1962) offered a specific

technique for self-analysis of countertransference by using the psychoanalyst's visual images in response to the narration of the patient's dreams. The analyst then associates to his or her visual images and applies self-analysis in this fashion. Their technique, although it is quite clever, stumbles on the same problem of how one validates the insights gained; a sudden change in level of tension, a sudden feeling of understanding one's self better, and a spurt in the progress of the patient's analysis, as Ross and Kapp conceded, can occur with both correct and inexact interpretations. These authors suggested a process utilizing a supervisor to cross-check the validity of the insight, but this would not be practical for an on-going self-analysis.

Ross and Kapp presented an excellent brief vignette of what I consider to be first-class self-analytic work. In summary, while a patient was

telling a dream, the analyst suddenly visualized a certain dinette from his own recent social experiences. On free association by the analyst to the dinette a link occurs to a woman acquaintance the analyst wishes to be rid of, and thence to an excessively demanding housekeeper in the home where the analyst lived as a child. When this demanding housekeeper, who insisted that he reciprocate her love, became unhappy in her job and quit, the analyst as a child was pleased. This led to the insight that the analyst was subtly and unconsciously encouraging the patient to defend herself against an emerging erotic transference by leaving treatment. It represented a countertransference straight-arming of the patient's incipient emerging demands for him to reciprocate her love.

But the vignette does not go on to consider whether the analyst was reacting to potentially

excessive erotic demands or to a potentially excessive idealization. Nor is there any analysis of whether he wishes to get rid of the woman because he dislikes her excessive erotic demands or because he is afraid of his possible erotic response, which may have oedipal overtones or, if the response is to idealization, may involve a mobilization of the analyst's own archaic grandiosity. Even a study of this little case vignette illustrates the enormous complexity and difficulty of validation of self-analysis.

Calder (1980) described his deliberate self-analysis over a period of fifteen years. He wrote down certain data and his associations to the data, and then attempted to understand the primary data on the basis of the associations, the written record permitting comparisons at different times. The primary data were dreams and then memories, daydreams, and symptoms. Calder

found his dreams to be too complex and less useful than expected. Memories and daydreams were much more useful, and symptoms both more frequent and more useful than anticipated.

He begins his self-analysis most mornings by recording the dreams of the night before: 'At the sacrifice of a careful reading of *The New York Times*, I record a few immediate associations and leave further work, including a description of the context in which the dream occurs, for the passage of the day and a moment of quiet at the end of the day' (p. 7). This method of recording allowed Calder to study and compare his material over years, after which he reported:

An insistent and compelling insight results from one's becoming aware of such patterns of response, an insight, I believe, resulting in conviction approximating that coming from a transference experience and a transference interpretation in personal analysis. A written

record, moreover, permits one to observe changes in oneself with greater clarity and in greater detail, (p. 7)

A similar technique was first proposed by Pickworth Farrow (1926) and used by Freud (1926c), who also told Jones (1953) that he devoted the last half hour of each day to self-analysis. Considering the incredible length of Freud's working day, one would like to know a lot more about this rather cryptic remark.

Calder illustrated this by a study of his own 'negative oedipal wishes' (p. 8). He found his technique useful in that several wishes which were strongly censored in the past were now more acceptable to him as a result of his self-analysis; self-analysis was most useful at times of regression, which tended to occur when he was anxious, angry, lonely, or tired.

Implicit in Calder's discussion is the important

differentiation between one's formal psychoanalysis and self-analysis in the absence of an analyst as the object of transference. Contrary to Kramer (1959) who, as mentioned above, reported the transference in self-analysis taking place to 'other objects', Calder claimed that insight in self-analysis can be achieved by means other than the analysis of transference. Calder concluded, 'self-analysis is a labor of love' (p. 19); there is clearly an important narcissistic factor at work.

Indeed Warner (1980), in his study of the misalliances formed by Guntrip with both of his analysts, noted that self-analysis during a formal psychoanalysis can be a formidable resistance. Abraham (1919) first pointed this out, and Warner provided a striking case illustration. In fact, Pickworth Farrow's (1926) self-analysis was brought about by his failures in psychoanalysis. It

is in this area of the narcissistic aspects of self-analysis that the greatest potential deceptions of the procedure clearly lie.

Beiser (1984) attempted a systematic self-analytic approach somewhat like Calder's but did not have the 'patience or persistence' involved and soon gave it up. Her final technique was similar to that of Myerson (1960), using the self-analytic process in situations of anxiety or distress. An example of the most intensive self-analysis arising in a situation of acute stress or the sudden appearance of a symptom is presented by Engel (1975), who proceeded to focus his self-analysis on that situation and its anniversary—in Engel's case the death of his twin brother. Beiser, Myerson, and Engel therefore, in contrast to Calder, call up self-analysis only in specific extraordinary situations rather than as a non-specific on-going methodical process.



Beiser believed that the choice of technique of self-analysis is dependent on the personality of the individual who wishes to pursue self-analysis, but she did not consider those defensive features which may form an important determinant in one's particular choice of self-analytic technique. Thus regardless of the technique chosen, the self-analyst would have to analyze the motivations for his or her choice of technique. This is not so extraordinary—for example, patients choose certain psychoanalysts to go to for various unconscious reasons, regardless of the rationalizations involved in their choice, and such reasons sooner or later must emerge and be analyzed in the formal psychoanalysis. Thus a feminist may demand a woman psychoanalyst, a Catholic, a Catholic psychoanalyst, a narcissist, a famous psychoanalyst in whose fame he or she wishes to share, and so on. In good psychoanalytic

work this is always analyzed and worked through; in fact it may lead to a change of analysts or even a reanalysis.

Many authors from Weigert (1954) to Tyson (1986) centered all their discussion of self-analysis on the problem of countertransference, and there are many scattered references to self-analysis throughout the literature on countertransference (Chessick 1986). A formal discussion of countertransference is outside the scope of the present chapter, but Tyson pointed out that authors:

... are unanimous in explicitly or implicitly advocating that the analyst subject himself to unremitting self-scrutiny and interminable self-analysis in order to obtain and maintain that degree of self-awareness required for the optimal performance of his work, a view which has supplanted the recommendation of intermittent re-analysis earlier proposed by Freud, (p. 260)

Tyson recognized that though it is often suggested, 'the practice of self-analysis seems not so often to be followed' (p. 260). He mentioned Gray's (1973) review of the literature on the capacity for self-analysis, but he added that so far no one has described satisfactorily how to successfully accomplish a self-analysis. Tyson is not optimistic about self-analysis because he feels that, without the 'holding' aspects experienced in an ordinary psychoanalysis, defensive mechanisms will predominate to protect against threatened regression.

To my knowledge Tyson is the first author to point out in discussing self-analysis that identifications with one's former psychoanalyst do not represent simply a positive identification with the analyst's analyzing attitude: 'For example, they may have been made in the course of identification with the aggression of the aggressor, or, at

termination, with an ambivalently loved lost object, or in pursuit of narcissistic gratifications' (p. 263). Tyson did not make the connection of this to the remarkable clinical vignette presented at the end of his paper, which involved the acting out of two analysands and their analyst. He simply concluded that the analyst was experiencing countertransference as manifest in his contribution to the episode, but adds, 'I also knew this did not relieve me from investigating my contribution to it' (p. 270). What is not investigated is the effect this vignette might have on the kind of identification the analysand might make with his psychoanalyst, and how that identification would affect the subsequent self-analysis of the analysand.

An important principle arises from this material: the choice of self-analytic technique and the relative success or failure of one's self-analysis

after training psychoanalysis is closely related to the internalization process that has taken place in one's formal psychoanalysis. Tyson's paper concentrated more on resistances to self-analysis, for example, resistance to uncovering homosexual countertransferences based on an insufficient analysis of the analyst's own latent homosexuality, rather than on the interferences with one's self-analysis by certain identifications with one's psychoanalyst.

Although, like all other authors, Kohut (1984) encouraged the notion of a pragmatically successful psychoanalysis that leads to a reasonably balanced life in which the former patient supports himself or herself during times of stress at least by activating the self-analytic function, he stressed that theoretically self-analysis means that the need for working through in the psychoanalysis was never completed—the

ideal goal of psychoanalysis had not been reached. From the self psychological point of view, 'the selfobject imago of the analyst had not been transmuted into smoothly functioning psychic structures during the course of the analysis, that it had, at least in part, retained a quasi-external separateness within the analysand's psyche' (p. 155). For Kohut the reactivation of the analytic process, as is only appropriate when countertransference appears, represents a kind of transitional phenomenon calling on partially internalized structures, like the little girl proclaiming herself naughty as she reaches into the cookie jar in mother's absence.

Kohut (1984) warned against the 'tool and method pride' of psychoanalysts who are eager to report experiences of their self-analysis in a countertransference situation, and that an addiction to self-analysis could hide the presence

of 'the fear of the return of former insecurities and imbalances if the protective activity is given up or even relaxed' (p. 161). He described the danger of 'the addictionlike application of certain technical rules and traditions during the analyst's clinical activity' (p. 162) and argued that, referring to occasional parapraxes as they arise:

... on many occasions it is more 'analytic,' more an expression of the seasoned analyst's analytical wisdom, to pay little attention to such a minor manifestation of the unconscious than to concentrate on it and pursue it relentlessly until the underlying meaning has become manifest, (p. 162)

Thus the occurrence of self-analytic activity 'may not be as mature as it seems whereas the need for archaic selfobject functions may not be as immature as it appears to be' (p. 224). This refers again to the appearance of pregenital material in one's self-analysis, which of course could be stimulated by the absence of an archaic selfobject

transference, since there is no holding psychoanalyst as an available transference figure.

Kohut suggested that the diminution of conscious self-analysis taking place in some psychoanalysts as they mature in their profession is not necessarily deleterious, and could be evaluated as a positive sign indicating that the total functioning of the analyst *qua* analyst has improved. He asked, 'Has he replaced plain self-analysis, consciously undertaken, with more nuanced reactions that proceed silently?' (p. 224). Indeed, for Kohut the continuous deliberate exercise of self-analysis represents 'the need to reinstate the functions of the selfobject analyst in the form of a conscious exercise of self-analysis' (p. 170). This view seems to cast doubt on the motivation for regular methodical self-analysis, seeing self-analysis appropriate only as a nuanced reaction to countertransference, and suggesting



that the decline of self-analytic activity could be a manifestation of increasing maturity and smoother preconscious personality functioning. It is almost diametrically opposed to the position of Calder (1980) described above, who did not undertake fifteen years of self-analysis for the specific purpose of dealing with countertransference phenomena but rather as an 'experiment'. Calder admitted, 'What prompted my interest in self-analysis I don't now recall' (p. 6), but for Calder it is a valuable research activity.

## II

My self-analysis has been carried out using a similar method to Calder's for a period of over forty years. With Calder I believe that regular self-analysis is a valuable research tool, but its primary value is in dealing with countertransference problems that inevitably arise in a busy full-time

psychoanalytically oriented practice, with almost all patients being seen quite intensively. Like Calder (1980), 'several wishes which were strongly censored in the past are now more acceptable to me as a result of self-analysis' (p. 15) and I agree with his advocacy of self-analysis in order to understand one's self better, to understand the psychoanalytic process better, to reduce weekend and summer crust on the part of the analyst, to improve one's sense of autonomy and well-being, and to perform a labor of love. Beside its main value of help in dealing with countertransference, its other main value at this time is to afford research into the difference between formal psychoanalysis and self-analysis; the more these are studied the less similar they seem to be.

It remains moot whether genuine new insights arise in self-analysis or whether it consists of the

re-working of old insights in new contexts. I am convinced that one important contribution of self-analysis is a re-working and better integration of the internalization of one's psychoanalyst. This especially pertains to issues of negative transference that have remained unresolved or, even if the analysis was conducted very thoroughly in that area, there are reactions to negative countertransference that sometimes surface only after termination and may appear in self-analysis or which have been 'forgotten' by both analyst and analysand over the course of years of analysis. Thus certain blind spots in one's psychoanalyst tend to become adjusted to, taken for granted, or by collusion ignored; this forms the negative side of an unresolved ambivalence towards one's psychoanalyst even in a successful psychoanalysis, while the successful psychoanalysis with its various pragmatic

improvements generates the strong positive side of the ambivalence on termination.

Calder's report concentrates on the appearance of certain unacceptable 'negative oedipal wishes' in his self-analysis, and so is cast in the tradition of the Oedipus complex as the nucleus of all neuroses, whereas my material deals with the struggle of the psychoanalytic physician attempting to empathically understand and interpret the archaic demands of many patients on the one hand, and maintain a sense of autonomy and a personal empathic matrix in private life on the other. My decision to follow my psychoanalysis with a methodical self-analysis was consistent with my determination to have a thorough personal training analysis and with my research interests and scientific curiosity that formed a central aspect of my nuclear self from as far back in my life as I can remember; this goes back before

the usual primal scene determinants—which are there also of course—to my earliest identifications, consolidated in adolescence, with idealized family figures and a family tradition. In my case it was not all a shared familial narcissistic fantasy, because there were some genuinely brilliant European intellectual and scientific types in my background available for me to form what Kohut would call an ideals pole of one aspect of myself, and which in a 'twinsip experience' (Kohut 1984) allowed me to develop and maintain a continuous research activity that forms a bridge, or 'unbroken continuum' as Kohut (1977, p. 63) put it, between the ambitions and ideals pole of my nuclear self.

My psychoanalyst was a gifted, intuitive, and empathic clinician, and I was in formal training psychoanalysis for eight years because two of those years were of military service during which

only sporadic sessions could take place; termination was by mutual consent and mutual agreement that the treatment was a success. I did not consciously much experience the post-analytic disappointment phase mentioned by Wheelis (1956) and Ticho (1967), and for a number of years after termination I idealized both my psychoanalysis and my psychoanalyst; it was only after a prolonged period of self-analysis that I was able to develop a more objective and balanced view of both which enabled me to become more independent as a thinker and to evaluate the various competing schools of psychoanalytic thought and the variety of personalities among psychoanalysts in a more mature perspective.

The above material sounds rather intellectual, but this is not true of my self-analysis, which at times was just as dramatic and painful as my personal psychoanalysis. This raises the difficulty

of communicating either a personal psychoanalysis or a self-analysis to an audience without making it sound more intellectual than it is. If it is pursued with an addiction-like intensity or as an obsession I agree with the authors quoted above that self-analysis becomes a defense and yields only relief from anxiety; I did not pursue it that way and I am convinced that my self-analysis was helpful to my personal growth, as I hope to demonstrate.

I will present some material from the last ten years of my self-analysis to illustrate a variety of themes as I struggled with them. I am not convinced that the changes in me are necessarily the result of new insights gathered during this struggle; I believe that even the struggle itself enables one to become on better terms with one's unconscious and to have easier access to it in countertransference difficulties. This is supported

by one of Ticho's respondents who said that 'in his self-analysis he relies heavily on his unconscious as a friendly collaborator' (p. 313). This is going too far, but my unconscious, even though it is not a friendly collaborator, is certainly no longer a terrifying enemy as it often is at the beginning of one's personal psychoanalysis.

As I have written elsewhere (Chessick 1991), our patients are entitled to our continuing struggle with our countertransference, which is the least we can expect of ourselves in a situation where we expect our patients to be involved in a continuing struggle with their own unconscious, resistances, defenses, and so on. As Freud (1900) noted, 'To interpret and report one's dreams requires a high degree of self discipline' (p. 485).

Here is a dream from ten years ago introduced in my self-analysis diary as 'dream from the deep



unconscious':

I'm on the psychiatry ward. I'm a physician but I'm in bed. I'm telling the nurses that the other doctors on the ward don't care about the patients, they just want them out of there. An attractive head nurse comes over and sits seductively on my bed. She says she thought I was like the others too, that I was just clinging to my mother who was also a patient on the ward. The scene then shifted and naval officers (I wore a naval uniform in military service) are changing shifts; there are tears and a sad parting and now a new and harsher group of officers come on duty.

