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PSYCHOANALYTIC PSYCHOTHERAPY

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Psychoanalytic Psychotherapy

In this chapter the term "psychoanalysis" has specific boundaries. It is explicitly referred to as a method of treatment and not as a general psychology, a tool of clinical research, or a social movement.

Distinguishing Between Psychoanalysis and Psychotherapy

We characterize psychoanalysis as follows: first, it represents a strictly deterministic view of all human behavior; second, this determinism is manifested by the significant effect that early life experiences have upon adult behavior, attitudes, and feelings; third, the fact of unconscious mental activity can be inferred; and fourth, consciousness produces "cure." We believe these characteristics are common denominators for treatment by "classical" analysis and by the other analytic "schools" with which we are familiar, those of Adler, Fromm, Horney, Jung, Rado, Rank, and Sullivan. Nevertheless, it has been our experience that there are several common misconceptions about classical psychoanalysis *as it is currently practiced* and since we will be describing psychoanalytic psychotherapy as a derivative of classical analysis, we believe it is worthwhile to begin by outlining the classical analytic treatment method as well as some of these misconceptions. Classical analysis is usually characterized, by both its practitioners and its critics, as "a systematic analysis of the transference." Transference is a concept that is not

always well understood, even though its use is not restricted to any one analytic school. As defined by Freud (1953), transference is a manifestation of the mind's general tendency to displace the emotions of early life that are still unconsciously involved with important objects[1] and forgotten experiences. These early emotions are displaced onto, among other things, (a) activities of waking life (as when one makes slips and errors); (b) perceptions while asleep (dream images); and (c) symptoms (phobias, conversion phenomena, compulsive rituals, obsessional thoughts, and others). Freud regarded the distorted perceptions of the analyst that may occur under the influence of these unconscious emotions as only special cases of the more general phenomenon.

The classical analytic situation is organized to promote a regression to a "transference neurosis." This is evidenced by a re-experiencing with the analyst of the most affectively intense involvements, from before age six, that are still unconsciously active in the patient's mind. The principal factor that promotes this intentional therapeutic regression to the transference neurosis is the frustrating ambiguity with which the patient is faced in the analysis. He reacts to this frustration by trying to achieve gratification through means he has learned in the past—that is, through regression to re-experienced demands and expectations. At the same time, a therapeutic alliance is developing between the conflict-free "adult portion of the patient's mind" and the analyst. This indispensable alliance is characterized by the patient's

ability to experience his regressive transference reactions with full intensity, and then, alternately, to "stand off," observe, and understand them in collaboration with the analyst.

One common misconception of this process is the idea that, as it once was in the 1930's, the classical analyst's goal still is to uncover the original historical "trauma"—the "why" of a behavior—with the implication that this discovery is the curative act. It would be more correct to say that an analysis can be roughly divided into two phases. The therapeutic task of the first phase is to make the "here-and-now" experience between patient and analyst come alive with feeling, in order to discover the ways in which the past is still active in the patient's current perceptions and behavior. In this process, recovered memories only enhance the patient's sense of the personal reality of the continuity between his past and present.

A second common misconception of this regression to a transference neurosis is that it induces an unnecessary, deleterious dependency relationship. Actually, it is clearly understood by the classical analyst that the experiencing of the therapist as identical with the objects of the patient's memories is indeed to the patient's end of maintaining the transference as a child to a powerful parent. Therefore—and this is crucial—the classical analyst understands that in the second phase the task of treatment is to help the patient grasp the way in which the present is different from the past. This

must include the patient's coming to understand how he tries to make present people, especially the analyst, behave in particular ways. If he can do this the patient's conviction of what his parents really were like will be perpetuated or, more often, the way in which he wished to see his parents will be sustained. By preserving this mythology about his past, the patient can maintain his current behavior, using the past as justification for it. It is our impression that this distinction between present and past takes place in any successful psychoanalytic treatment, whether it is called "classical" or some different adjective. But it does not necessarily occur in psychotherapy.

A third misconception is that the classical analyst attempts the impossible task of preserving his relationship with the patient as that of a blank screen for the patient's projections. The facts are that, throughout the analysis, not only are the reactions of the classical analyst used by himself as an orienting guide to the meaning of the material, but also these spontaneous reactions as a "real" person are particularly important in the terminal part of the second phase. They enhance the process of differentiating present from past. For example, a woman patient with no distortion of her reality-testing function comes into a session in the terminal part of the second phase and says, "I noticed you sent your secretary out as I was coming down the hall, to see how much better-looking I am now." In the initial phase of treatment the analyst's task is to help the patient understand the way in which this is a transference reaction that recreates the feelings she had toward her father, a

man who really was too inhibited to tell her directly when he was pleased at how well she was doing. In the terminal part of the second phase, the analyst might respond, "Why would I he that indirect?" This is a correct use of the analyst's characteristics as a real person—*if* it facilitates the task of helping the patient to become aware that she *wants* to continue seeing the analyst as she saw her father, so that she can continue to believe that her father really did secretly prefer her to her mother. In that case, she would never have to face either her former inadequacies as a child, or her shame at still wanting the preferred position with a currently unavailable object, or her need to assume what for her are painful adult responsibilities.

Having thus described classical psychoanalysis, we can proceed to characterize "classical" psychoanalytic psychotherapy. One difference already noted is that the distinction made between past and present may not occur in psychotherapy. A second difference is that the transference should he handled differently. In psychotherapy there will be equally intense emotional experiences, including transference reactions, and the understanding and interpreting of these transferences may be crucial for the success of the therapy. However, there will not be a systematic effort to create a transference neurosis. The therapist is required to deal with these transferences in a much more flexible way than is generally considered appropriate or necessary in ordinary psychoanalytic technique. Thus we believe that in some ways the psychotherapeutic task is more difficult, and in

accord with this belief we will discuss the technique of making transference interpretations in a later section.

Other Relevant Concepts

In addition to transference, several other concepts are relevant in understanding psychotherapy from a variety of seemingly disparate viewpoints—including behavioral analysis and modification, transactional and existential analysis, and the various "neo- Freudian" schools previously listed. These concepts are: self-esteem (including the concept of "narcissism"—see page 201), superego, ego-ideal, and identification. We recognize that these are at different and not necessarily optimal distances from the data of (self) observation, but we find them all indispensable to our understanding.

We will generalize that patients come for treatment because of a loss in self-esteem either when: (1) they have experienced a real or imagined defeat; or (2) they have lost their previous ability to integrate the normal balance of love and hate that characterizes all important human relationships; or (3) they have lost the ability to regulate other aspects of their inner life that are important for the maintenance of self-esteem. This loss of selfesteem is associated either with guilt at having transgressed the prohibitions of unconscious and preconscious conscience (super-ego), or with shame at

having failed to live up to unconscious and preconscious goals and ambitions (ego-ideal [Ovesey, 1956]). But for whichever reasons they come, patients experience shame about their need for help from another person. The way in which they deal with this shame is a crucial element in their readiness (or lack of it) to accept a dependent relationship with the therapist. Usually these tensions set in motion the desire to believe in the benevolent power of another person-—in this instance a therapist—who will relieve the patient's guilt, shame, and lowered self-esteem by some means. This belief usually results in the process of identification, a concept discussed in the section on methods of psychotherapy.

Indications for and Goals of Psychotherapy

The following situations, in our experience, indicate the adoption of psychoanalytic psychotherapy.

1. *Patients who show acute symptomatic reactions*. Among such reactions are: acute or free-floating anxiety attacks; acute symptom- formation in the "transference neuroses," including conversion and anxiety hysteria, obsessional thinking, or compulsive rituals (because psychoanalysis cannot be effective during the acute phase of these neuroses); traumatic neuroses; adolescent crises (delinquency or acute inhibition of schoolwork); and acute grief reactions.

2. *Patients who show more chronic, characterological forms of psychopathology*. For such conditions (in contrast with the fourth situation listed below) the desirability of psychoanalysis is outweighed by factors "inside" the patient, and (in contrast with the third situation below) these internal factors are not of the nature that makes analysis a high-risk treatment. These are the patients who may for a variety of reasons not be introspective, whose cultural background is such that a procedure such as analysis is opposed by powerful group norms, or who are afraid of the procedure (without, however, demonstrating excessive rigidity of the high-risk group in (3) below.) Among them are: hysterical characters; obsessive-compulsive characters; depressive characters, including addicts and parent- loss patients; paranoid characters, including schizoid and borderline characters; true hypochondriasis; and narcissistic personality disorders.

3. *Patients who have psychotic disorders*. These include schizophrenic reactions or manic-depressive reactions that are considered unsuitable for psychoanalysis, usually because of excessively rigid attitudes and behavior patterns masking a weak "ego structure." Such persons superficially manifest an insufficient motivation for analysis. However, it is important to understand that this superficial disinterest actually serves to protect the patient against his potential for disintegration under the pressure of a therapeutic regression in analysis.

4. *Psychoanalysis would he desirable hut is "externally" unavailable*. Such instances arise either because of geography, time,

money, or a crippling external life situation, or because a practitioner or trainee wants the gratification of successful therapy with a patient otherwise well suited for psychoanalysis.

5. *If suitability is uncertain*. Psychoanalytic psychotherapy may be used for exploratory purposes when it is difficult to decide whether psychotherapeutic or psychoanalytic methods are more suitable. The patient's experience during psychotherapy in any of the above categories may also serve as an important preparation for the work of analysis.

What are the goals of psychoanalytic psychotherapy? They are, primarily, the alleviation or elimination of "symptoms," defined by us as whatever distress the patient comes for "help" with. When this goal is reached, it is important for a therapist with integrity to make it easy for the patient to terminate the treatment—to believe that the therapist's door is open for him to return without risking humiliation. Under integrity we include such gross issues as a therapist's capacity to deal with his need of the patient for his income, but we also mean facing up to subtler issues, such as the therapist's need of the patient for personal training goals. And finally, by integrity we mean the capacity to face the problem that we believe is the common denominator for all psychotherapists: determining whether, if he is reluctant to help the patient terminate, it is because he is unwilling to deprive himself of the pleasure or the self-esteem, or both, that he obtains from the patient's progress. If the patient does express a desire to continue, after the

original symptomatic relief has been achieved, the therapist should make an explicit agreement with the patient to work toward one or more goals in the areas of intimacy, work, or general interpersonal relations.