My associations began with the narcissistic disappointment of playing bridge poorly the night before and ran to wondering about a mixture of 'sickness' and health in me, a wish to start over, clinging to mother and feeling the loss of my father who died a couple of years ago. My associations then ran to a number of people who I was extremely close to in my younger years and who have all died, including my psychoanalyst (who

died many years ago)—the dead are the departing officers and I wish to go back to them again. My reality has become harsher with losses and aging, as typically occurs.

I believe this dream has to do with the search for self-cohesion and is regressively based on the narcissistic wounding that resulted from yesterday's disappointing bridge play—failure in an intellectual challenge. Thus we have the merger longing for idealized figures from the past including the psychoanalyst, as a regressive reaction to a narcissistic wound. It also contains the 'fear' that Kohut (1984) mentioned in the reference quoted above, where I recognize what I learned in my analysis: that I was 'a patient', that my mother also should have been 'a patient'. The attractive head nurse can represent either a manifestation of the oedipal mother if one adheres to traditional theory of conflict and defenses,

which of course was a major theme of my training psychoanalysis, or as a narcissistic yearning for a beautiful woman who wants excitedly to seduce me; the wish for this can be understood as a disintegration product of the disappointed longing for mirroring and soothing empathy from my mother when I was wounded; she could not provide it.

Material of this sort arose and was worked through again and again in my self-analysis and I became increasingly comfortable with it; none of this spilled over into my actual everyday functioning but was confined essentially to the diary reports of my self-analysis in which I was deliberately looking for unresolved neurotic areas. Themes of death and loss came up repeatedly as my children grew into adults, moved away and developed healthy lives of their own. At the time of my psychoanalysis, thirty-five years ago, this all

looked as if it were in the far future and received little attention, just as Freud (1937) predicted.

As I struggled with these losses over the years I began to re-evaluate some of my early identification figures. For example, at the end of 1976 I dreamed:

An aunt is there, who was almost as close to me when I was a child as my mother. My psychoanalyst was pushing a legal suit against my father. A trial occurs and my father is acquitted. I am very aggressive and angry, almost acting like an adolescent.

In associations I began to realize that my psychoanalyst, in his eagerness to deal with the defects in my father, had overlooked his major strength: he was an empathic and gentle man who grew up in a slum world both hostile and competitive. Regardless of the fact that this may have represented a reaction-formation in his character, it became clear that my psychoanalyst

had a certain countertransference contempt for him, as manifest in certain epithets I began to remember that he used to describe my father. There resurfaced in my self- analysis the little noticed positive features of my father which had been vital in the formation of my nuclear self but ignored in the psychoanalysis.

In defense of my psychoanalyst, this took place before Kohut introduced the psychology of the self; mine was a traditional psychoanalysis based on uncovering the competitive rivalry with my father for the seduction of my mother. Thus the important pregenital contributions to my nuclear self or ego functions of tension-regulation from my father were ignored; I believe that in my psychoanalysis my psychoanalyst sometimes intuitively performed this function, but the need for it was never analyzed.

Notice from this example that my continuing self-analysis was extremely useful for catharsis; there are many entries in which I was able to express openly a variety of sexual and aggressive desires that would be appropriate to talk about only in one's psychoanalysis. Thus self-analysis formed a valuable avenue for the ventilation of emotions and wishes; in contrast to a very stable existence characterized by psychoanalytic work and the successful raising of a large family, my diaries are stormy, dramatic, restless, and complaining. Like a formal psychoanalysis they also steadied my judgment in the real world; for example when inevitable narcissistic wounds took place, the rage and regressive reactions were expressed and analyzed in the diaries. For me then, the diaries became a holding transference figure, the transitional object, the 'container' (Bion 1967), taking the place of the lost analyst-father.

They served the 'holding' function of the formal psychoanalysis that Ticho notes is lost in a self-analysis. This is an advantage of methodical self-analysis over the practice of reactive self-analysis to countertransference crises. Perhaps an important factor in the choice of methodical self-analysis is the value it has for those who have experienced repeated losses and disappointments throughout their lives.

My diary is filled with reactions to literary references; for example in 1977 I carefully re-read Saul Bellow's *Herzog* (1964). I learned from this how depressives cannot surrender their childhood and how Herzog as a reaction to narcissistic wounding preoccupies himself with his own past: 'To haunt the past like this—to love the dead!' (p. 177). But as Bellow, from a background somewhat similar to mine, portrays how Herzog researches the past, he ultimately stresses the value of the

imagination in rising above it. I appreciated Bellow's exquisite sensitivity to other suffering humans; this was contributory to my growing interest in the problems of empathy in psychoanalytic work.

During this time I was under extreme pressure because I was completing my thesis on Freud for my PhD in philosophy. I was totally immersed once again in the study of Freud and fascinated by Freud's personality; this was another idealization figure that re-emerged for me out of my adolescence, for I first read Freud as an adolescent in college and, like so many students, found that it opened a new path to understanding myself, others, and the culture in which I live. Thus a major theme of my self-analysis was a searching for lost idealization figures *pari passu* with the re-evaluation and more realistic appraisal of the strengths and weaknesses of my psychoanalyst



and my parents. Kohut (1984) warns of the constricting danger to psychoanalytic creativity of the shift of the unanalyzed idealizing transference to Freud after a training psychoanalysis, but in my case it was the re-establishing of a 'compensatory structure' (p. 166) from adolescence that allowed a better resolution of my psychoanalysis. He adds, 'it is my impression that the most productive and creative lives are lived by those who, despite high degrees of traumatization in childhood, are able to acquire new structures by finding new routes toward inner completeness' (p. 44).

Many of my creative ideas for new papers and books arose out of the free associations in my self-analysis; here the production of idealized creative products functioned in self-cohesion as described by Kohut (1984, p. 205, for details see Chessick 1985a). The actual work of shaping these ideas into finished papers and books took place

separately from my self-analysis and of course was largely an intellectual endeavor. The impressions received during worldwide travel were recorded in the self-analysis as they worked themselves into free associations in response to the various new environments; self-analysis of these responses had a similar broadening effect to the self-analysis of my responses to various artistic creations. For example, after a visit to Vienna and Freud's apartments I noted in my diary a quote from Fichte (1870):

The kind of philosophy one adopts depends upon the sort of man one is; for a philosophical system is not a lifeless piece of furniture that one might take or discard but it is animated by the soul of the man who has it. (paraphrased from p. 16)

The most dramatic response to new psychoanalytic knowledge occurred when I began, slowly and carefully with much self-searching and

testing in the consulting room, to study Kohut in the 1970s; as during my first encounter with Freud a new vista of understanding seemed open to me in which aspects of my clinical work, myself, my psychoanalysis, and my psychoanalyst suddenly became clear. As in Kohut's (1979) case of Mr. Z. (see discussion in Chessick 1985a), I began to look at the data of my psychoanalysis in a new way, stressing not so much the oedipal ramifications, but the narcissistic aspects of the intersubjective field between myself and my psychoanalyst.

I became enabled to see how occasionally—as is inevitable in every long psychoanalysis—my psychoanalyst used me as a selfobject and how at the time I was unable to recognize this, both of us attributing my anger to an oedipal transference. This is consistent with Kohut's description of the late phase of the first analysis of Mr. Z., where he

felt it necessary to 'hammer home' oedipal interpretations to fit the theory. My psychoanalyst did not do this, but there were certain aspects of his personality that were out of empathic attunement with me and a function of his countertransference, even though on the whole he was an unusually good intuitive analyst. The point is that these episodes of my response to empathic failure were never analyzed, so I never had a chance to study my response to reactions to the sense of loss of an archaic selfobject; all this had to surface in my subsequent self-analysis.

I dreamed in late 1977:

I was at a movie watching a lion shot. I had bad seats and it was hard to see. There were young does there being led around tied together with a rope and it was first summer and then winter. A policeman was on a horse training it.

My associations led to the death of my

psychoanalyst, of a fellow psychiatrist who was shot, and of an idealized uncle who had died recently. The does represented my children, who were growing up as my life moved from summer toward wintry old age, and my wish to control them as a regressive reaction to these various losses. The horse and rider metaphor was directly from Kohut (1971, p. 187) and I believe represented the working through and gradual transformation of previous archaic narcissistic configurations, with the consequence of 'ego dominance'. Either narcissistic rage at these losses or murderous wishes towards the oedipal father-analyst could lurk behind this material, or both.

In 1978 while continuing in full-time private practice I finished my philosophy examinations and my PhD thesis finally passed the committee. During that time my mother developed what appeared to be a myocardial infarction (it was not)

and I had a nightmare:

Someone had broken into our basement and  
was coming up the stairs. It was very spooky.  
I had seen a raging patient.

My associations were to the heavy load of raging  
borderline patients that I was carrying and I  
believe this dream manifested an overburdened  
self at the time; my own aggression at my  
troublesome angry mother also threatens to  
surface in the dream. To be angry at my sick  
patients and mother is not entirely compatible  
with my ego ideal.

So at this stage, in attempting to recover from  
an overburdened situation, I created my own  
idealized selfobjects out of studying figures in the  
philosophical and psychoanalytic literature. This  
for me was a resurgence of a development from  
adolescence where in college such figures as Plato  
and Aristotle also provided this function for me.

Thus in self-analysis I discovered that even my return to philosophy and the achieving of a PhD represented a search for the lost idealization figures of the past. Plato during the time of my adolescent turmoil held out for me the possibility of an ordered stable eternal world; in addition his dramatic illustrations of civilized urbane dialogue were a powerful soothing counterpoint to the stormy clamor of my adolescent desires. I returned to this during periods of extreme stress in my self-analysis. This surfaced repeatedly in my reaction to contemporary philosophical works such as the last writings of Hannah Arendt (1978), who postulated the self as a friend with whom to carry on a dialogue. In Kohut's (1984) terms, I have been 'sustained by feeling uplifted by ideals' (p. 203), and for me culture has functioned 'as a selfobject' (p. 203).

From the self-analysis of my reactions to

teaching my first philosophy course I recognized a narcissistic aspect of the personality of my psychoanalyst: he saw too many patients and lived an isolated life in the consulting room, not concerning himself with meetings, writing, teaching, or activities on behalf of social causes. This recognition propelled me towards an identity in which empathy with the unfortunate became a major factor in my personality; I believe this represented a stage of emotional growth and maturation that was post-analytic and fostered by self-analysis. It represents a further transformation of narcissism beginning with the early identification with my empathic father, to my psychoanalyst who was 'holding' an office full of private patients, to an idealized concern for society as a whole. Notice that here the self-analysis produced transformations rather than new insights; problems resurfaced and were



reanalyzed in a new way. Their working through resulted in creativity, better ego function, and a stronger sense of an autonomous identity. I regard this as good clinical evidence that self-analysis can have a therapeutic effect similar to a formal psychoanalysis and that the patient in a self-analysis can create his or her own transference figures as necessary and analyze the transference.

There were plenty of negative transference figures also, for example one of my publishers who endlessly frustrated me. The fact that he also was a psychoanalyst (although he resigned from the American Psychoanalytic Association) made him a handy target for the negative transference. I believe such targets always arise in every person's life and it was my self-analysis of the negative transference that enabled me to retain a relationship with this publisher and to work with him in spite of both of our limitations. This is not

dissimilar to the very common situation in psychoanalysis where the psychoanalytic process enables individuals to maintain a relationship with their employer, their spouse, and so forth, by, fostering perspective through analyzing what is being projected, what is transference, and what is the reality of the situation.

The most important function of my self-analysis, however, was in the continuing analysis of countertransference. This usually showed itself in my dreams, and I found the self-analysis of dreams most valuable, in contrast to Calder (1980). Sometimes my countertransference appeared in the dreams of patients depicting me in a certain fashion which I then reanalyzed in my self-analysis, and sometimes in dreams of my own involving patients. When something is unresolved I seem to dream that I am watching a movie or a play but I don't have a good seat and I can't see it

clearly. For example in 1980, while I was working on a paper on the music of Wagner, I dreamed:

I was at the Bayreuth Festival but the seats were not very good because in front of us was a small child and his large father; they were talking and disturbing the music. I lose interest in the performance and instead am enjoying being kissed and cuddled by a baby across the aisle; it is a lovely baby but the mother is nervous that it might catch something from me.

My associations began with striving to understand my intense emotional reaction to the magnificent music of that great narcissist, Richard Wagner. They ran to my endless rage at copy editors who wound my narcissism by rigidly altering my manuscripts. Soothing comes from the wish for a grandchild and, at a deeper level, I return to be disappointed by my hypochondriacal mother, and then, in the chain of associations, appeared a wish for the love of one of my young women patients

who stood in my self-analysis for one of my daughters. This enabled me to recognize that out of countertransference I was pressing this patient to describe manifestations of her beginning erotic and idealizing transference and producing a counterproductive effect.

There were two results of this self-analysis. First, I changed my technique with the patient with salutary results in her treatment; second, I suddenly remembered that in the dream, sitting in the back of the movie theater behind me, was a man in black to whom I associated my psychoanalyst. To the dream image of my dead psychoanalyst I associated the question of whether my watching the movie represented a re-experiencing of the primal scene and my oedipal strivings, or the longing to fuse, with latent homosexual overtones, with a successful narcissist like Wagner in order to restore narcissistic

equilibrium. Here the silent man in black was a figure to whom I could attribute either interpretation; since I was in the middle of repeated narcissistic woundings at the hands of copy editors who were working over the galleys of one of my books, I chose the latter. This was reinforced by my association to another narcissistic creation, the 'Black Monk' of Chekhov's great short story, who reassures the protagonist of his greatness but leads him to psychosis and death.

My choice raises a critical problem in self-analysis; how is one to validate interpretations? This is not an insurmountable problem because, as one reviews years of self-analysis in written notes, certain themes emerge over and over again until they attain an unshakeable conviction. This is similar to the process of formal psychoanalysis and lends a sense of central focus to the self-

analysis that, like a formal psychoanalysis, is hard to describe without experiencing it. The sense of change and conviction after a correct interpretation remains in both forms of analysis a central pivot for the validation of interpretations. Inexact interpretations tend to reveal themselves by the subsequent appearance, for example, of certain typical material that indicates an unresolved issue—for example in my case the repetitive dream (with primal scene implications) of being unable to see something clearly which is being enacted before me—or in transient psychosomatic symptoms, insomnia, malaise, preoccupation, and so forth just as may occur in a formal psychoanalysis.

Additional validation for the material of self-analysis is presented by patients' dreams depicting the psychotherapist. For example, over the period of forty years of clinical experience I

have learned that when a patient dreams of me as Richard Nixon—to whom I hope I have only a superficial resemblance—some need of mine is propelling me to use the patient as a selfobject in that situation. Such dreams tend to appear, for example, when I am financially pressed and preoccupied about when the patient will pay my bill, especially if it is a manifestation of countertransference. The depiction by patients of neurotic aspects of the therapist in their dreams and associative material, when it fits the revelations that emerge in self-analysis, in my opinion serves as additional validation that these revelations are neither defensive nor inexact.

As one becomes familiar with one's unconscious and neurotic propensities, the appearance of these depictions in patient material form an invaluable signal that countertransference enactment is either taking place or in danger of

taking place, and in my experience makes a major contribution to the smooth and empathically tuned conduct of an intensive psychotherapy. This is especially true in the treatment of borderline patients who become extremely disruptive as a response to countertransference and thereby, if their treatment is to be successful, require a major focus on the many countertransference manifestations they inevitably provoke.

Finally, here is the dream from my self-analysis that occurred the night before I began this report, and which illustrates how many themes can be woven into a dream and analyzed by self-analysis:

My patient, Mrs. P., is sneering at certain scabs on my head. She is trying to decide whether or not to buy an apartment which needs decorating. The apartment is very large and has huge store-front windows through which you can see everything.

In the second scene I am back at the



University of Chicago and I have a very nice schedule with plenty of leisure to think.