The Methods of Psychoanalytic Psychotherapy

Before listing specific methods of psychotherapy, we will continue our earlier discussion of the distinguishing characteristics of the procedure by describing some of the external configurations of treatment that are methodological expressions of our basic concepts.

Psychotherapy is an asymmetrical (Goldman, 1956) two- person relationship with an outpatient, initially occurring once or twice a week. Our experience has been that psychotherapy occurring more than twice a week makes strong transference reactions inevitable, with the concomitant likelihood of strong countertransference reactions. It then follows that transference interpretations as well as systematic self-scrutiny by the therapist must become a regular part of the treatment. Therapists who choose not to do this are urged not to increase the frequency of sessions.

The treatment may go on for an agreed- upon number of sessions or for an indefinite period. In either case, the original agreement to proceed is explicitly related to some consciously formulated distress that the patient experiences. The duration of each session is not as important as the patient's

sense that the sessions will recur regularly and that during each one he will have the therapist's attention, free of external distractions. We ignore here the subtleties involved when the therapist takes notes, answers telephones, offers different appointment times each week, sees patients in several different locations, including vacation places, and so forth. Our general position is that within broad limits, any conditions enabling the therapist to function with sufficient freedom to understand the patient cognitively and empathically are their own justification. We include the possibility that some patients cannot accustom themselves to a therapist who, for example, needs to answer the telephone. A therapist free to respond in the ways we have just described will refer that patient elsewhere before the patient interrupts the treatment or a stalemate occurs.

Whenever possible, an appropriate fee should be set. Preferably it should be given by the patient to the therapist, even if a third party either has produced the money or is to receive it. The purpose of this is to increase the likelihood that important positive or negative feelings about the therapy will be brought into awareness and expressed.

All of the foregoing characteristics potentially enhance the patient's self-esteem by identification with a therapist who, at least by "middleclass, contemporary American" criteria, experiences himself as serious in his work and possessed of personal dignity. Such a person appears at least to be getting

satisfaction from treating patients. This implies a hope of success with which the patient can identify. It is enhanced by the therapist's sense of assurance, which the patient experiences as encouragement to be hopeful about himself.

Dependency and Identification

A second brief remark about identification is relevant in connection with the referring of patients for psychotherapy. We believe that the patient's learning about himself and about the external world (particularly as seen through the therapist's eyes) are important tools for achieving the goals of psychotherapy. Further, we agree with Piers and Piers (1964) that this learning occurs in three modes during treatment: by identification, by conditioning, and by insight. We also agree with their suggestion that our unconscious or preconscious predictions regarding the potential ease with which such identifications will be likely to occur may determine our choice of the therapist to whom we refer a particular patient. Another way of expressing this is that we unconsciously estimate the congruence between the patient's and the potential therapist's ego- ideal and superego. This is generally experienced by the therapist and patient as "liking each other." We will return to this point in the later section on folk-wisdom, where we will explicate certain transactional characteristics of therapy with particular types of patients.

Of the traditional approaches to the methods of psychotherapy, the best one we are familiar with is by Goldman (1956), who lists the following methods: management of dependency needs, evaluation of emotional reactions with positive focus, objective review of stress situations, emotional decompression, reinforcement of ego defenses, educative guidance, effecting of changes in the life situation, modification of patient's goals, use of magical omnipotence, and use of transference. For the student of psychotherapy, Goldman's presentation is a valuable orientation to the field because it helps organize a series of techniques within the adaptational approach to psychodynamics, emphasizing the interaction between the individual and his current environment. Most useful is Goldman's explicit awareness that "the ways in which the therapist gratifies the dependent needs of the patient are infinite." This correctly conveys the idea that the major beneficial effects of all the methods he details result from their occurrence within the context of an ubiquitous, but frequently covert, dependency relationship in which the patient experiences the therapist as a benign, powerful parent. lie also realizes that it is crucial not to underestimate the powerful tendency in this direction set in motion by the sincere interest, attention, and reliable presence of the therapist, and the reciprocal tendency of one human being to want to believe in the benevolent power of another.

However, we find that Goldman has not taken the next, necessary step in the understanding of the therapeutic process, although we believe it is

implicit in many of his comments. This step is: the inevitable following of the ubiquitous, covert frequent dependency relationship by the tendency, both conscious and unconscious, to want to be like the loved or admired object (the therapist). This tendency refers to the process of *identification.* When it occurs, it increases the likelihood that the patient's self-esteem will be elevated because his subjective sense of self will be enhanced, as Schafer (1968, p. 164) says, by "enriching it with the object's good qualities." More precisely, the particular good quality with which the patient will identify in the therapist is that, insofar as the patient perceives him, the therapist either does not have the same conflicts as the patient or does not have guilt or shame, as the patient does, in response to his impulses.

One immediate consequence of understanding the importance of identification in therapy is that it provides a more dynamic view of a traditionally misunderstood concept: abreaction, which is synonymous with Goldman's phrase, "emotional decompression." This is usually taken to mean the reliving, in therapy, of a forgotten, painful experience, with re-experiencing of the hitherto repressed emotion. The beneficial effect is thought to be the result of the release of tension on a "hydraulic" model, a concept still derived from Freud's original view of the etiology of hysteria (Bibring, 1954). Our own view is that when a hitherto unacceptable feeling is remembered, or is experienced for the first time and expressed verbally, in the presence of a comprehending and accepting authority figure, the patient's

self-esteem rises. This occurs because when the patient perceives the therapist's reaction, he can then identify himself with the more realistic prohibitions and ideals of the therapist instead of his own archaic prohibitions and ideals.