My associations ran to the reaction I will receive on presenting this self-analysis report. Will the self-revelations in it be sneered at and used by the *ad hominem* tradition to condemn me? This led to my guilt over a minor countertransference enactment with Mrs. P., which was precipitated by her need to continually sneeringly devalue me over years of treatment. Mrs. P. is a borderline personality who unerringly finds every flaw in my character and technique, and uses them to distance herself continuously from me in spite of my best efforts to maintain empathic attunement with her. The reason for this is her own fear of self-dissolution if she allows herself to become aware of her intense merger yearnings. She is constantly threatening to leave therapy and devaluing the process, with special emphasis on my innumerable blemishes or 'scabs'. In spite of

this she has made remarkable progress in her outside life and has come more or less regularly to several years of treatment, albeit with continual complaints about it. The store-front window represents her analytic treatment, which at this point is not going very well as I suffer repeated exposure to her narcissistic wounding and her continual threats to quit. This led to a minor countertransference enactment when I pressed her to admit that the therapy was of some value, which merely led to her sneering depreciation and her casually skipping of a couple of sessions.

My return in the dream to intellectual college days represents a wish to escape from the anticipated narcissistic wounding which threatens to occur (a) if I present a paper on self-analysis using my own material as clinical data and (b) if, as I will have to do, I will agree with her complaint of my empathic failure in the enactment described.

My countertransference behavior here, as Gunther (1976) explained it, was an attempt to resolve the threat to my narcissistic equilibrium. Countertransference enactment, said Gunther, is already the result of a narcissistic wound in the analyst's professional self-expectation. In the realm of the analyst's unanalyzed narcissism there are dangers to the core stability and self-esteem regulation of the analyst's cohesive adult self due to the archaic demands of the patient for perfection and, in the case of presenting this chapter, the demands of the ego ideal and the clamor of the grandiose self for mirroring acclaim. In Gunther's view countertransference enactment restores equilibrium and constitutes a defense against narcissistic wounding. I believe this is vividly illustrated in the dream sequence.

In an alternative traditional interpretation of the dream, a disguised oedipal wish towards this

patient as a harsh maternal figure could be embedded. Thus the mother sneers at the little genital displayed in the front of the little boy. The dream represents a compromise because the mother does not yet reject the genital and choose the father's, but is still trying to decide whether to buy it. The boy escapes to phallic narcissistic intellectual achievement, which would then represent a regression from the forbidden oedipal wish and the threatened disappointment; a case of this nature with a traditional oedipal interpretation has been presented in the literature by Reich (1960).

I do not believe that a self-analysis can decide whether the self psychological approach to this material is more valid than the traditional psychoanalytic approach, or even, as some have claimed (see Chessick 1985a) is a defense against it, but it is clear from my presentation that I feel

that the general tenor of the material of my self-analysis is sometimes best explained by the use of Kohut's concepts. This proves nothing. What I have attempted to do is only offer an idea of the vast richness of self-analytic material as it is collected over many years of time and restudied and reanalyzed.

## Summary

In this chapter I first reviewed the scanty publications on the subject of self-analysis. Although it was recommended by Freud as early as 1910 for every analyst, self-analysis turns out to have many pitfalls and to be quite a complicated and controversial procedure. There is no agreement on the proper technique of self-analysis in the literature, nor is there any discussion of the determinants of the particular choice of technique of self-analysis that is employed, or even of the

reasons why some analysts do not engage in it at all.

Using clinical data gathered from written material of many years of self-analysis following the termination of a successful training psychoanalysis, I have attempted to elucidate some of the problems posed by this procedure. These problems are in some ways similar to formal psychoanalysis but in some ways contingent on the fact that it is a basically different technique. It is a solitary occupation and therefore suffers from the dangers of disintegration into autism, narcissism, and obsessional rumination. There is no living presence of an analyst to serve either as a transference figure or to make interpretations and stimulate the production of material. The identification with the analyst's analyzing function is far from simple in self-analysis because of the complex nature of the

various internalizations of the analyst that take place over years of a formal training analysis. Thus Ticho (1967) is correct when she claimed that self-analysis is a skill that the analysand has to acquire by himself or herself.

An important phase of the beginning of self-analysis involves the working through of the separation from the psychoanalyst and the re-evaluation of the analyst and the analytic process. This results in a heightened sense of independence and autonomy, increased cohesion of the self, and maturation—which is manifested by greater autonomous ego functioning, a more mature sense of identity, and continued transformations of narcissism. These highly valuable goals, on the basis of the data I have presented, can be approached through the process of self-analysis.

Above all this stands the most important goal

of self-analysis, the understanding of one's countertransference reactions. This is especially important in the treatment of seriously disturbed patients who become disruptive, and thus get labeled borderline, often as a response to unconscious countertransference manifestations from the analyst which are experienced in the selfobject transference as failures in empathy. For the psychoanalytic therapist therefore, it seems mandatory that some process of self-analysis be continued throughout one's professional life; I have tried to illustrate the enormous personal and professional values that result as a reward for taking the time and trouble to pursue self-analysis.

Because of the ever-present danger of defenses and resistances in self-analysis already recognized by Freud (1935), it is not possible to resolve the issue of whether self-analysis can reveal genuinely new insights or consists primarily of re-working



unfinished material from one's training psychoanalysis. It also seems evident that theoretical issues such as choices between self-psychological interpretations and traditional oedipal interpretations as applied to psychoanalytic data cannot be resolved by self-analysis; one's employment of various theoretical orientations is so multiply determined that it cannot be separated convincingly from defenses and compromise formations. Only the gradual accumulation of clinical experience by psychoanalysts can resolve these theoretical disputes.

Even the intrapersonal struggle involved in an on-going self-analysis has numerous advantages for the therapist and the patient. It keeps a sharp focus on the intersubjective field of the treatment and prevents the all-too-human tendency to slide into stereotyped rituals and hackneyed

interpretations. In addition, for the therapist it enhances creative activity and provides a valuable tool to aid in dealing with the painful vicissitudes of life, both anticipated and unanticipated, as they occur in the ensuing years after one's formal training psychoanalysis.

On the other hand, let us remember the report of Jacobs (1986), quoting a colleague in a case conference:

By mistake I ended one session three minutes early ... and I became aware then of how intensely frustrated this patient was making me. In fact, I was in a fury. She reminded me of the step-sister I could never get along with. She is the same kind of controlling, manipulative woman. After I realized my error, I did a piece of self-analysis which has helped me avoid a repetition of this problem. Now ... I usually begin sessions a couple of minutes late, (p. 291)

### Note

Originally published in the *Psychoanalytic Review* 77: 311-40, 1990. Reprinted by permission.

## Epilogue: Archaic Sadism

The heart within them screamed  
for all-out war.

(Aeschylus, *Agamemnon*)

Whenever I tire of the jargon and trivia that fills our current psychoanalytic literature, and when I am starting to feel burned out about our discipline (notice I did not say 'our science' because I think our discipline is, as Ricoeur (1970) put it, a unique combination of science and hermeneutics), I return to Freud. Reading Freud is like taking a breath of fresh air; one cannot help but marvel at the clarity and penetration of his thought, with the exception of his occasional offensive remarks about women and his short-sightedness about art and religion (see Chessick 1999b). Freud (1930) deals with the problem of

archaic sadism in civilization, especially in his philosophical masterpiece, 'The Malaise Inherent in Civilization', often misleadingly mistranslated as 'Civilization and Its Discontents'. Here he tells us '*Homo homini lupus*'—there is a powerful instinctual aggressiveness in humans: our neighbors attempt to exploit our capacity for work without compensation, to use us sexually without our consent, to seize our possessions, to humiliate us, to cause us pain, to torture us, and to kill us. He asks, 'Who, in the face of all his experience of life and of history, will have the courage to dispute this assertion?' (p. 111).

This 'primary mutual hostility of human beings' (p. 112), as Freud puts it—and this was written even before World War II and the Holocaust and Hiroshima—perpetually threatens civilized society with disintegration. Furthermore, Freud continues, 'But even when it emerges

without any sexual purpose, in the blindest fury of destructiveness, we cannot fail to recognize that the satisfaction of the instinct is accompanied by an extraordinarily high degree of narcissistic enjoyment' (p. 121), and this 'inclination to aggression is an original, self-abusing instinctual disposition in man, and ... it constitutes the greatest impediment to civilization' (p. 122). What Freud calls 'the fateful question for the human species' (p. 145) is whether our cultural development will be able to master the disturbance of communal life by the human instinct of aggression and self-destruction. Shortly after that, World War II broke out, in which 60 million humans lost their lives.

H. S. Sullivan (1953) introduced the important clinical concept of 'malevolent transformation', which occurs in the juvenile era when the child, after many disappointments in his or her need for

tenderness, develops a 'basic malevolent attitude, the attitude that one really lives among enemies' (p. 214). This of course creates a vicious circle, in which people with a malevolent stance usually generate more malevolent treatment from those around them. Of course his concept is only a modern version of the great saying of Heraclitus: character is demon for man. So here already we have the alternative to Freud's postulation of an aggressive instinct; for Sullivan, 'matters paranoid and paranoiac' (p. 344) are generated by a failure in the interpersonal relations of childhood. Sullivan considers the malevolent transformation to be 'the greatest disaster that happens in the childhood phase of personality development' (p. 216), and surely he is correct.

All this, of course, represents an ancient, probably unresolvable dispute, for example between the two main followers of Confucius in

the fourth and third century BCE. To Mencius, human nature is originally good, and the way to achieve perfection is to nourish the mind and fully develop one's nature. His philosophical opponent Hsün-tsu insisted that human nature is evil and needs to be disciplined through ceremonies, music, religious rites, and law. Human nature at birth, he said, consists of instinctual drives that are selfish, anarchic, and antisocial. Society must exert a civilizing influence upon the individual, gradually training and molding him or her into a disciplined conscious human being.

How and why does a person begin to view others as objects rather than, as Kant (1785) urged us to do, as humans with precious autonomous moral selves? Novick and Novick (1996) argue that sadomasochism is an integral part of all pathology. They view it as secondary to a sense of magical omnipotence, which in turn

takes place as the consequence of the experiences of a helpless traumatized child. For such unfortunate individuals, they claim, 'the currency of existence becomes pain' (p. 142). The pain of helplessness becomes transformed into an affect associated with control, and our society encourages these hostile control fantasies and the idea that it is masculine to be sadistic and feminine to be masochistic. So narcissistic issues become involved in the infliction and reception of pain, but these authors concentrate on all this as pathology, not the general human condition. For example, Palestinian suicide bombers are reported by the *New York Times* (March 18, 1996) as 'young, bitter, and out of luck', unmarried, childless, and unemployed, and suffering from 'long-standing personal frustration. Some have reportedly had trouble finding a bride; others have been shamed by friends for fearing to throw



stones at Israeli jeeps.' With one stroke suicide bombers achieve the status of movie stars among their compatriots!

Here is one example. You are brought up from childhood in a culture where there is total poverty, a medieval set of surroundings with not even a decent toilet, repression of your racial or religious group, all the adults around you filled with hatred of those whom they are convinced are the oppressors, riots, *intifadas*, lack of proper schooling, nothing to do, no hope, and observing your older brothers brutalized, beaten, seriously injured, and incarcerated by the police or occupying soldiers. Immersed in that milieu will you not begin to view the world as consisting of 'we' and 'they', in which the 'they' are no longer thought of as human but rather as monsters who should be destroyed? Remember 'zap the Jap', a slogan from World War II? Did this not lead to the

bombing of Hiroshima? In turn did not the Japanese view us as 'barbarians' who deserved no quarter even as prisoners? Are you not then ready for a 'holy war' even if it costs you your life?

This must be distinguished from another setting such as *The Story of O*, in which a woman is treated as an object from the beginning and subjected to one form of sadism after another. Why is this kind of story such a bestseller? Why do torturers often have orgasms and ejaculations while torturing their victims? Here again the victim is an 'object', but of sexual sadism, a perversion. I maintain that this sadism, sexual or otherwise, is present in us all; war is a socially accepted form of discharging it, as is the horrible so-called 'ethnic cleansing' that we witness today in various countries such as Yugoslavia, Cambodia, and Indonesia. The Holocaust was of course the supreme example of mass sadism, in which the

scientific and industrial establishment of a putatively advanced country all cooperated with the collection of SS sadistic perverts to find the most efficient way of killing people. Here we have what Heidegger (1954), remarkably a Nazi himself, demonstrated to be the result of our contemporary stance toward the world which he called 'enframing', a stance in which humans are viewed as 'objects' to be manipulated, stored in places, and destroyed if undesirable, perhaps like so many railroad cars that constitute the 'rolling stock' of a railroad corporation.

The psychoanalytic question is whether all these forms of sadism (torture, brutality, violence and terrorism) can be attributed to failures in parenting, as Fairbairn or Kohut would, have it, or to a built-in aggressive instinct, as Hartmann and Hsün-tsu would have it, or to the fundamental splitting between the chaotic self and the ego, as

Lacan would have it, or to a death instinct, as Freud and Melanie Klein would have it.

Homer's *Iliad* is considered the foundation stone of the literature of classical Greece, from which, it is generally agreed, our entire western scientific and technological culture developed. The Greeks considered the *Iliad* their bible-like masterpiece of theology, cultural values, and psychology, and students were expected to memorize it in its entirety. Written in about 900 BCE, it begins like this:

μῆνιν ἄειδε θεὰ Πηληϊάδεω Ἀχιλῆος  
οὐλομένην, ἣ μυρὶ Ἀχαιοῖς ἄλγε' ἔθηκε,  
πολλὰς δ' ἰφθίμους ψυχὰς Ἄϊδι προΐαψεν  
ἡρώων, αὐτοὺς δὲ ἐλώρια τεῦχε κύνεσσιν  
σοίωνοίσι τε πᾶσι, Διὸς δ' ἐτελείετο βουλή,

The first word of the *Iliad* means 'rage', and in Greek usage the first word of the sentence is the word that is meant to be the most emphasized. In

my rough translation the complete opening sentence tells us 'Of the rage sing, oh muse, of Achilles, son of Peleus, which brought pain and death to the Achaians, sending many heroic souls to Hades and leaving the bodies to the feasting of dogs and birds; and the will of Zeus was fulfilled.' Is it really so far from the description in the *Iliad* of the ordinary mass of the Achaians gleefully destroying the Trojans to that of the ordinary mass of the Germans gladly participating in the torture and killing of Jews as described by Goldhagen (1996)? Do these situations not simply liberate something inherent in the psyche of every person, and are there not countless other examples of such slaughters, lynchings, and pogroms throughout history, in which the ordinary average law-abiding citizen cooperated and joined in without protest?

The basic axiom is that everyone contains in

their personality a powerful drive toward hatred and total destructiveness (Hartmann et al. 1949). We must face squarely the fact that the aim of the aggressive drives is 'total destruction of objects, animate or inanimate, and that all attempts to be satisfied with less, with battle with or domination of the object, or with its disappearance imply restrictions of the original aims' (p. 18). The aims of aggression are modified by a simultaneous cathexis of the object with libido, by displacement of the aggression to other objects—'the problem of man in search of a target'—by restriction of the aims of aggressive drives, and by sublimation of aggressive energy, for example in the building of civilization.

This demoniacal aspect of humanity can be approached in at least five ways: (1) evolution and ethology, (2) group psychology, (3) psychoanalysis, (4) rational, conscious psychology,

and (5) existentialism. All the approaches have a valid contribution to make.

The evolutionary and ethological viewpoint states that the evolution of man's mind has not kept pace with the development of his technological capacity. The most important protagonist of this viewpoint is Konrad Lorenz, but there are many others. Lorenz (1966) sees intraspecies aggression as species-preserving in evolution, assuring balanced distribution of animals of the same species over the available environment, selection of the strongest by fights between rivals, and defense of the young. Thus, because it has species-preserving functions, intraspecies aggression has not been eliminated even in species requiring close social aggregation for survival. In order to permit social aggregation in the face of intraspecies aggression, certain inhibitor mechanisms obviously have to evolve,

such as ritual and symbolic aggression and submission behavior.

In those species capable of vicious destruction, such as the wolf, these inhibitory rituals and symbolic gestures—which literally stop murder at the last minute—are reliable and well developed; while in man, who in his natural state is not so endowed with murderous ability, such inhibitors to intraspecies aggression did not have to evolve. Man resembles not the wolf but the rat, for rats, exceptionally among carnivores, do sometimes kill other rats. The paradox, of course, is that man has now become capable of instant, vicious destruction thanks to science, and he lacks the automatic inhibitor mechanisms to stop spontaneously carrying out such destruction. So we have the definite possibility that man is actually one of evolution's mistakes.