However, this rise in self-esteem may be spurious (Ovesey, 1956), precisely because the identification is still largely dependent on the reassuring presence of the external object. That is, the object of the identification may be experienced only as an "introject," in Schafer's sense, (1968, p. 164) with whom an internal dialogue is being carried on because "relations with introjects are as variable as those between two persons." Thus, the new attitude may not yet be an indication that, within the patient's mind, his actual self-representation coincides with the representation of the therapist. However, if the patient can use the rise in self-esteem he gains in the therapist's office to risk new behaviors in the "real" world, he may then experience approval—or at least the absence of distress—from significant people. When this happens, we believe that the rise in self-esteem, which began with dependent longings toward the "parentified" therapist, becomes a more real expression of an internal shift in self-perception.

Until therapists understand the power of covert dependency gratification and the identification that results from it, they sometimes miss the importance to the patient of the therapist's subtly communicated pleasure

when the patient risks these "new behaviors." A corollary to this pleasure is that the therapist also accepts the patient's inevitable failures in a way different from either the patient's view of them or the view held by the patient's original objects.

Interpretation "From the Side of the Ego"

One important technical consideration is the way in which the therapist communicates his comprehension and acceptance of the patient's hitherto unacceptable impulses. Our shift from our earlier word "feelings" to "impulses" indicates the usefulness to us of the structural point of view provided by classical psychoanalytic metapsychology. The structural metaphor (ego, super-ego, and id) admittedly represents a very high level of abstraction within this theory, in contrast to the data of clinical observation and clinical inference (Waelder, 1962, p. 617). Nevertheless we find it a useful shorthand, because it enables us to conceptualize the therapist's communications as interpretations "from the side of the ego" (Fenichel, 1941, p. 57). A simple example of this is when the therapist might say, "I understand how painful it is to feel so angry at me and yet be so afraid to express it." The appropriateness of such a remark derives from the contact that is thus made with the patient's experiencing ego, which "feels itself caught" between the id impulse (hostile feelings) and the super-ego reaction (feelings of guilt, fear of retaliation, inferiority, or helplessness). The therapist's interpretation

promotes an identification by the patient with the therapist's ego, which is better able to tolerate both sides of such a conflict. This process is analogous, on a higher developmental level, to the one by which a child learns to neutralize his own untamed impulses by identification with his parents. For example, when a mother is confronted with her little boy's unneutralized sexuality, she responds with a firm but loving "No"—that is, with her neutralized aggression. The little boy can identify with this attitude in his mother and thus achieve mastery over his own impulses as she has over hers. Thus the therapist is like the optimally frustrating parent when he confronts the patient's excessive emotionality with his words and his calmness, in the face of the patient's anxiety over his powerful feelings.

If the patient has been unable to express directly to the therapist either his impulses or his reaction against them, he may do it in the form of "latent language" (Mazzanti, 1956) The patient can do this unconsciously, for example, by making reference to a situation involving two people outside the therapy. In such an instance, the therapist may do well to respond with a congruent latent reference to the same people outside the treatment, so as to avoid confronting the patient prematurely with his impulses.

In the event that the patient has responded to the permissive atmosphere of the therapy with an upsurge of dependency longings that he does not experience with shame, but only with frustration when they are not

gratified, the therapeutic problem is different. Then it is important to acknowledge explicitly the unusual quality of the treatment situation, and the special relationship to the therapist that makes many kinds of intense feelings inevitable (including whatever form the dependency demand has taken). Further, as long as the therapist is privately convinced that the patient *wants* but does not *need* whatever is being asked for, he should explicitly acknowledge the frustration that the patient feels when these demands are not gratified. If the dependent demand for explicit gratification continues, the indication is for the therapist to direct the inquiry toward a different time and place in the patient's life, which is the first step in making a transference interpretation.

The Use of Transference Interpretations

Our experience in the supervision of trainees of varying disciplines as well as in consultation with colleagues has been that, except for psychoanalysts, other psychotherapists usually regard transference interpretations as a subject either for exaltation or depreciation. In the former case, the psychotherapist feels that transference interpretations are not in his province. In the latter, he feels that they are a pejorative invitation to the patient to turn attention away from the "more important issues here and now" in the patient's current life. Our position is that every competent psychotherapist, regardless of discipline, must (a) be able to recognize the

occurrence of a transference reaction, (b) define the criteria for deciding when to interpret its presence, and (c) know how to make a transference interpretation. These three tasks are discussed below.

Recognition of Occurrence

The occurrence of a transference reaction is suggested when the therapist empathically perceives any overly strong emotional reaction during a session. If this becomes repetitive and eventually predictable, the likelihood is high that the patient is experiencing a transference reaction. A simple example is a patient who feels criticized and responds defensively whenever the therapist asks a clarifying question, even when the query does not begin with the infamous blame-seekers, "Why?". Another common example is a patient who believes the therapist is angry or sexually aroused. The first step is for the therapist to investigate himself to determine whether the patient's perception is accurate. Occasionally, when it is, the therapist can infer from his specific countertransference reaction a clue to the nature of what the patient may he denying and projecting from within himself—that is, the nature of the patient's transference. Thus if the therapist feels exasperated, it can indicate that the patient, by behaving as a disobedient, provocative child, may he expressing unconscious feelings in a parental transference. However, if the same qualitative reaction in the therapist reflects a more personal idiosyncratic anxiety, it may reach a maladaptive level. Then it may be

experienced as exasperation with *all* patients who unconsciously feel themselves to he helpless and longing in the presence of a powerful parent, and who then react against these longings in provocative ways.