It is clear from group psychology as studied by Freud (1921) that groups tend always and naturally to behave toward each other as children or primitive savages; there is a collective lowering of intellectual ability of the group just by virtue of its being a group. This *barbarizing tendency*, as I shall call it (Freud calls it a regressive tendency), is inherent in the psychological nature of all groups, and it calls out continuously for a particular type of leader.

Freud raises the question of how to procure for the group precisely those features that were characteristic of the individual and that are extinguished in him by the formation of the group. That is, how can we develop a *civilizing tendency* for the group and work against its inherent barbarizing tendency? Unfortunately, Freud has little to say on this problem. I will discuss it below.

Turning to the contemporary psychoanalytic approach, an important step forward has come from our psychoanalytic understanding of the psychoses, especially paranoia. Just how murderous and brutal our aggressive proclivities are has been elucidated by clinical study and historical research. Paranoia is now understood as an attempt to deal with murderous rage by attributing the rage and hatred to others rather than oneself. A far deeper understanding of paranoid projection and its roots has been developed, but this is not of as great a significance to the present discussion as is the recognition that the proclivity to brutality and paranoid projection is constantly present in the unconscious of everyone.

A text edited by Bychowski (1969) contains psychoanalytic thinking on the 'evil in man'. Bychowski (as well as the present author) has

been interested in borderline types of patients for many years, and concerned with what are technically known as 'malevolent introjects'. The point is that not all hatred and aggression developed during infancy in man is instinctual. Some also arises from infantile deprivation and some from the introjection of the hatred of the parents. Cycles of projection and reintroduction of rage and hatred may lead to a progressive self-perpetuating build-up of aggression.

The most recent contribution is from the work of Kohut (1971, 1977) emphasizing the phenomenon of narcissistic rage—the rage generated when narcissistic injuries, or blows to one's pride or self-esteem have been suffered. Kohut believes the original drive in infancy is assertive in nature, and changes to hate and aggression only as a consequence of phase-inappropriate disappointments in empathic

soothing. He prefers to focus on narcissistic aspirations and the subsequent fury at the thwarting of hidden grandiosity which produces a deadly, implacable rage that consumes the individual with a need for revenge, regardless of the personal cost.

Hope for reducing humanity's proclivity to hatred and paranoia comes not only from medical treatment but from the amelioration of social conditions. This leads to the fourth or rational, conscious approach to the problem, perhaps first emphasized by Marx and Engels. For example, Bertrand Russell said that because of the haunting fear of ruin that most people have, anything that increases the general security is likely to diminish cruelty. Obviously general security cannot be achieved by making one portion of mankind secure at the expense of another, since this only increases the dominant group's fear that the

oppressed will rebel.

Our time has seen the 'encounter with nothingness'. This has been brought about by the decline of religion and belief in God and in an eternal moral order, the collectivization of the state backed by a brutal police and based on the creation of either artificial consumer needs or dogmatic mythologies with subsequent depersonalization of the individual, and the advance of science, which has destroyed all sense of certitude in nature and reduced our conception of our role in the universe to an irrelevant minimum. Nietzsche has been recognized as the original spokesman for the dangerous consequences of the first of these factors, Jaspers for the second, and Kierkegaard for the third.

Kierkegaard (1954) claimed that all humans are in existential despair, and that three categories

of solution have been found: the religious, the unsuccessful, and the demoniacal. It is the 'demoniacal' solution to existential anxiety—our anxiety over the irrelevance and brevity of our lives—that is of interest in the present context. Psychoanalysts today speak of a counterphobic reaction as a common type of defense against anxiety. In such a defense the person wildly plunges into the extreme situation that he or she fears the most. The counterphobic solution to existential anxiety is the desire to place oneself in a situation where death is likely and to 'cheat death', hence soldiers sing cheerful songs as they happily and proudly march off to war.

There is a great need for cooperative exploration by psychologists, psychiatrists, and philosophers into the notion of a demoniacal and counterphobic solution to existential anxiety. Such solutions may represent an important factor in the

propensity of middle-aged men to make wars for young men to fight and the enthusiasm of masses of people to follow them into war. Hitler's Germany certainly demonstrated how the demoniacal and the religious solutions could be cleverly combined to produce a pagan religion based on the making of war.

My own view is that all humans are born with a primal biological archaic aggressive-destructive drive, the gratification of which gives satisfaction just like the sexual drive. So I am in the Freudian camp, although I leave open the question of the origin of these drives, regarding Freud's (1930) 'battle of the giants', the so-called life and death instincts, as a kind of metaphysical question, a 'mythology', as he (1933) himself calls it (see Chessick 1992c). I agree with Freud (1930) that civilization is charged with helping the individual sublimate such a drive or neutralize it, as

Hartmann would say, or harness it for constructive assertiveness, and for what Spengler (1962) called Faustian projects such as building skyscrapers or sending people to explore Mars, and so on.

But what sort of civilization is most suited to this task? Every child develops a set of basic fantasies, both sexual and aggressive, and sometimes combined, based on an intermixture of misunderstood experiences such as the inevitable birth of siblings, disappointments in expectations of parental empathy, traumatic or overstimulating events such as the primal scene, and so forth. These are fired and fueled by and intermixed with the innate sexual and aggressive drives, producing highly charged core fantasies that often have little relationship to the child's actual parents or experiences, assuming an average expectable environment. But they have psychic reality for the



child, they determine perception and behavior all through adult life, and they may be extremely sadistic and require projection as a defense against being overwhelmed by them. The secret of why sadistic torture and sexual abuse and rape generate so much intense pleasure and why terrorism, violence, and brutality generate so much narcissistic elation lies in the acting out of these archaic fantasies by pathological individuals for whom the childhood environment was neither average nor expectable. Again we are into matters both paranoid and paranoiac. Granting that the helpless child must project his or her sadism onto the world which subsequently increases the need for protection against the imagined evil coming from the outside—witness this problem as expressed in innumerable fairy tales—how can we develop a civilization that minimizes the reality validation of this projection and helps channel

fundamental human aggression into sublimation and neutralization?

Is our contemporary international civilization, the so-called 'advanced' countries of the world such as the United States, Europe, and Japan, which are at the forefront of technology, most suited to this task? Or do these wonderful examples of advanced capitalism have built into them just the opposite effect? As psychoanalysts we cannot at this time resolve the issue of the origin of sadism, but we can exert an influence on our culture by calling attention to those aspects of it which foster and abet sadism and confirm the malevolent transformation and the projection of intrapsychic hatred and destructiveness onto the 'Other', justifying drive-by shootings, wars, racial and religious prejudice, and so forth.

Thurow (1995) tells us about companies

downsizing, people suddenly losing jobs that they have held for years, families breaking up as companies merge:

No country without a revolution or a military defeat and subsequent occupation has ever experienced such a sharp shift in the distribution of earnings as America has in the last generation. ... Never before have a majority of American workers suffered real wage reduction while the per capita domestic product was advanced. ... With the death of Communism, and, later, market socialism as economic alternatives, capitalists have been able to employ more ruthless approaches to getting maximum profits without worrying about political pressure. Survival of the fittest capitalism is on the march.

This has made the one-earner middle-class family extinct in America. Thurow, professor of economics at the Massachusetts Institute of Technology, continues:

Children exist but no one takes care of them.

Parents are spending 40 percent less time with their children than they did 30 years ago. ... The traditional family is being destroyed not by misguided social welfare programs coming from Washington but by a modern economic system that is not congruent with 'family values.'

This is an example of Heidegger's 'enframing' described above, in which corporate science and technology have run wild, viewing humans as objects for manipulation, control, storage, and destruction, the current attitude that generates the process of 'downsizing', a euphemism for increasing profits by dumping workers and hiring cheaper and more docile labor in the so-called Third World. Some very serious social thinkers have addressed this problem, almost in a panic over the inaction about it manifested by the governments of the countries involved and over the increasing signs of international corporations achieving political power and dominance in the

world. Lasch, for example, gave us a book, *The Culture of Narcissism* (1978) that, although it contained some misconceptions about psychoanalytic theories of narcissism, was an important beginning. He then went on (1995) to more and more 'far-out' populist solutions to the problem.

More traditional liberal thinkers like Taylor (1995, Tully 1995) hope to combat the inherent relativism of the postmodern philosophic position by substituting a philosophy-based civic liberalism in which citizens play an active role in politics and the enrichment of the common culture. He does not explain how to motivate somebody whose options are to spend the rest of his or her life in a low-paying, menial job (if he or she has a job at all), or to make a lot of money dealing in drugs, or to put him- or herself into a kind of self-induced hypnotic trance and become a follower of a

fanatical terrorist sect that justifies brutality, violence, and torture on religious grounds, to instead become politically active and work for the enrichment of a culture that he or she views as evil and deserving of destruction. It is for this reason — lack of hope and lack of education — that the underprivileged in our society tend not even to vote at all, even though it is clearly very much against their best interest not to make their numbers count.

What is to be done? Barber, in a work entitled *Jihad vs. McWorld* (1995) describes how democracy and the nation-state are threatened from two directions. These are McWorld, the rampant consumer-oriented economy that leads to the destruction of family values and the value of the individual mentioned above, and Jihad, a return to fanatical religious or ethnic communities provoked by the imperialistic reach of the

American dominated global consumer economy. America's most distinctive product, he says, is pop culture promulgated by media monopolies. A professor of political science at Rutgers University, Barber punctures the fantasy that unregulated markets equal democracy and well-being. Instead of that, multinational corporations engender enormous impoverishment and homelessness with a thin layer of wealth over it, as well as relentless dumbing down and civic passivity. People turn from all this with disgust and a feeling of spiritual void. The same McWorld media monopolies offer them an alternative: archaic warriorism in the service of some cause held fanatically to be 'good' and so justifying the violence and destruction it entails, a violence sold to the public as being manly and macho—hence 'the exterminator'. So we end with terrorism and violence, the Jihad, defined by Barber as bloody

holy war that is a rabid response to colonialism, capitalism, and modernity. Clearly both McWorld and Jihad are cancerous to democracy and civic participation, and to any sense that the individual human has an indigenous autonomous self that deserves preservation for its own sake, as Kant proclaimed.

So who is going to own and control the vast wealth produced by the workers in the multinational corporations and produced under the worst possible conditions with the lowest possible pay? Those who control the wealth determine what the political system will be, and so far in our political system the wealthy have become more wealthy and everybody else has become poorer. The Soviet system was no better; in spite of doing lip service to the ideals of Marxism and socialism, it was just another dictatorship and shifted the wealthy ruling class



from the aristocracy to the Politburo (Silber 1994; Torrance 1995). Marx (1844) in his writings was ambiguous over whether or not there was something essential about the human or whether the human self was completely formed by the society. The notion that people will be essentially different if one changes the economic system was viewed with skepticism already by Freud (1930) and certainly has proven to be wrong by the Soviet experience, as Manuel (1995) has documented.

First, psychoanalysts must ask what kind of culture will most effectively promote civilized behavior and help to sublimate the tremendous sadistic proclivities I believe are inherent in humans. We must be aware of what Marx (1867) called fetishism, a concept emphasized by the neo-Marxist Lukács (1982: Chessick 1992b). We are more specifically interested in the fetishism of ideas, in which ideas are thought to have a quality

inherent within them as ideas *per se*, giving them the power to determine action. The assumption is that ideas determine history, which, Marx says, is an assumption that is 'upside down'. An example of: this comes from an international review of our own profession. It remains for psychoanalysts to ask why different psychoanalytic orientations tend to prevail in different countries, and to what extent even this demonstrates the effect of history and culture on the formation of one's self—in this case, one's psychoanalytic self.

We also need to ask whether the new versions of psychoanalytic theory that have emerged since the time of Freud, including those that view aggression as a secondary phenomenon to failure of parenting in one way or another, are not actually the product of their material socio-historical conditions. Such theories would then be what Marx called 'ideologies', defined as truth

claims based on misrecognition of reality arising from social causes (Torrance 1995), in this instance the need to maintain the illusion in capitalist society that humans are inherently rational and decent and will make rational choices about what they consume and how they treat each other. So the 'invisible hand' of Adam Smith will prevail all over the world and give us international capitalism and liberal democracies; history has now come to a happy end (Fukuyama 1992).

Concluding with Heidegger, let us not forget his contention that each epoch or culture has a basic conception of Being that determines to the inhabitants of that epoch what it is that fundamentally matters (Heidegger 1962, 1968; see also Chessick 1992b; Young 1995). Ours leads to the devastation of the earth as the condition for a promised guaranteed high standard of living and happiness for all, the darkening of the world, the

flight of the gods, and the transformation of humans into a mass with a hatred and suspicion of everything free and creative, and into devotees of speed and time-saving devices who paradoxically seem to have no time. Even the arts are just for pleasant diversion and entertainment, not for the expression of truths about ourselves and our world (Wood 1995).

We are cut off from nature; humankind today is like a fish out of water. From all this arises our treatment of each other as objects to be used in the service of the unprincipled ruthless entrepreneurial thirst for ever-increasing wealth and power. These 'CEOs', as they are called today in our multinational corporations, have now even transformed medical care into a profitable business for themselves, without any more concern about human needs or the human body than they have for our natural resources, the relics

and even burial grounds of our ancestors, the places and properties that constitute our heritage, or the magnificent products of centuries of the arts—all are treated indifferently as inanimate manufactured objects for the purpose of manipulation and control. An endless progression of human victims who have opposed this trend has taken place, the latest being the writer Ken Saro-Wiwa, executed in Nigeria in 1995, an environmental advocate who was essentially destroyed by the hoodlums that today tyrannize Nigeria with the connivance of the Shell Oil multinational corporation (Lewis 1996).

This epilogue is dedicated to the memory of Ms Bettina Pruckmayr, an attorney and the director and instigator of the World Federalist International Criminal Court Project. She was killed at the age of 26 in the course of a mugging for \$20 in Washington, DC on December 16, 1995.

She was stabbed thirty-six times with a hunting knife by a parole violator who had spent seventeen years in prison for a previous murder. As psychoanalysts we need to study how the spiritual void and the frustration of human aspirations this entails releases violence, torture, terrorism, and brutality—sadism in its most archaic forms—as a plague upon the modern world, and we need to try to combat the false consciousness foisted on the public by the corporate-controlled media that pictures consumerism as the solution to all human problems and the possession of material goods as the way to happiness.

### *Note*

Originally published in the *Journal of the American Academy of Psychoanalysis* 24: 605-18, 1996. Reprinted by permission.

## References

- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders IV*. Washington, DC: American Psychiatric Association.
- Abend, S. (1989) Countertransference and psychoanalytic technique. *Psychoanalytic Quarterly* 58: 374-95.
- \_\_\_\_\_(1990) Unconscious fantasies, structural theory, and compromise formation. *Journal of the American Psychoanalytic Association* 38: 61-74.
- Abend, S., Porder, M., and Willick, M. (1983) *Borderline Patients: Psychoanalytic Perspectives*. New York: International Universities Press.
- Abraham, K. (1919) A particular form of neurotic resistance to the psychoanalytic method. In *Selected Papers on Psycho-Analysis*. New York: Basic Books, 1954: 303-10.
- Adler, G. (1980) Transference, real relationship and alliance. *International Journal of Psycho-Analysis* 61: 547-58.

\_\_\_\_(1985) *Borderline Psychopathology and its Treatment*. Northvale, NJ: Jason Aronson.

Adams. P. (1968) Childhood ulcerative colitis: outlines of psychotherapy. *Psychosomatics* 9: 75-80.

Adorno, T. (1973) *Negative Dialectics*. London: Routledge.

Akiskal, H. (1981) Subaffective disorders: systhymic, cyclothymic and bipolar II disorders in the 'borderline' realm. *Psychiatric Clinics of North America* 4: 25-46.

Alexander, F. (1950) *Psychosomatic Medicine: Its Principles and Applications*. New York: W.W. Norton.

\_\_\_\_(1964) Social significance of psychoanalysis and psychotherapy. *Archives of General Psychiatry* 11: 235-44.