Apart from these common projections, which can be understood as transference expectations or wishes, a host of subtler misperceptions based on transferences frequently pass unnoticed in once-a-week or twice-a- week psychotherapy, because they are lost in the press of current, stressful material. Often these misperceptions are assumptions based on fantasies about the therapist's personal life —his religion, marital relations, children, financial status, cultural interests, professional relations with colleagues, superiors, and so forth. One "special" category of these subtler transference reactions is that of the fantasies of patients whose therapists are in training situations. These patients may re-experience old feelings of deprivation and injury because they believe the therapist's personal training goals are in conflict with the patient's own needs. What makes this "special" is that therapists in such a situation almost always experience anxiety about helping patients make these transference reactions explicit. This is usually due either to the therapist's shame at feeling less than fully adequate to his patient's needs, or to his guilty feeling that he is exploiting his patients. If the therapist cannot believe that his training needs and the patient's need for help can be met simultaneously, then the therapist will not be able to help the patient deal with these negative feelings. Following this failure, the patient may

improve for reasons not previously described in our discussion of identification; he will improve as a result of unconsciously depreciating the consciously idealized therapist. Following this depreciation, the patient again identifies with the therapist, who is now "no better off" than the patient. This new identification relieves the shame that the patient felt at needing to come for help. (Further consideration of the therapist's need for self-scrutiny is on page 204.)

Another special group of transference reactions occurs when the therapist is employed by an agency or institution or is paid by a third party. The therapist's relationship to this third party is frequently experienced by the patient in a primitive way. He may have a sadomasochistic fantasy in which the therapist is subservient and mistreated and then becomes the object of the patient's contempt or pity. Or it may be an exhibitionistic-voyeuristic fantasy in which the therapist is imagined to be exploiting the patient's improvement by showing it off to his institutional supervisors and colleagues, or to a third party payer, all of whom become very excited about the treatment. In all these situations the transference comes from the time in the patient's life when he had similar primitive fantasies about his parents' interactions with each other. He needed to create these fantasies to deal with the pain of being left out of his parents' ordinary interactions with each other. In addition, the fantasies were an expression of the child's primitive ways of experiencing his own sexual and aggressive feelings (both exhibitionistic-

voyeuristic and sadomasochistic), which he then projected onto his parents according to the formula, "If I don't understand them, they must be like me." Following this projection, he could more easily unconsciously identify with either one of the parents and consequently participate in their interaction by means of his fantasy, no longer feeling left out.

Definition of Criteria for Interpreting Transference

The second task of a competent therapist is to define when the existence of the transference reaction needs to be interpreted—that is, made known—to the patient. Four criteria are given here.

1. The first criterion is that it should not be interpreted until the peak of the affect is past. A transference interpretation is a method of helping the patient to observe himself and thereby to take distance from an affect that the therapist believes is not useful for the patient's treatment. And this is more difficult to accomplish if the full intensity of feeling is not over. In addition, when he is experiencing the feeling most intensely, the patient may not believe that this interpretation is being offered for his benefit. Instead he is likely to feel either (a) that the therapist is unable or unwilling to accept the reality of the patient's impulses toward the therapist, or (b) that the therapist accepts the reality of the feeling but depreciates its importance by calling it "nothing but" a re-experiencing of the past. This results in a narcissistic blow

to the patient, experienced as a loss of self-esteem.

If the patient's impulses have been object- instinctual (loving or hating), the frustration engendered by the premature interpretation will bring about the patient's characteristic life response; this must then be understood in turn. The responses cover the entire gamut from separation anxiety when primitive dependency longings arc frustrated, to guilt and expiatory self-punishment when aggressive impulses are turned against the self. If the transference is a narcissistic one (either mirroring or idealizing), then a premature transference interpretation will result in a pathognomonic regression. (See the section on narcissistic personality disorders beginning on page 201.) This is a more total regression than the narcissistic blow described in the preceding paragraph, which may occur with any type of patient.

2. The second criterion for determining when to make a transference interpretation comes from the therapist's sense of "the optimal flow of the material." This is often determined by his judgment regarding the degree of anxiety needed to promote the desired introspection in the service of the eventual relief of symptoms. By contrast, in psychoanalysis, a transference interpretation may be offered not only when a painful affect is too intense, but also at a time when the patient is experiencing only a pleasurable feeling toward the analyst. The analyst will do this if he believes that the pleasure is being used in the service of "resisting" further introspection. He will then

offer a transference interpretation as a means of providing optimal frustration. Also, in classical analysis, transference interpretations are made to promote the regression that is vital in helping the patient discover the ways in which his past is still alive in his present (see page 184). In psychotherapy, by contrast, transference reactions should be interpreted only when the intensity of the patient's unpleasant affect and discomfort is such that it is difficult for him to continue the work of introspection. However, this decision can be based on data of varying degrees of subtlety, as well as on observable or verbalizable discomfort.