Alexander, F., French, T., and Pollock, G. (1968) *Psychosomatic Specificity*. Chicago: University of Chicago Press.

Alt, P. and Alspach, R. (1977) *Variorum Edition of the Poems of W. B. Yeats*. New York: Macmillan.

Arendt, H. (1978) *The Life of the Mind. Vol. 1: Thinking*. New York: Harcourt, Brace, Jovanovich.



'Aristides' (1994) *American Scholar* 62: 496.

Arlow, J. (1969a) Unconscious fantasy and disturbances of conscious experience. *Psychoanalytic Quarterly* 38: 1-27.

\_\_\_\_(1969b) Fantasy, memory, and reality testing. *Psychoanalytic Quarterly* 38: 28-51.

\_\_\_\_(1980) Object concept and object choice. *Psychoanalytic Quarterly* 49: 109-33.

\_\_\_\_(1985) The concept of psychic reality and related problems, *Journal of the American Psychoanalytic Association* 33: 521-35.

Aronowitz, R. and Spiro, H. (1988) The rise and fall of the psychosomatic hypothesis in ulcerative colitis, *Journal of Clinical Gastroenterology* 10: 298-305.

Balint, M. (1953) *Primary Love and Psychoanalytic Technique*. New York: Liveright.

Barber, B. (1995) *Jihad vs. McWorld*. New York: Random House.

Barthes, R. (1968) *Writing Degree Zero*, trans. A. Lavers and C. Smith. New York: Hill and Wang.

Beiser, H. (1984) An example of self-analysis, *Journal of the American Psychoanalytic Association* 32: 3-

12.

Bellow, S. (1964) *Herzog*. Greenwich, CT: Fawcett.

Bernstein, A. and Warner, G. (1981) *An Introduction to Contemporary Psychoanalysis*. Northvale, NJ: Jason Aronson.

Bertens, H. (1993) The postmodern Weltanschauung and its relation to modernism: an introductory survey. In J. Natoli and L. Hutcheon (eds) *A Postmodern Reader*. Albany, NY: State University of New York Press.

Binswanger, L. (1963) *Being-in-the-World*, trans. J. Needleman. New York: Basic Books.

Bion, W. (1963) Elements of psychoanalysis. In *Seven Servants*. New York: Basic Books, 1977.

\_\_\_\_\_(1967) *Second Thoughts: Selected Papers on Psychoanalysis*. London: Heinemann.

Bird, H., Martin, P., and Schuham, A. (1983) The marriage of the 'collapsible' man of prominence. *American Journal of Psychiatry* 140: 290-5.

Blatt, S. and Behrends, R. (1987) Internalization, separation-individuation, and the nature of therapeutic action. *International Journal of Psycho-Analysis* 68: 279-97.

Bloom, A. (1987) *The Closing of the American Mind*.  
New York: Simon and Schuster.

Blum, H. (1973) The concept of erotized transference.  
*Journal of the American Psychoanalytic Association* 21: 61-76.

\_\_\_\_\_(1986) Countertransference and the theory of  
technique: discussion. *Journal of the American  
Psychoanalytic Association* 34: 309-28.

\_\_\_\_\_(1994) Discussion on the erotic transference:  
contemporary perspective. *Psychoanalytic  
Inquiry* 14: 622-35.

\_\_\_\_\_(1998) An analytic inquiry into intersubjectivity:  
subjective objectivity. *Journal of Clinical  
Psychoanalysis* 7: 189-208.

Boehlich, W. ed. (1990) *The Letters of Sigmund Freud  
to Eduard Silberstein 1871-81*. Cambridge, MA:  
Harvard University Press.

Boesky, D. (1988) Comments on the structural theory  
of technique. *International Journal of Psycho-  
Analysis* 69: 303-16.

\_\_\_\_\_(1990) The psychoanalytic process and its  
components. *Psychoanalytic Quarterly* 59: 550-  
84.

Bollas, C. (1987) *The Shadow of the Object: Psychoanalysis of the Unknown Thought*. New York: Columbia University Press.

\_\_\_\_\_(1994) Aspects of the psychoanalytic transference. *Psychoanalytic Inquiry* 14: 572-90.

Bonfils, S. and M'Uzan, M. (1974) Irritable bowel syndrome vs. ulcerative colitis: psychofunctional disturbance vs. psychosomatic disease? *Journal of Psychosomatic Research* 18: 291-6.

Boss, M. (1963) *Psychoanalysis and Daseinanalyse*, trans. L. Lefebvre. New York: Basic Books.

Bouhoutsos, J. (1985) Therapist-client sexual involvement: a challenge for mental health professionals and educators. *American Journal of Orthopsychiatry* 55: 777-82.

Brenner, C. (1982) *The Mind in Conflict*. New York: International Universities Press.

Bretall, R. (ed.) (1947) *A Kierkegaard Anthology*. Princeton, NJ: Princeton University Press.

Brodey, W. (1965) On the dynamics of narcissism: I. Externalization and early ego development. *Psychoanalytic Study of the Child* 20: 165-93.

Bruch, H. (1973) *Eating Disorders*. New York: Basic

Books.

\_\_\_\_(1974) *Learning Psychotherapy*. Cambridge, MA: Harvard University Press.

\_\_\_\_(1975) Anorexia nervosa. Chapter 32 in S. Arieti (ed.) *American Handbook of Psychiatry*, vol. 4, 2nd edn. New York: Basic Books.

\_\_\_\_(1979) *The Golden Cage*. New York: Vintage Books.

\_\_\_\_(1982) Anorexia nervosa: an affective disorder. *American Journal of General Psychiatry* 139: 1531-8.

Buckley, P. (1989) Fifty years after Freud: Dora, the Rat-Man and the Wolf-Man. *American Journal of Psychiatry* 146: 1394-403.

Bychowski, G. (1969) *The Evil in Man*. New York: Grune and Stratton.

Calder, K. (1980) An analyst's self-analysis. *Journal of the American Psychoanalytic Association* 28: 5-20.

Cantwell, D., Sturzenberger, S., Bourroughs, J., Salkin, B., and Breen, J. (1977) Anorexia nervosa: an affective disorder. *Archives of General Psychiatry* 34: 1087-96.

Casper, R. (1982) Treatment principles in anorexia

nervosa. *Adolescent Psychiatry* 10: 431-54.

\_\_\_\_\_(1983) On the emergence of bulimia nervosa as a syndrome. *International Journal of Eating Disorders* 2: 3-16.

Casper, R. and Davis, J. (1977) On the course of anorexia nervosa. *American Journal of Psychiatry* 134: 974-9.

Casper, R., Elke, E., Halmi, K., Goldberg, S., and Davis, J. (1980) Bulimia. *Archives General of Psychiatry* 37: 1030-5.

Casper, R., Offer, D., and Ostrov, J. (1981) The self-image of adolescents with acute anorexia nervosa. *Journal of Pediatrics* 98: 656-61.

Castelnuovo-Tedesco, P. (1991) *Dynamic Psychiatry: Explorations in Psychotherapy, Psychoanalysis, and Psychosomatic Medicine*. Madison, CT: International Universities Press.

Chessick, R. (1960) The 'pharmacogenic orgasm' in the drug addict. *Archives of General Psychiatry* 3: 545-56.

\_\_\_\_\_(1971) The use of the couch in the psychotherapy of borderline patients. *Archives of Psychiatry* 25: 306-13.

- \_\_\_\_(1972) Externalization and existential anguish. *Archives of General Psychiatry* 27: 764-70.
- \_\_\_\_(1977a) *Intensive Psychotherapy of the Borderline Patient*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1977b) *Great Ideas in Psychotherapy*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1980) Some philosophical assumptions of intensive psychotherapy. *American Journal of Psychotherapy* 34: 496-509.
- \_\_\_\_(1981) What is intensive psychotherapy? *American Journal of Psychotherapy* 35: 489-501.
- \_\_\_\_(1982a) Psychoanalytic listening. *Contemporary Psychoanalysis* 18: 613-34.
- \_\_\_\_(1982b) Intensive psychotherapy of a borderline patient. *Archives of General Psychiatry* 39: 413-22.
- \_\_\_\_(1983a) *A Brief Introduction to the Genius of Nietzsche*. Washington, DC: University Press of America.
- \_\_\_\_(1983b) *Why Psychotherapists Fail*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1983c) Problems in the intensive psychotherapy of the borderline patient. *Dynamic Psychotherapy* 1: 20-36.

- \_\_\_\_(1983d) *How Psychotherapy Heals*. New York: Science House.
- \_\_\_\_(1984) A failure in psychoanalytic psychotherapy of a schizophrenic patient. *Dynamic Psychotherapy* 2: 136-56.
- \_\_\_\_(1985a) *Psychology of the Self and the Treatment of Narcissism*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1985b) Clinical notes toward the understanding and intensive psychotherapy of adult eating disorders. *Annual of Psychoanalysis* 13: 301-22.
- \_\_\_\_(1986) Transference and countertransference revisited. *Dynamic Psychotherapy* 4: 14-33.
- \_\_\_\_(1987) Coronary artery disease as a narcissistic psychosomatic disorder. *Dynamic Psychotherapy* 5: 16-29, 130-43.
- \_\_\_\_(1990) Self-analysis: a fool for a patient? *Psychoanalytic Review* 7:311-40.
- \_\_\_\_(1991) *The Technique and Practice of Intensive Psychotherapy*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1992a) *The Technique and Practice of Listening in Intensive Psychotherapy*. Northvale, NJ: Jason Aronson.
- \_\_\_\_(1992b) *What Constitutes the Patient in*



*Psychotherapy*. Northvale, NJ: Jason Aronson.

\_\_\_\_(1992c) The death instinct revisited, *Journal of the American Academy of Psychoanalysis* 20: 3-28.

\_\_\_\_(1993a) *A Dictionary for Psychotherapists: Dynamic Concepts in Psychotherapy*. Northvale, NJ: Jason Aronson.

\_\_\_\_(1993b) The outpatient psychotherapy of the borderline patient. *American Journal of Psychotherapy* 47: 206-27.

\_\_\_\_(1994) What brings about change in psychoanalytic treatment. *Psychoanalytic Review* 81: 279-300.

\_\_\_\_(1995) Postmodern psychoanalysis or a wild analysis? *Journal of the American Academy of Psychoanalysis* 23: 47-62.

\_\_\_\_(1996a) *Dialogue Concerning Contemporary Psychodynamic Therapy*. Northvale, NJ: Jason Aronson.

\_\_\_\_(1996b) The application of postmodern thought to the clinical practice of psychoanalytic psychotherapy, *Journal of the American Academy of Psychoanalysis* 24: 385-407.

\_\_\_\_(1996c) Archaic sadism. *Journal of the American*

*Academy of Psychoanalysis* 24: 605-18.

\_\_\_\_\_(1996d) Nothingness, meaninglessness, chaos, and the 'black hole' revisited, *Journal of the American Academy of Psychoanalysis* 23: 581-601.

\_\_\_\_\_(1997a) Psychoanalytic treatment of the borderline patient, *Journal of the American Academy of Psychoanalysis* 28: 91-105.

\_\_\_\_\_(1997b) Book review of *Boundaries and Boundary Violations in Psychoanalysis*, by G. Gabbard and E. Lester. *American Journal of Psychiatry* 154: 573-6.

\_\_\_\_\_(1998) Empathy in psychoanalysis and psychotherapy. *Journal of the American Academy of Psychoanalysis* 26: 487-502.

\_\_\_\_\_(1999a) Contingency and the unformulated counter-transference, *Journal of the American Academy of Psychoanalysis* 27: 135-49.

\_\_\_\_\_(1999b) *Emotional Illness and Creativity*. Madison, CT: International Universities Press.

Claman, J. (1987) Mirror hunger in the psychodynamics of sexually abusing therapists. *American Journal of Psychoanalysis* 47: 35-40.

Coen, S. (1981) Sexualization as a predominant mode of defense, *Journal of the American Psychoanalytic*

*Association* 29: 893-920.

Coen, S. (Reporter) (1994) Report of a panel on impasses in psychoanalysis. *Journal of the American Psychoanalytic Association* 42: 1225-35.

Cooper, A. (1989) Concepts of therapeutic effectiveness in psychoanalysis: a historical review. *Psychoanalytic Inquiry* 9: 4-25.

Dally, P. (1969) *Anorexia Nervosa*. New York: Grune and Stratton.

Dahlberg, C. (1970) Sexual contact between patient and therapist. *Contemporary Psychoanalysis* 6: 107-24.

Davies, P. ed. (1989) *The New Physics*. New York: Cambridge University Press.

DeLuca, J. (1970) The ulcerative colitis personality. *Nursing Clinics of North America* 5: 23-34.

Derrida, J. (1979) *Spurs: Nietzsche's Styles*, trans. B Harlow. Chicago: University of Chicago Press.

Deutsch, L. (1980) Psychosomatic medicine from a psychoanalytic viewpoint. *Journal of the American Psychoanalytic Association* 28: 653-702.

Dostoevsky, F (1991) *The Brothers Karamazov*, trans. R Pevear and L Volokhonsky. New York: Vintage

Books.

Dowling, S. (1990) Fantasy formation: a child analyst's perspective. *Journal of the American Psychoanalytic Association* 38: 93-112.

Drossman, D. (1986) The psychosocial aspects of inflammatory bowel disease. *Stress Medicine* 2: 119-28.

\_\_\_\_\_(1988) Psychosocial aspects of ulcerative colitis and Crohn's disease. In J. Kirsner and R. Shorter (eds) *Inflammatory Bowel Disease*, 3rd edn. Philadelphia, PA: Lea and Febiger.

Druss, R. (1976) Indecision and /or reality. *International Review of Psycho- Analysis* 3: 203-6.

Eissler, K. (1953) The effect of the structure of the ego in psychoanalytic technique. *Journal of the American Psychoanalytic Association* 1: 104-43.

Emerson, C. (1997) *The First Hundred Years of Mikhail Bakhtin*. Princeton, NJ: Princeton University Press.

Engel, G. (1954) Studies of ulcerative colitis II. The nature of the somatic processes and the adequacy of psychosomatic hypotheses. *American Journal of Medicine* 16: 416-33.

- \_\_\_\_(1955) Studies of ulcerative colitis III. The nature of the psychologic processes. *American Journal of Medicine* 19: 231-56.
- \_\_\_\_(1956) Studies of ulcerative colitis IV. The significance of headaches. *Psychosomatic Medicine* 18: 334-46.
- \_\_\_\_(1958) Studies of ulcerative colitis V. Psychological aspects and their implications for treatment. *American Journal of Digestive Diseases* 3: 315-37.
- \_\_\_\_(1961) Biologic and psychologic features of the ulcerative colitis patient. *Gastroenterology* 40: 313-22.
- \_\_\_\_(1975) Ten years of self-analysis—reaction to the death of a twin. *International Journal of Psycho-Analysis* 56: 23-40.
- Esman, A. (1989) Psychoanalysis and general psychiatry: Obsessive compulsive disorder as paradigm. *Journal of the American Psychoanalytic Association* 37: 319-36.
- Etchegoyen, R. (1991) *The Fundamentals of Psychoanalytic Technique*, trans. P. Pitchon. New York: Karnac Books.
- \_\_\_\_(1999) *The Fundamentals of Psychoanalytic*

*Technique*, revised edn. London: Karnac Books.

Faltus, F. (1984) The positive effect of alprazolam in the treatment of three patients with borderline personality disorder. *American Journal of Psychiatry* 141: 802-3.

Federn, P. (1947) Principles of psychotherapy in latent schizophrenia. *American Journal of Psychotherapy* 2: 129-47.

Feinsilver, D. (1999) Counteridentification, comprehensive countertransference, and therapeutic action: toward resolving the intrapsychic- interactional dichotomy. *Psychoanalytic Quarterly* 68: 264-301.

Feldman, F., Cantor, D., Soli, S., and Bachrach, W. (1967) Psychiatric study of a consecutive series of 34 patients with ulcerative colitis. *British Medical Journal* 3: 14-17.

Fenichel, O. (1945) *The Psychoanalytic Theory of the Neuroses*. New York: Norton.

Fichte, J. (1870) *Science of Knowledge*, trans. P. Heath and J. Lachs. New York: Appleton-Century-Crofts, 1970.

Finell, J. and McDougall, J. (1985) A case presentation —the treatment of a man with a severe

obsessional disorder. *Current Issues in Psychoanalytic Practice* 2: 3-24.

Fleming, J. (1971) Freud's concept of self-analysis. In I. Marcus (ed.) *Currents in Psychoanalysis*. New York: International Universities Press.

Folch, T. (1992) Communication and containing in child analysis: towards terminability. In E. Spillius (ed.) *Melanie Klein Today: Developments in Theory and Practice. Vol. 2: Mainly Practice*. London: Routledge and the Institute of Psycho-Analysis.

Fonagy, P. (1999) Memory and therapeutic action. *International Journal of Psycho-Analysis* 80: 215-23.

Freud, A. (1965) *Normality and Pathology in Childhood*. New York: International Universities Press.

Freud, S. (1900) *The Interpretation of Dreams. Standard Edition* 4-5.

\_\_\_\_\_(1905) Fragment of an analysis of a case of hysteria. *Standard Edition* 7: 7-122.

\_\_\_\_\_(1908) Civilized sexual morality and modern nervous illness. *Standard Edition* 9: 177-204.

- \_\_\_\_(1909) Notes upon a case of obsessional neurosis. *Standard Edition* 10: 153-318.
- \_\_\_\_(1910) A special type of choice of object made by men (contributions to the psychology of love, I). *Standard Edition* 11: 163-76.
- \_\_\_\_(1911) Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides) *Standard Edition* 12: 3-84.
- \_\_\_\_(1912a) The dynamics of transference. *Standard Edition* 12: 97-108.
- \_\_\_\_(1912b) On the universal tendency to debasement in the sphere of love (contributions to the psychology of love, II). *Standard Edition* 11: 177-90.
- \_\_\_\_(1913) The disposition to obsessional neurosis. *Standard Edition* 12: 311-26.
- \_\_\_\_(1914) On narcissism: introduction. *Standard Edition* 14: 67-104.
- \_\_\_\_(1916) Introductory lectures on psycho-analysis. *Standard Edition* 16: 243-463.
- \_\_\_\_(1917) Mourning and melancholia. *Standard Edition* 14: 239-58.
- \_\_\_\_(1918) From the history of an infantile neurosis.



*Standard Edition* 17: 3-122.

\_\_\_\_(1921) Group psychology and the analysis of the ego. *Standard Edition* 28: 67-144.

\_\_\_\_(1923) The ego and the id. *Standard Edition* 19: 3-68.

\_\_\_\_(1926a) The question of lay analysis. *Standard Edition* 20: 179-258.

\_\_\_\_(1926b) Inhibitions, symptoms, and anxiety. *Standard Edition* 20: 77-178.

\_\_\_\_(1926c) Prefatory note to a paper by E. Pickworth Farrow. *Standard Edition* 20: 280.

\_\_\_\_(1930) Civilization and its discontents. *Standard Edition* 21: 64-148.

\_\_\_\_(1933) New introductory lectures on psychoanalysis. *Standard Edition* 22: 3-184.

\_\_\_\_(1935) The subtleties of a faulty action. *Standard Edition* 22: 233-8.

\_\_\_\_(1937) Analysis terminable and interminable. *Standard Edition* 23: 211-54.

Freyberger, H. (1970) The doctor/patient relationship in ulcerative colitis. *Psychotherapy and Psychosomatics* 18: 80-9.

- Freyberger, H., Künsebeck, H., Lempa, W., Wellmann, W., and Avenarius, H. (1985) Psychotherapeutic interventions in alexithymic patients: with special regard to ulcerative colitis and Crohn patients. *Psychotherapy and Psychosomatics* 44: 72-81.
- Friedman, L. (1976) Cognitive and therapeutic tasks of a theory of mind. *International Review of Psycho-Analysis* 3: 259-75.
- Fromm-Reichmann, F. (1950) *Principles of Intensive Psychotherapy*. Chicago: University of Chicago Press.
- Frosch, J. (1977) The relation between acting out and disorders of impulse control. *Psychiatry* 40: 295-314.
- Fukuyama, F. (1992) *The End of History and the Last Man*. New York: Free Press.
- Gabbard, G. (1989] *Sexual Exploitation in Professional Relationships*. Washington, DC: American Psychiatric Press.
- \_\_\_\_\_(1991) Psychodynamics of sexual boundary violations. *Psychiatric Annals* 21: 651-5.
- \_\_\_\_\_(1994) Psychotherapists who transgress sexual boundaries with patients. *Bulletin of the*

*Menninger Clinic* 58: 124-35.

\_\_\_\_(1995a) Countertransference: the emerging common ground. *International Journal of Psycho-Analysis* 76: 475-85.

\_\_\_\_(1995b) When the patient is a therapist: special challenges in the psychoanalysis of mental health professionals. *Psychoanalytic Review* 82: 709-25.

\_\_\_\_(1995c) The early history of boundary violations in psychoanalysis. *Journal of the American Psychoanalytic Association* 43: 111 5-36.

\_\_\_\_(1996a) *Love and Hate in the Analytic Setting*. Northvale, NJ: Jason Aronson.

\_\_\_\_(1996b) Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy* 50: 311-22.

\_\_\_\_(1997) A reconsideration of objectivity in the analyst. *International Journal of Psycho-Analysis* 78: 15-26.

Gabbard, G. and Lester, E. (1996) *Boundaries and Boundary Violations in Psychoanalysis*. New York: Basic Books.

Gardiner, M. (1971) *The Wolf-Man*. New York: Basic Books.

- Garfinkel, P., Moldofsky, H., and Garner, D. (1980) The heterogeneity of anorexia nervosa. *Archives of General Psychiatry* 37: 1036-40.
- Garner, D., Garfinkel, P., Stancer, H., and Moldofsky, H. (1976) Body image disturbances in anorexia nervosa and obesity. *Psychosomatic Medicine* 38: 327-36.
- Gartrell, N., Herman, J., Olarte, S., Feldstein, M., and Localio, R. (1986) Psychiatrist-patient sexual contact: results of a national survey, I: prevalence. *American Journal of Psychiatry* 143: 1126-31.
- Gedo, J. (1977) Notes on the psychoanalytic management of archaic transferences. *Journal of the American Psychoanalytic Association* 25: 787-803.
- \_\_\_\_\_(1979) *Beyond Interpretation: Toward a Revised Theory for Psychoanalysis*. New York: International Universities Press.
- \_\_\_\_\_(1986) *Conceptual Issues in Psychoanalysis*. Hillsdale, NJ: Analytic Press.
- \_\_\_\_\_(1988) *The Mind in Disorder: Psychoanalytic Models of Pathology*. Hillsdale, NJ: Analytic Press.
- \_\_\_\_\_(1991) *The Biology of Clinical Encounters*:

*Psychoanalysis as a Science of Mind*. Hillsdale, NJ: Analytic Press.

\_\_\_\_\_(1997) *Spleen and Nostalgia: A Life and Work in Psychoanalysis*. Northvale, NJ: Jason Aronson.

Gedo, J. and Gehrie, M. eds (1993) *Impasse and Innovation in Psychoanalysis: Clinical Case Seminars*. Hillsdale, NJ: Analytic Press.

Gedo, J. and Goldberg, A. (1973) *Models of the Mind: A Psychoanalytic Theory*. Chicago: University of Chicago Press.

Gill, M. (1982) *Analysis of Transference*. New York: International Universities Press.

Giovacchini, P. (1967) Frustration and externalization. *Psychoanalytic Quarterly* 36: 571-83.

Glover, E. (1931) The therapeutic effect of inexact interpretation: a contribution to the theory of suggestion. *International Journal of Psycho-Analysis* 12: 397. (Reprinted in E. Glover, *The Technique of Psycho-Analysis*, New York: International Universities Press, 1965.)

\_\_\_\_\_(1937) Symposium on the theory of the therapeutic results of psychoanalysis. *International Journal of Psycho-Analysis* 43: 125-

32.

\_\_\_\_(1956) *On the Early Development of Mind*. New York: International Universities Press.

Gluck, M. (1985) *George Lukács and his Generation: 1900-1918*. Cambridge, MA: Harvard University Press.

Glucksman, M., Rand, L., and Stunkard, A. (1978) Psychodynamics of obesity, *Journal of the American Academy of Psychoanalysis* 6: 103-55.

Goldberg, A. (1995) *The Problem of Perversion: The View from Self Psychology*. New Haven, CT: Yale University Press.

Goldberger, M. (1988) The two-man phenomenon. *Psychoanalytic Quarterly* 57: 229-33.

Goldhagen, D. (1996) *Hitler's Willing Executioners: Ordinary Germans and the Holocaust*. New York: Knopf.

Gray, P. (1973) Psychoanalytic technique and the ego's capacity for viewing intrapsychic activity. *Journal of the American Psychoanalytic Association* 21: 474-94.

Greenberg, J. and Mitchell, S. (1983) *Object Relations in Psychoanalytic Theory*. Cambridge, MA:

Harvard University Press.

Greenson, R. (1965) The working alliance and the transference neurosis. *Psychoanalytic Quarterly* 34: 155-81.

\_\_\_\_(1967) *The Technique and Practice of Psychoanalysis*. New York: International Universities Press.

Grossman, S. (1992) Psychosomatic disorders. Chapter 19 in M. Aronson and M. Scharfman (eds) *Psychotherapy: The Analytic Approach*. Northvale, NJ: Jason Aronson.

Grotstein, J. (1983) Deciphering the schizophrenic experience. *Psychoanalytic Inquiry* 3: 37-70.

\_\_\_\_(1990a) The 'black hole' as the basic psychotic experience: some newer psychoanalytic and neuroscience perspectives on psychosis. *Journal of the American Academy of Psychoanalysis* 18: 29-46.

\_\_\_\_(1990b) Nothingness, meaninglessness, chaos, and the 'black hole' I. *Contemporary Psychoanalysis* 26: 257-90.

\_\_\_\_(1990c) Nothingness, meaninglessness, chaos, and the 'black hole' II: the black hole. *Contemporary Psychoanalysis* 26: 377-407.

- \_\_\_\_(1991) Nothingness, meaninglessness, chaos, and the 'black hole' III: self and interactional regulation and the background presence of primary identification. *Contemporary Psychoanalysis* 27: 1-33.
- Grotstein, J. and Rinsley, D. eds (1994) *Fairbairn and the Origins of Object Relations*. New York: Guilford Press.
- Grünbaum, A. (1984) *The Foundations of Psychoanalysis: A Philosophical Critique*. Berkeley: University of California Press.
- \_\_\_\_(1993) *Validation in the Clinical Theory of Psychoanalysis*. Madison, CT: International Universities Press.
- Gunderson, J. and Elliott, G. (1985) The interface between of personality disorder and affective disorder. *American Journal of Psychiatry* 142: 277-88.
- Gunderson, J. and Phillips, K. (1991) A current view of the interface between borderline personality disorder and depression. *American Journal of Psychiatry* 148: 967-75.
- Gunther, M. (1976) The endangered self: a contribution to the understanding of narcissistic



determinants of counter-transference. *Annual of Psychoanalysis* 4: 201-24.

\_\_\_\_\_(1982) The prototypical archaic transference crisis: critical encounters of the archaic kind. In G. H. Pollock and J. Gedo (eds) *Psychoanalysis: The Vital Issues*. New York: International Universities Press.

Gutheil, T. (1989) Borderline personality disorder, boundary violations, and patient-therapist sex: medicolegal pitfalls. *American Journal of Psychiatry* 146: 597-602.

Halmi, K. (1980) Anorexia nervosa. Chapter 26.5 in H. Kaplan, A. Freedman, and B. Sadock (eds) *Comprehensive Textbook of Psychiatry—III*, vol. 2. Baltimore: Williams and Wilkins.

Hamburger, W. (1951) Emotional aspects of obesity. *Medical Clinics of North America* 35: 483-99.

Hamilton, E. and Cairns, H. eds (1973) *Plato: The Collected Dialogues*. Princeton, NJ: Princeton University Press.

Hanly, C. (1997) Commentary, *Journal of Clinical Psychoanalysis* 6: 485-93.

Hartmann, H., Kris, E., and Lowenstein, B. (1949) Notes on the theory of aggression. *Psychoanalytic*

*Study of the Child* 3/4: 9-36.

Hawking, S. (1993) *Black Holes and Baby Universes and Other Essays*. New York: Bantam Books.

Hegel, G. (1840) *Introduction to the Philosophy of History*, trans. L. Rauch. Indianapolis, IN: Hackett.

Heidegger, M. (1954) *The Question Concerning Technology and Other Essays*, trans. W. Lovitt. New York: Harper and Row.

\_\_\_\_(1962) *Being and Time*, trans. R. Macquarrie and E. Robinson. New York: Harper and Row.

\_\_\_\_(1968) *What Is Called Thinking!*, trans. F. Wieck and J. Gray. New York: Harper and Row.

Heimann, P. (1950) On counter-transference. *International Journal of Psycho- Analysis* 31: 81-4.

Heisenberg, W. (1971) *Physics and Beyond*. New York: Harper and Row.

Heller, A. (1993) Existentialism, alienation, postmodernism: cultural movements as vehicles of change in the patterns of everyday life. In J. Natoli and L. Hutcheon (eds) *A Postmodern Reader*. Albany, New York: State University of New York Press.

Herman, J., Gartrell, N., Olarte, S., Feldstein, M., and

- Localio, R. (1987) Psychiatrist-patient sexual contact: results of a national survey, II: psychiatrist's attitudes. *American Journal of Psychiatry* 144: 164-9.
- Hilgard, E. and Bower, G. H. (1966) *Theories of Learning*, 3rd edn. New York: Appleton-Century-Crofts.
- Himmelfarb, G. (1994) *On Looking into the Abyss*. New York: Knopf.
- Hirsch, I. (1996) Observing-participation, mutual enactment, and the new classical models. *Contemporary Psychoanalysis* 32: 359-83.
- Holinger, P. (1989) A developmental perspective on psychotherapy and psychoanalysis. *American Journal of Psychiatry* 146: 1404-12.
- Holland, N. (1983) Postmodern psychoanalysis. In I. Hassan and S. Hassan (eds) *Innovation/Renovation: New Perspectives on the Humanities*. Madison, WI: University of Wisconsin Press.
- Hollender, M. H., Luborsky, L., and Scaramella, T.J. (1969) Body contact and sexual excitement. *Archives of General Psychiatry* 20: 188-91.
- Hollender, M. H. (1970) The need or wish to be held.

*Archives of General Psychiatry* 22: 445-53.

Holt, R. (1973) On reading Freud. In C. Rothgeb (ed.) *Abstracts of the Standard Edition of the Complete Psychological Works of Sigmund Freud*, pp. 3-79. Northvale, NJ: Jason Aronson.

\_\_\_\_\_(1981) The death and transfiguration of metapsychology. *Journal of the American Psychoanalytic Association* 25: 835-72.

Horney, K. (1942) *Self-Analysis*. New York: Norton.

Hornsby, L. (1970) Ulcerative colitis: a contemporary overview. *Diseases of the Nervous System* 31: 338-43.

Horowitz, M., Gabbard, G., Allen, J., Frieswyk, S., Colson, D., Newson, G., and Coyne, L. (1996) *Borderline Personality Disorder: Tailoring Psychotherapy to the Patient*. Washington, DC: American Psychiatric Press.

Huyssen, A. (1993) Mapping the postmodern. In J. Natoli and L. Hutcheon (eds) *A Postmodern Reader*. Albany, New York: State University of New York Press.

Inderbitziw, L. and Levy, S. (1990) Unconscious fantasy: a reconsideration of the concept, *Journal of the American Psychoanalytic Association* 38:

113-30.

Ingram, D. (1976) Psychoanalytic treatment of the obese person. *American Journal of Psychoanalysis* 36: 227-35.

\_\_\_\_(1994) Poststructuralist interpretation of the psychoanalytic relationship. *Journal of the Academy of Psychoanalysis* 22: 175-93.

Innaurato, A. (1977) *The Transfiguration of Benno Blimpie*. London: T. Q. Publications.