For example, a thirty-year-old male patient continually referred to his closest female friend as "this girl" in the first several weeks of therapy. When the therapist wondered aloud about this, the patient responded with a memory from seventh grade, when his school suddenly became coeducational and he told his family of his interest in a twelve-year-old girl who had just joined his class. His father had depreciated his interest in her, and the patient spontaneously connected the shame of that experience with the fear that the therapist might react like his father if he used the woman's name in therapy. The question might be raised, whether this example truly indicates a difficulty in carrying on the work of introspection that required the therapist to speak. The answer is that the therapist's first intervention was a tentative observation that gently pointed to an omission in the flow of the material. The observation also served the therapist's conscious goal of using the

psychotherapy as an exploration of the patient's suitability for analysis.

In accord with our basic position that psychotherapy in large measure should promote symptom relief through identification, it follows that not all interruptions of introspection will be attended to as potential transferences. W hen symptom relief is the primary goal, then the flow of the material and the nature of the transference will all be secondary. For example, a patient experiencing a negative transference—that is, behaving as an angry or distrustful or provocative child—may achieve symptom relief in order to *defy* the therapist. It is commonly thought that negative transferences impede symptomatic relief because of the wish to deprive the parentified therapist of the pleasure he will obtain from the patient's improvement. However, a negative transference may also protect a patient against his fear of dependency longings, which he then deals with by a pseudo-independent protest that results in the disappearance of symptoms. The important reminder in this regard is to help the patient leave when the "symptom" has been relieved. The corollary is that the patient must believe he is free to return without risking humiliation for either party. In the case of a positive transference, this means that returning will not be experienced by the therapist as a blow to his own pride. In the case of a negative transference, this means that the therapist will not experience the return as a victory over the patient.

3. A third criterion for the timing of transference interpretations relates to when the interpretation provides a truly psychologically- minded patient with an opportunity to understand the nature of his own inner life. This is particularly likely to occur when a patient experiences regressive reactions during psychotherapy and—while not overwhelmed by the intensity of the unpleasant emotion— seeks an explanation. A common manifestation (of this regression) that occurs at the start of therapy and responds well to transference interpretation is the temporary deterioration of the patient's previous capacity for expending energy on highly integrated vocational or personal activities. The relevant interpretation may be the patient's fear of failure, in making a commitment to this new challenge of therapy; or his pleasurable anticipation that an interested expert will wish to show him what needs to be done to improve his life; and so on. In any event, when the connection is made with the past, the patient may experience relief and be motivated to introspect more deeply.

4. A fourth criterion for the timing of a transference interpretation derives from evidence that the reaction may be close to the patient's awareness. Such evidence would include the following: (a) a dream in which the transference feeling, as well as the original figure toward whom it was directed, can be inferred by the therapist from the manifest content; (b) any of the manifestations of the slips and errors of everyday life, in which the original object is alluded to or named; and (c) sequential, direct references to

the original person, following thoughts about a present day experience. A typical instance of this would be a patient who falls silent every time he complains about his boss, then reports a thought about his father. What is omitted from this sequence is the patient's reaction to the therapist as part of his present day experience that he needs to bring into full awareness (Menninger, 1958, p. 150).

Making the Interpretation

The third task of a competent therapist is to know how to make a transference interpretation. (1) The first step is to invite the patient's curiosity about what seems to the therapist to be a relatively extreme form of emotional reaction. The importance of this step cannot be overestimated, because the patient's reaction to this invitation will indicate whether or not the crucial split has taken place upon which the therapeutic alliance must be based—that is, whether the patient, having experienced the emotion, can now "stand off alongside the therapist" and observe himself. It would be a hopeful sign if the patient responds to the therapist's invitation by making some generalization about the therapist's example of extreme affect to indicate that it occurs outside the therapy situation as well. (2) The second step is to demonstrate for the patient the repetitive nature of the reaction, after both have agreed that it exists. (3) The third step is to suggest to the patient that what he is feeling, while certainly real "right here and now," is also a reaction

to people from a different time and different place in his life. If the therapist is reasonably sure of what he understands about the patient, he may name the person from the patient's past life with whom this reaction was most commonly experienced. (4) The fourth step is to assess what follows the interpretation. We are not particularly concerned with whether or not the patient agrees with it, as a criterion for assessing its correctness. What is of the essence is that which comes to the patient's mind next," which the therapist then evaluates as a potential corroboration, correction, denial, or refutation of the interpretation. A complete transference interpretation must eventually include the naming of the past person and situation that is being re-experienced. This is a process that takes many repetitions before the situation is completely understood, hence the designation "interpretive process" (Bibring, 1954, pp. 184-185).

What are the advantages and the risks in making transference interpretations? In addition to the pitfall cited earlier (that the patient may feel put off if he believes the therapist will not accept or will depreciate the reality of the patient's experience), there are other dangers. One is that the patient may feel that the therapist is afraid of the emotion the patient is experiencing. Another is the possibility that when the interpretation relieves the anxiety that may be disrupting the optimal flow of material, it may simultaneously dissipate the very tension that is helping the patient to continue the process of self-examination.

Treatment According to Diagnostic Entities: "Folk Wisdom"

In this section we present an idiosyncratic approach to the psychotherapy of several diagnostic categories. First we discuss several commonly-seen acute symptomatic reactions. We then proceed to the more stable, characterological disorders. We have selected the ones whose frequency in our practices leads us to hope that they are similarly familiar to other psychotherapists and hence merit consideration. Because of our psychoanalytic bias, we will emphasize the limitations as well as the usefulness of symptom-relief-oriented psychotherapy. We will also emphasize the psychotherapist's reactions, as a clue to the presence of a particular diagnostic entity among those discussed below, and as an indication for a desirable form of treatment. The reader is advised to consult other chapters for a systematic approach to each of these entities—their psychopathology, the range of psychodynamic conflicts, the typical life histories, and a balanced view of the most complete forms of treatment. The lack of balance in our own approach will be particularly evident in our omission of the use of medication, either as an alternative to psychotherapy or in conjunction with it.

Acute Symptomatic Reactions

Any discussion of acute reactions might begin with acute symptom-formation in the transference neuroses: anxiety hysteria (phobias);

conversion hysteria; obsessional thinking; compulsive rituals; or an acute, endogenous depressive reaction. Our recommended approach for these symptoms of acute onset is to investigate with extreme care the circumstances surrounding the onset of the symptoms. Our experience suggests that by doing this, a prior equilibrium will once more be established for the patient on the basis of an identification with the therapist, regardless of the diagnostic category of the patient.

In approaching patients with *free-floating anxiety* attacks or a *traumatic neurosis,* the therapist should again foster identification with himself. Since he does not have the same problems, he can help the patient with his shame over having "broken down." It is often useful to explain to the patient, in these very terms, what he has been experiencing. In other words, the therapist should couch his explanations in terms of problems of selfesteem and loss of pride, as reactions to adaptive failure. This is more useful than it is to confront the patient experiencing acute anxiety attacks with the underlying issues of his involvement (in libidinal or aggressive ways) with members of the same or the opposite sex, even though it is these issues which are implicated in the onset of the symptoms. In addition, the use of the patient's prior group allegiances—to the extended family, the church, and others—are extremely helpful. In the case of traumatic neuroses, following any of the disasters of modern life, further special problems derive from the guilt of the survivor, his fear of the aggressive impulses that have been stimulated by the violence of

the disaster, and his shame over having been helpless at the time of the trauma.

Certain reactions are usually acute and always taxing for the therapist. These reactions occur in adolescents and often present themselves as problems of delinquency or acute inhibition of schoolwork. Many techniques have been devised to accomplish the difficult task of establishing a libidinal bond of friendship between the adolescent delinquent and the therapist. Aichhorn's (1953) success with these patients seems to have been achieved by setting aside his middleclass superego and "playing by the patient's rules" in order to bridge the differences in cultural background and social class between himself and his patients. Kohut's (1968) understanding of Aichhorn's success seems cogent to us. He suggests that the therapist may initially mirror the adolescent's grandiosity by falling in with his view of life and trying to "beat the delinquent at his own game"—for example, by cheating at cards. This will then initiate a "veiled mobilization" of the delinquent's need to idealize a strong parental figure, without challenging the patient's grandiosity by confronting him with this need. Thus the initial behavioral improvement may take place on the basis of wanting to impress the therapist with the patient's omnipotence. Later, this can shift to a desire for an identification with the idealized therapist. This may achieve a symptomatic improvement, which will then permit normal tendencies for maturation and development to occur once more.

A more ambitious goal with these patients is to help them understand that their behavior is the acting out of an (unconscious) fantasy. And when the delinquent comes from a middleclass background characterized by a "stable" family, that fantasy is often shared by the entire nuclear family. (This is more difficult to uncover, since the patient's total family group unconsciously discourages revelation and cooperation with the therapeutic process while consciously encouraging it.) The most difficult requirement for a therapist in these situations is that he be able to function in the face of the danger of the patient's further delinquent behavior. His task is to avoid becoming a controlling superego figure, by consistently empathizing with and "interpreting from the side of" the patient's ego. This inevitably involves active interpretive intervention with the persons in the patient's familial or institutional milieu. They must be helped to understand that the delinquent is living out a fantasy that may be unconscious, and that they may be unwitting participants in or perpetrators of the drama, or both.

Another form of adolescent maladaptation may be reflected in an inhibition of schoolwork, in the absence of delinquent behavior. If the patient has previously identified himself with excessive demands made upon him by his parents and is now failing (either to spite them or to avoid the shame of trying to meet their demands and then failing), the therapist should offer his own ego ideal as a source of pleasure and self-esteem in achieving more realistic goals—as, by implication, the therapist has also done. The pitfall here

is that the patient will feel depreciated, a hopeless second-rater, unless the therapist genuinely believes in the value of what he is covertly suggesting. The paradox of such treatment is that once the patient is able to lower his goals more realistically by identification with the therapist, he is subsequently frequently able to live up to his full potential.

In the psychotherapy of *acute grief reactions* to death and so forth—in contrast to the traumatic neuroses—it *is* important to help the patient express his guilt or shame about the negative feelings that he has had difficulty facing toward the loved one who has been lost. Another helpful approach for mastering the grief is to encourage the patient to re-experience it in regard to each action, place, or event that reminds him of the loved one. This approach, although requiring the patient to experience the painful grief once more, has the desirable effect of encouraging the re-experiencing of life as the lost person did, thereby decreasing the sense of loss by identification with the departed object.