Jacobs, T. (1986) On countertransference enactments, *Journal of the American Psychoanalytic Association* 34: 289-308.

Jacques, E. (1980) The midlife crisis. In S. I. Greenspan and G. H. Pollock (eds) *The Course of Life: Psychoanalytic Contributions Toward Understanding Personality Development, vol. 3, Adulthood and the Aging Process*. Washington, DC: National Institute of Mental Health, 1-24.

Jaspers, K. (1965) *Nietzsche*. Tucson: University of Arizona Press.

Jones, E. (1953) *The Life and Work of Sigmund Freud*. New York: Basic Books.

Jones, W. T. (1969) *A History of Western Philosophy*:

vol. 4. *Kant to Wittgenstein and Sartre*. New York: Harcourt Brace.

Joseph, E. and Widlöcher, D. eds (1983) *The Identity of the Psychoanalyst* New York: International Universities Press.

Kagen, J. (1971) *Change and Continuity in Infancy*. New York: John Wiley and Sons.

Kahn, E. (1963) On crises. *Psychiatric Quarterly* 37: 297-305.

Kakar, S. (1982) Mapping the postmodern. In J. Natoli and L. Hutcheon (eds) *A Postmodern Reader*. Albany, New York: State University of New York Press.

Kane, R. (1993) The ends of metaphysics. *International Philosophical Quarterly* 33: 413-28.

Kant, I. (1781) *Critique of Pure Reason*, trans. by N. Kemp-Smith. New York: St Martin's Press, 1965.

\_\_\_\_\_(1785) Foundations of the metaphysics of morals. In *Critique of Practical Reason and Other Writings in Moral Philosophy*, trans. L. Beck. Chicago: University of Chicago Press, 1949.

\_\_\_\_\_(1790) *Critique of Judgment*, trans. W. Pluhar. Indianapolis: Hackett, 1987.

- Kantrowitz, J. (1999) The role of the preconscious in psychoanalysis. *Journal of the American Psychoanalytic Association* 46: 65-89.
- Kaplan, H., Freedman, A., and Sadock, B. (1980) *Comprehensive Textbook of Psychiatry—III*, vol. 1. Baltimore: Williams and Wilkins.
- Kaplan, H., Sadock, B., and Grebb, J. (1994) *Synopsis of Psychiatry*, 7th edn. Baltimore, MD: Williams and Wilkins.
- Karush, A., Daniels, G., O'Connor, J., and Stern, L. (1968) The response to psychotherapy in chronic ulcerative colitis I: pretreatment factors. *Psychosomatic Medicine* 30: 255-76.
- Karush, A., Daniels, G., O'Connor, J., and Stern, L. (1969) The response to psychotherapy in chronic ulcerative colitis II: factors arising from the therapeutic situation. *Psychosomatic Medicine* 31: 201-26.
- Karush, A., Daniels, G., Flood, C., and O'Connor, f. (1977) *Psychotherapy in Chronic Ulcerative Colitis*. Philadelphia, PA: Saunders.
- Kellner, R. (1975) Psychotherapy in psychosomatic disorders: a survey of controlled studies. *Archives of General Psychiatry* 32: 1021-8.

Kernberg, O. (1975) *Borderline Conditions and Pathological Narcissism*. Northvale, NJ: Jason Aronson.

\_\_\_\_\_(1976) *Object Relations Theory and Clinical Psychoanalysis*. Northvale, NJ: Jason Aronson.

\_\_\_\_\_(1980) *Internal World and External Reality*. Northvale, NJ: Jason Aronson.

\_\_\_\_\_(1987) Projection and projective identification: developmental and clinical aspects, *Journal of the American Psychoanalytic Association* 35: 795-819.

\_\_\_\_\_(1994) Fairbairn's theory and challenge. Chapter 4 in J. Grotstein and D. Rinsley (eds) *Fairbairn and the Origins of Object Relations*. New York: Guilford Press.

\_\_\_\_\_(1995) *Love Relations: Normality and Pathology*. New Haven, CT: Yale University Press.

Kernberg, O., Seltzer, M., Koenigsberg, H., Carr, A., and Applebaum, A. (1989) *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books.

Khorana, S. (1983) A study of psychological factors and psychotherapy in ulcerative colitis II. Factors arising from the therapeutic situation. *Psychosomatic Medicine* 31: 201-26.



Kierkegaard, S. (1946) *The Concept of Dread*. Princeton, NJ: Princeton University Press.

\_\_\_\_\_(1954) *Fear and Trembling and Sickness Unto Death*. Princeton, NJ: Princeton University Press.

Klein, M. (1975a) *Love, Guilt and Reparation and Other Works 1921-1945*. New York: Free Press.

\_\_\_\_\_(1975b) Notes on some schizoid mechanisms. In *Envy and Gratitude and Other Works 1946-1963 by M. Klein*. New York: Dell.

Kohut, H. (1971) *The Analysis of the Self*. Madison, CT: International Universities Press.

\_\_\_\_\_(1977) *Restoration of the Self*. Madison, CT: International Universities Press.

\_\_\_\_\_(1979) The two analyses of Mr. Z. *International Journal of Psycho-Analysis* 60: 3-27.

\_\_\_\_\_(1982) Introspection, empathy, and the semi-circle of mental health. *International Journal of Psycho-Analysis* 63: 395-407.

\_\_\_\_\_(1984) *How Does Analysis Cure!* Chicago: University of Chicago Press.

\_\_\_\_\_(1994) *The Curve of Life: Correspondence of Heinz Kohut 1923-1981*. ed. G. Cocks. Chicago: University of Chicago Press.

Kolb, L. and Brodie, H (1982) *Modern Clinical Psychiatry*. Philadelphia, PA: W.B. Saunders Co.

Kramer, M. (1959) On the continuation of the analytic process after psycho-analysis (a self-observation). *International Journal of Psycho-Analysis* 40: 17-25.

Kristeva, J. (1982) *Powers of Horror: An Essay on Abjection*, trans. L. Roudiez. New York: Columbia University Press.

Krystal, H. (1982) Adolescence and the tendencies to develop substance dependence. *Psychoanalytic Inquiry* 2: 581-618.

Krystal, H. and Raskin, H. (1970) *Drug Dependence: Aspects of Ego Function*. Detroit: Wayne State University Press.

Kuhn, T. (1962) *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Kulish, N. (1988) Precocious ego development and obsessive compulsive neurosis. *Journal of the American Academy of Psychoanalysis* 16: 167-87.

Lacan, J. (1978) *The Four Fundamental Concepts of Psycho-Analysis*, trans. A. Sheridan. New York: Norton.

Laing, R. (1960) *The Divided Self*. New York: Pantheon Books.

Langs, R. (1979) *The Therapeutic Environment*. Northvale, NJ: Jason Aronson.

Lasch, C. (1978) *The Culture of Narcissism*. New York: Norton.

\_\_\_\_ (1995) *The Revolt of the Elites and the Betrayal of Democracy*. New York: Norton.

Lefebvre, P. (1988) The psychoanalysis of a patient with ulcerative colitis: the impact of fantasy, affect, and the intensity of drives on the outcome of treatment. *International Journal of Psycho-Analysis* 69: 43-53.

Leon, G. (1982) Personality and behavioral correlates of obesity. In B. Wolman (ed.) *Psychological Aspects of Obesity*. New York: Van Nostrand and Reinhold.

Lepore, M. (1965) The importance of emotional disturbance in chronic ulcerative colitis. *Journal of the American Medical Association* 191: 24.

Leuba, J. (1949) Introduction a l'etude clinique du narcissisme. *Revue Française Psychoanalyse* 13: 456.

- Lewis, P. (1996) Nigeria's deadly oil war: Shell defends its record. *New York Times* Feb. 13: 1, 4.
- Lewis, W. (1963) Some observations relevant to early defenses and precursors. *International Journal of Psycho-Analysis* 44: 132-42.
- Lindemann, E. (1950) Modifications in the course of ulcerative colitis in relationship to changes in life situations and reaction patterns. *Annual Review of Nervous and Mental Disease Proceedings* 29: 706.
- Linehan, M. (1993) *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.
- Lipton, S. (1977a) The advantages of Freud's technique as shown in his analysis of the Rat Man. *International Journal of Psycho-Analysis* 58: 255-74.
- \_\_\_\_\_(1977b) Clinical observations on resistance to the transference. *International Journal of Psycho-Analysis* 58: 463-72.
- \_\_\_\_\_(1979) An addendum to 'The advantages of Freud's technique as shown in his analysis of the Rat Man'. *International Journal of Psycho-Analysis* 60: 215-16.

\_\_\_\_(1983) A critique of so-called standard psychoanalytic technique. *Contemporary Psychoanalysis* 19: 35-46.

Little, M. (1951) Counter-transference and the patient's response to it. *International Journal of Psycho-Analysis* 32: 32-40.

\_\_\_\_(1957) 'R' — the analyst's total response to his patient's needs. *International Journal of Psycho-Analysis* 38: 240-54.

\_\_\_\_(1990) *Psychotic Anxieties and Containment: A Personal Record of an Analysis with Winnicott*. Northvale, NJ: Jason Aronson.

Loewald, H. (1960) On the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis* 75: 3-20.

\_\_\_\_(1980) On the therapeutic action of psychoanalysis. In *Papers on Psychoanalysis*. New Haven, CT: Yale University Press.

Lorenz, K. (1966) *On Aggression*. New York: Harcourt Brace.

Lowrie, W. (1971) *A Short Life of Kierkegaard*. Princeton, NJ: Princeton University Press.

Lukács, G. (1982) *History and Class Consciousness*:

*Studies in Marxist Dialectics*, trans. R. Livingstone.  
Cambridge, MA: MIT Press.

Lyotard, J. (1984) *The Postmodern Condition: A Report on Knowledge*. Minneapolis, MN: University of Minnesota Press.

McGlashan, T. (1983a) The borderline syndrome II: is it a variant of schizophrenia of affective disorder? *Archives of General Psychiatry* 40: 1319-23.

\_\_\_\_(1983b) Intensive individual psychotherapy of schizophrenia. *Archives of General Psychiatry* 40: 909-20.

MacLean, G. (1976) An approach to the treatment of an adolescent with ulcerative colitis: conjoint therapy of the parents. *Canadian Psychiatric Association Journal* 21: 287-93.

McLaughlin, J. (1987) The play of transference: some reflections on enactment in the psychoanalytic situation, *Journal of the American Psychoanalytic Association* 35: 557-82.

Maguire, J. (1990) Notes on stalemate: a particular negative reaction affecting therapeutic outcome. *Annual of Psychoanalysis* 18: 63-83.

Malcolm, R. (1992) The mirror: a perverse sexual phantasy in a woman seen as a defense against a

psychotic breakdown. In E. Spillius (ed.) *Melanie Klein Today: Developments in Theory and Practice*. New York: Routledge.

Mallinger, A. (1984) The obsessive's myth of control, *Journal of the American Academy of Psychoanalysis* 12: 147-65.

Manuel, F. (1995) *A Requiem for Karl Marx*. Cambridge, MA: Harvard University Press.

Marder, L. (1967) Symposium: psychiatric aspects of ulcerative colitis. *Southern Medical Journal* 60: 1281-8.

Marsh, J., Caputo, J., and Westphal, M. (1992) *Modernity and Its Discontents*. New York: Fordham University Press.

Marx, K. (1844) *Early Writings*, trans. T. Bottomore. New York: McGraw- Hill, 1963.

\_\_\_\_(1867) *Capital*, vol. 1. New York: Vantage, 1977.

Masterson, J. (1981) *The Narcissism and Borderline Disorders: An Integrated Developmental Approach*. New York: Brunner/Mazel.

May, R. (1950) *The Meaning of Anxiety*. New York: Ronald Press.

Meares, R. (1994) A pathology of privacy: towards a

new theoretical approach to obsessive-compulsive disorder. *Contemporary Psychoanalysis* 30: 83-100.

Meissner, W. (1988) *Treatment of Patients in the Borderline Spectrum*. Northvale, NJ: Jason Aronson.

Melville, H. (1850) *Moby Dick*. New York: Norton, 1951.

Menninger, K. (1958) *The Theory of Psychoanalytic Technique*. New York: Basic Books.

Modell, A. (1968) *Object Love and Reality*. New York: International Universities Press.

\_\_\_\_\_(1975) A narcissistic defense against affects and the illusion of self-sufficiency. *International Journal of Psycho-Analysis* 56: 137-46.

\_\_\_\_\_(1976) The holding environment and the therapeutic action of psychoanalysis. *Journal of the American Psychoanalytic Association* 24: 285-308.

\_\_\_\_\_(1978) The nature of psychoanalytic knowledge, *Journal of the American Psychoanalytic Association* 26: 641-58.

Moore, B. and Fine, B. eds (1990) *Psychoanalytic*



*Terms and Concepts*. New Haven, CT: Yale University Press.

Munich, R. (1986) Transitory symptom formation in the analysis of an obsessional character. *Psychoanalytic Study of the Child* 41:515-35.

Murray, C. (1930) Psychogenic factors in the etiology of ulcerative colitis and bloody diarrhea. *American Journal of the Medical Sciences* 180: 239-48.

Murray, J. (1984) Psychological factors in ulcerative colitis, *Journal of General Psychology* 110: 201-21.

Mussen, P. H. et al. (1969) *Child Development and Personality*, 3rd edn. New York: Harper and Row.

Myerson, P. (1960) Awareness and stress: post-psychoanalytic utilization of insight. *International Journal of Psychoanalysis* 41: 147-56.

\_\_\_\_\_(1993) Listening for the effects of psychoanalytic interventions. *Contemporary Psychoanalysis* 29: 397-417.

Nacht, S. (1962) The curative factors in psychoanalysis. *International Journal of Psycho-Analysis* 43: 206-11.

Natoli, J. and Hutcheon, L. eds (1993) *A Postmodern*

*Reader*. Albany, New York: State University of New York Press.

Newman, K. (1988) Countertransference: its role in facilitating the use of the object. *Annual of Psychoanalysis* 16: 251-85.

Nichols, C., Nowlin, J., Bogdonoff, M. (1967) Some psychologic considerations in the medical management of ulcerative colitis. *Southern Medical Journal* 60: 1285-8.

Nietzsche, F. (1968) *Beyond Good and Evil*, trans. W. Kaufmann. New York: Random House.

Norris, C. (1990) *What's Wrong with Postmodernism?* Baltimore, MD: Johns Hopkins University Press.

North, C., Clouse, R., Spitznagel, E., and Alpers, D., (1990) The relation of ulcerative colitis to psychiatric factors: a review of findings and methods. *American Journal of Psychiatry* 147: 974-81.

Novick, J. and Novick, K. (1996) A developmental perspective on omnipotence. *Journal of Clinical Psychoanalysis* 5: 129-73.

Nunberg, H. and Federn, E. eds (1962) *Minutes of the Vienna Psychoanalytic Society*. New York: International Universities Press.

Nunberg, H. and Federn, E. eds (1967) *Minutes of the Vienna Psychoanalytic Society*, vol. 2. New York: International Universities Press.

Nuttall, A. (1983) *A New Mimesis: Shakespeare and the Representation of Reality*. New York: Methuen.

O'Connor, J. (1966) Ulcerative colitis: emotional problems and their management. *Medical Times* 94: 106-12.

\_\_\_\_ (1968) Psychological considerations in ulcerative colitis. *New York State Journal of Medicine* 68: 1055-65.

O'Connor, J., Daniels, G., Flood, C., Karush, A., Moses, L., and Stern, L., (1964) An evaluation of the effectiveness of psychotherapy in the treatment of ulcerative colitis. *Annals of Internal Medicine* 60: 587-602.

Offenkrantz, W. and Tobin, A. (1974) Psychoanalytic psychotherapy. *Archives of General Psychiatry* 30: 593-606.

Ogden, T. (1986) *The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue*. Northvale, NJ: Jason Aronson.

Ornstein, P., and Ornstein, A. (1977) On the continuing evolution of psychoanalytic

psychotherapy: reflections and predictions.  
*Annual of Psychoanalysis* 5: 329-70.

Osman, M. and Tabachnick, N. (1988) Essentials of psychoanalytic cure: a symposium, introduction and survey of some previous views.  
*Psychoanalytic Review* 75: 185-215.

Pao, P. (1979) *Schizophrenic Disorders*. New York: International Universities Press.

Perse, S. (1949) *Anabasis*, trans. T. Eliot. New York: Harcourt Brace Jovanovich.

Person, E. (1983) Women in therapy: therapist gender as a variable. *International Review of Psychoanalysis* 10: 193-204.

Pickworth Farrow, E. (1926) A method of self-analysis. *British Journal of Medical Psychology* 5: 106-18.

Pine, F. (1985) *Developmental Theory and Clinical Process*. New Haven, CT: Yale University Press.

\_\_\_\_\_(1992) From technique to a theory of psychic change. *International Journal of Psycho-Analysis* 73: 251-4.

Podolsky, D. (1991) Inflammatory bowel disease. *New England Journal of Medicine* 325: 928-36, 1008-

15.

Pope, H.( Hudson, J., Jonas, J. and Yurgelun-Todd, D.  
(1983) Bulimia treated with imipramine.  
*American Journal of Psychiatry* 140: 554-8.

Powers, P. (1980) *Obesity: The Regulation of Weight*.  
Baltimore: Williams and Wilkins.

Prosen, H., Martin, R., and Prosen, M. (1972) The  
remembered mother and the fantasized mother:  
a crisis of middle age. *Archives of General  
Psychiatry* 27: 791-4.

Rado, W. (1926) The psychic effects of intoxication.  
*International Journal of Psycho-Analysis* 7: 396-  
413.

Rand, C. (1981) Psychoanalytic treatment of obesity.  
In B. Wolman (ed.) *Psychological Aspects of  
Obesity*. New York: Van Nostrand and Reinhold.

Rand, C. and Stunkard, A. (1983) Obesity and  
psychoanalysis: treatment and four-year follow-  
up. *American Journal of Psychiatry* 140: 1140-4.

Rangell, L. (1989) Action theory within the structural  
view. *International Journal of Psycho-Analysis* 70:  
189-203.

Ray, A. (1986) Janos Starker: maverick genius of the

cello. *Manchester Guardian Weekly* Aug. 31: 13.

Raymond, L. and Rosbrow-Reich, S. (1997) *The Inward Eye: Psychoanalysts Reflect on Their Lives and Work*. Hillsdale, NJ: Analytic Press.

Reich, A. (1960) Pathological forms of self-esteem regulation. *Psychoanalytic Study of the Child* 15: 215-32.

Rey, J. (1990) Schizoid phenomena in the borderline. In E. Spillius (ed.) *Melanie Klein Today: Developments in Theory and Practice Vol. 1: Mainly Theory*. New York: Routledge.

Renik, O. (1993a) Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly* 62: 553-71.

\_\_\_\_\_(1993b) Countertransference enactment in the psychoanalytic process. In M. Horowitz, O. Kernberg, and E. Weinshel (eds) *Psychic Structure and Psychic Change*. Madison, CT: International Universities Press.

\_\_\_\_\_(1996) The perils of neutrality. *Psychoanalytic Quarterly* 65: 495-517.

\_\_\_\_\_(1998) The analyst's subjectivity and the analyst's objectivity. *International Journal of*

*Psycho-Analysis* 79: 487-97.

Rescher, N. (1973) *Conceptual Idealism*. Oxford: Basil Blackwell.

\_\_\_\_\_(1991) Conceptual idealism revisited. *Review of Metaphysics* 44: 495-523.

\_\_\_\_\_(1992) *A System of Pragmatic Idealism, vol. 1: Human Knowledge in Idealistic Perspective*. Princeton, NJ: Princeton University Press.

Rice, E. (1992) Review of *Dynamic Psychiatry* by P. Castelnuovo-Tedesco. In *Psychoanalytic Books* 3: 259-63.

Ricoeur, P. (1970) *Freud and Philosophy*, trans. D. Savage. New Haven, CT: Yale University Press.

\_\_\_\_\_(1977) The question of proof in Freud's psychoanalytic writings, *Journal of the American Psychoanalytic Association* 25: 835-72.

Riis, P. (1983) Therapy of ulcerative colitis: a critical evaluation. *Scandinavian Journal of Gastroenterology* Supplement 88: 24-9.

Rilke, R. (1983) *The Unknown Rilke: Selected Poems*, trans. F. Wright. Oberlin, OH: Oberlin College Press.

Ritvo, S. (1976) Adolescent to woman, *Journal of the*

*American Psychoanalytic Association*. 24: 127-38.

Ritvo, S. and Solnit, A. (1995) Instinct theory. In B. Moore and B. Fine (eds) *Psychoanalysis: The Major Concepts*. New Haven, CT: Yale University Press.

Robinson, P. (1993) *Freud and His Critics*. Berkeley, CA: University of California Press.

Rorty, R. (1979) *Philosophy and the Mirror of Nature*. Princeton, NJ: Princeton University Press.

\_\_\_\_\_(1989) *Contingency, Irony and Solidarity*. Cambridge: Cambridge University Press.

Rosenblum, S. (Reporter) (1994) Report of a panel on analyzing the 'unanalyzable' patient: implications for technique. *Journal of the American Psychoanalytic Association* 42: 1251-9.

Ross, D. and Kapp, F. (1962) A technique for self-analysis of countertransference. *Journal of the American Psychoanalytic Association* 10: 643-57.

Rothstein, A. ed. (1988) *How Does Treatment Help? On the Modes Of Therapeutic Action of Psychoanalytic Psychotherapy*. New York: International Universities Press.

Rubins, J. (1978) *Karen Horney: Gentle Rebel of*



*Psychoanalysis*. New York: Dial Press.

Sartre, J. (1956) *Being and Nothingness*. New York: Washington Square Press.

Savitt, R. (1977) Conflict and somatization: psychoanalytic treatment of the psychophysiologic response in the digestive tract. *Psychoanalytic Quarterly* 46: 605-22.

Schafer, R. (1993) Five readings of Freud's 'observations on transference-love'. In E. Person, A. Hagelin, and P. Fonagy (eds) *On Freud's 'Observations on Transference-Love'*. New Haven, CT: Yale University Press.

Scharfman, M. (1979) Panel on conceptualizing the nature of therapeutic action of psychoanalysis. *Journal of the American Psychoanalytic Association* 27: 627-42.

Schur, M. (1955) Comments on the metapsychology of somatization. *Psychoanalytic Study of the Child* 10:119-64.

Shainess, N. (1979) The swing of the pendulum—from anorexia to obesity. *American Journal of Psychoanalysis* 39: 225-35.

Shane, E. and Shane, M. (1989) Prologue: the developmental perspective in psychoanalysis.

*Psychoanalytic Inquiry* 9: 333-9.

Shane, M. and Shane, E. (1990) Unconscious fantasy: developmental and self psychological considerations, *Journal of the American Psychoanalytic Association* 38: 75-92.

Shane, M., Shane, E. and Gales, M. (1997) *Intimate Attachments: Toward a New Self Psychology*. New York: Guilford Press.

Shapiro, T. (1990) Unconscious fantasy: introduction, *Journal of the American Psychoanalytic Association* 38: 39-46.

Shields, R. (1972) Psychosomatic aspects of ulcerative colitis. *Practitioner* 209: 851-8.

Shoenberg, P. (1983) An experience of ulcerative colitis. *British Journal of Psychiatry* 143: 517-18.

Silber, I. (1994) *Socialism: What Went Wrong?* London: Pluto Press.

Slakter, E. (1987) *Countertransference* Northvale, NJ: Jason Aronson.

Soloff, P. and Millward, J. (1983) Psychiatric disorders in the families of borderline patients. *Archives of General Psychiatry* 40: 36-44.

Spence, D. (1982) *Narrative Truth and Historical*

*Truth: Meaning and Interpretation in Psychoanalysis.* New York: Norton.

Spengler, O. (1962) *The Decline of the West*, trans. C. Atkinson. New York: Norton.

Spillius, E. ed. (1990) *Melanie Klein Today: Developments in Theory and Practice*, vol. 1: *Mainly Theory*. New York: Routledge.

Spira, D. (1988) The defensive function of psychoanalytic theories. *Annual of Psychoanalysis* 16: 81-92.

Stern, D. (1985) *The Interpersonal World of the Infant*. New York: Basic Books.

Stolorow, R. and Atwood, C. (1992) *Contexts of Being: the Inter-Subjective Foundations of Psychological Life*. Hillsdale, NJ: Analytic Press.

Stone, L. (1961) *The Psychoanalytic Situation: An Examination of Its Development and Essential Nature*. New York: International Universities Press.

——(1981) Notes on the noninterpretive elements in the psychoanalytic situation and process. *Journal of the American Psychoanalytic Association* 29: 89-118.

Stone, M. (1980) *The Borderline Syndromes: Constitution, Personality and Adaptation*. New York: McGraw-Hill.

Strachey, J. (1934) The nature of the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis* 15:117-26.

Stunkard, A. (1975) Obesity. Chapter 31 in *American Handbook of Psychiatry*, vol. 4, 2nd edn. New York: Basic Books.

\_\_\_\_\_(1980) Obesity. Chapter 26.4 in H. Kaplan, A. Freedman, and B. Sadock (eds) *Comprehensive Textbook of Psychiatry—III*, vol. 2. Baltimore: Williams and Wilkins.

Stunkard, A. and Burt, V. (1967) Obesity and the body image II. *American Journal of Psychiatry* 123: 1443-7.

Sullivan, H. (1953) *The Interpersonal Theory of Psychiatry*. New York: Norton.

Sundby, H. and Austed, A. (1967) Ulcerative colitis in children: a follow-up study with special reference to psychosomatic aspects. *Acta Psychiatrica Scandinavica* 43: 410-23.

Taylor, C. (1995) *Philosophical Arguments*. Cambridge, MA: Harvard University Press.

- Taylor, G. (1987) *Psychosomatic Medicine and Contemporary Psychoanalysis*. Madison, CT: International Universities Press.
- Thurow, L. (1995) Companies merge; families break up. *New York Times* Sept. 3.
- Ticho, G. (1967) On self-analysis. *International Journal of Psycho-Analysis* 48: 308-18.
- Tolpin, P. and Tolpin, M. (1996) *Heinz Kohut: The Chicago Institute Lectures*. Hillsdale, NJ: Analytic Press.
- Torrance, J. ed. (1995) *Philosophy in an Age of Pluralism: The Philosophy of Charles Taylor in Question*. New York: Cambridge University Press.
- Tower, L. (1956) Countertransference, *Journal of the American Psychoanalytic Association* 4: 224-55.
- Trilling, L. (1972) *Sincerity and Authenticity*. London: Oxford University Press.
- Trosman, H. (1990) Transformations of unconscious fantasy in art. *Journal of the American Psychoanalytic Association* 38: 47-60.
- Tully, J. ed. (1995) *Karl Marx's Theory of Ideas*. New York: Cambridge University Press.
- Tustin, F. (1972) *Autism and Childhood Psychosis*. New

York: Science House.

\_\_\_\_(1981) *Autistic States in Children*. London: Routledge and Kegan Paul.

\_\_\_\_(1986) *Autistic Barriers in Neurotic Patients*. New Haven, CT: Yale University Press.

\_\_\_\_(1988) The 'black hole'—a significant element in autism. *Free Associations* 11: 35-50.

\_\_\_\_(1990) *The Protective Shell in Children and Adults*. London: Karnac Books.

Tyson, R. (1986) Countertransference evolution in theory and practice. *Journal of the American Psychoanalytic Association* 34: 251-74.

Updike, J. (1986) *Roger's Version*. New York: Knopf.

Wallerstein, R. (1988) One psychoanalysis or many? *International Journal of Psycho-Analysis* 69: 5-21.

\_\_\_\_(1995) *The Talking Cures: Psychoanalysis and the Psychotherapies* New Haven, CT: Yale University Press.

Warner, S. (1980) A clinical note on auto-analysis as a narcissistic resistance. *Journal of the American Academy of Psychoanalysis* 8: 279-86.

Weigert, E. (1954) Counter-transference and self-

- analysis of the psychoanalyst. *International Journal of Psycho-Analysis* 35: 242-6.
- \_\_\_\_\_(1960) Soren Kierkegaard's mood swings. *International Journal of Psychoanalysis* 41: 521-5.
- Weiner, H. (1977) *Psychobiology and Human Disease*. New York: Elsevier.
- \_\_\_\_\_(1992) Specificity and specification: two continuing problems in psychosomatic research. *Psychosomatic Medicine* 54: 567-87.
- Weinstock, H. (1962) Successful treatment of ulcerative colitis by psychoanalysts: a survey of 28 cases, with follow-up. *Journal of Psychosomatic Research* 6: 243-9.
- Weiss, E. and English, O. (1957) *Psychosomatic Medicine*. Philadelphia, PA: W.B. Saunders.
- Weiss, J. and Sampson, H. (1986) *The Psychoanalytic Process: Theory, Clinical Observation and Empirical Research*. New York: Guilford.
- Weiss, S. (1987) The two-woman phenomenon. *Psychoanalytic Quarterly* 56: 271-86.
- West, M. (1971) Ulcerative colitis reconsidered as a psychosomatic disease. *British Medical Journal* 757: 340-1.

Wheelis, A. (1956) The vocational hazards of psychoanalysis. *International Journal of Psycho-Analysis* 37: 171-84.

Whitaker, C. and Malone, T. (1953) *The Roots of Psychotherapy*. Philadelphia, PA: Blakiston.

Wile, D. (1972) Negative countertransference, therapist discouragement. *International Journal of Psychoanalytic Psychotherapy* 1: 36.

Wilson, C. ed. (1983) *Fear of Being Fat*. Northvale, NJ: Jason Aronson.

Wilson, J. (1993) *The Moral Sense*. New York: Free Press.

Winnicott, D. (1949) Hate in the counter-transference. *International Journal of Psycho-Analysis* 30: 69-74.

\_\_\_\_\_(1958) *Collected Papers*. New York: Basic Books.

\_\_\_\_\_(1965) *The Maturational Process and the Facilitating Environment*. New York: International Universities Press.

\_\_\_\_\_(1968) *The Family and Individual Development*. London: Tavistock.

\_\_\_\_\_(1969) The use of an object. *International Journal of Psycho-Analysis* 50: 711-16.



\_\_\_\_(1975) *Through Paediatrics to Psycho-Analysis*.  
London: Hogarth/Institute of Psychoanalysis  
(originally published 1954).

Wittgenstein, L. (1961) *Tractatus, Logico-philosophicus*, trans. D. Pears and B. McGuinness.  
New York: Humanities Press.

Wolf, E. (1985) The search for confirmation: technical aspects of mirroring. *Psychoanalytic Inquiry* 5: 271-82.

Wood, R. (1995) Six Heideggerian figures. *American Catholic Philosophical Quarterly* 69: 312-31.

Wooley, S. and Wooley, O. (1980) Eating disorders: obesity and anorexia. In A. Brodsky and R. Hare-Muslin (eds) *Women and Psychotherapy*. New York: Guilford Press.

Woollcott, P. (1981) Addiction: clinical and theoretical considerations. *Annual of Psychoanalysis* 9: 189-206.

Yeats, W. B. (1989) The song of the wandering Aengus. In *The Collected Works of W.B. Yeats, Vol. 1: The Poems*. Revised, ed. Richard J. Finneran. New York: Scribner, a division of Simon & Schuster Inc.

Yorke, C. (1995) Freud's psychology: can it survive?

*Psychoanalytic Study of the Child* 50: 3-31.

Young, J. (1995) Being and value: Heidegger contra Nietzsche. *International Studies in Philosophy* 27: 105-16.

Young, J. (1996) Schema-focused therapy for borderline patients. *Audio Digest Foundation* 25: 18, 19 (audiotape).

Zales, M. (1982) *Eating, Sleeping and Sexuality: Treatment of Disorders in Basic Life Functions*. New York: Brunner/Mazel.

Zetzel, E. (1956) Current concepts of transference. *International Journal of Psycho-Analysis* 37: 369-76.