In all of the foregoing conditions we understand the limited nature of symptom relief based on a transference reaction and a positive identification with the therapist, as we have described it in earlier sections. Thus the therapist needs to be alert, when symptom relief has occurred, to any communication from the patient indicating a desire for a more thorough exploration of his inner life in regard to conflicts that are sensed although

they do not produce symptoms. The indication then may be for psychoanalysis rather than continued symptom-relief-oriented psychotherapy. A second possible path for the therapist is the one described earlier (see page 192), which leads to a recommendation for the patient to return if decompensation occurs in the future.

Hysterical Characters

Hysterical patients, particularly when they are of the opposite sex, make their therapists feel important. This is a result of the patient's "pleasurizing" the relationship—superficially in a sexual way while, more deeply, obtaining dependency gratification. How the therapist responds will depend on whether or not he enjoys the stimulation of apparently being thought of as sexually desirable or omnipotently desirable. Many therapists feel a rise in self-esteem at such times. Others feel teased, provoked, and either indignant or anxiously angered by such stimulation.

What should be done about this? If the patient's transference as an obedient or seductive child results in the loss of symptoms, do nothing. Accept the transference cure. Therapists frequently have difficulty in dismissing hysterical patients (particularly those of the opposite sex) when this point has been reached, because the patients are such fun to be with; treatment is often continued past the time when the symptoms have

disappeared and therapy is no longer indicated.

If the symptoms do not disappear, what should be done about it? To begin with, we define "the disappearance of symptoms" as the subjective experience of a patient who feels that he has now received relief for whatever it was that moved him to come. However, when frustration occurs, either because of external circumstance or because of a shift in the therapist's previous willingness to be emotionally available, the patient feels pain. This frustration is commonly experienced by hysterics as damage inflicted on them. One occasion for such painful frustration is any discussion of termination of treatment. During the termination phase, hysterical patients want to believe that the therapist's efforts have been to make up to them for the ways in which life has been unfair. They believe that the therapist has wanted to do this because he finds them irresistible. As one patient put it, "If I ever really allow myself to accept the fact that life has been unfair to me, then there will never be a reason to come back to you."

It is not an infrequent occurrence that psychotherapists—who are, on the average, probably more obsessional than they are hysterical —are made uneasy and are perhaps annoyed by the extravagant displays of emotion that characterize the hysteric. An emotional storm, full of feeling and signifying nothing, is characterologically uncomfortable for a therapist heavily invested in cognitive functioning. The psychotherapist's job may be seen as an effort to

put content into the emotionality—that is, to help the patient get at the specific fantasies that accompany the affect. Initially these patients usually react with denial. When denial gives way to the therapist's continued pressure, it is replaced by anger as a result of the frustration produced when the fantasy is brought into the open, where it cannot be gratified in an emotional storm.

Obsessive-Compulsive Characters

Obsessive-compulsive characters usually make therapists feel depreciated in a very specific way. In general the therapist finds himself trying to demonstrate to the obsessive the presence of affect, and to help the patient experience that affect from reported experiences and fantasies. Usually the obsessive first treats this effort with doubt and intellectualization, and then with contempt. The therapist frequently feels not only depreciated but also enraged. This is true even if the therapist does not have a problem with competitive strivings, because of the universally appropriate vulnerability of therapists to having their offerings depreciated by the recipient.

Treatment requires the therapist to wait until he has his feelings under control, before trying to help the patient understand what he is doing. This may be accomplished by helping the patient see that it is difficult for either

therapist or patient to know whether the therapist's interpretations are correct, because each time the patient finishes talking about them the interpretations have disappeared. Many obsessive-compulsive characters are dimly aware that they are unsuccessful in their relations with other people, because they perceive they are disliked. However, they have no clear sense of why this is. Potentially, the psychotherapist's approach suggested above may offer the patient a sense of relief, at which time he can begin to see what he does to many different people. This is clearly easier for the patient to realize when the therapist is no longer feeling depreciated or angered.

Our understanding of the origin of this kind of behavior is that it derives from the familiar struggle around toilet-training and autonomy. This results in alternating attitudes of defiance and submission in the child, which then continue over into the adult obsessive. What is less well known is the patient's unconscious pleasure in the struggle with the therapist, and in the endless continuation of an alternating defiance and submission. The other side of this coin is the experience by obsessives of their own vulnerability to feeling depreciated by verbal criticism. This vulnerability is stimulated every time the therapist speaks, because he may be about to demonstrate his power to depreciate the patient by his knowledge of the patient. Thus these patients deal with their fear by the use of verbal "magic" to preserve their autonomous self-esteem and to perpetrate onto the therapist what they themselves fear. It may be necessary to make a transference interpretation to help the patient

realize the current inappropriateness of what lie is doing.

In contrast to hysterical and depressed characters, the obsessive-compulsive character is afraid to wish that the therapist would make up to him for life's unfairness. He fears this because he is already sufficiently frightened that such longings, if expressed, would give the therapist the power to control and manipulate him, usually by criticism.

Depressive Characters

The approach to depressive characters described here is based on our experiences in psychotherapy in which we did not use antidepressant medication. A psychotherapist is quite likely to feel guilty at the unconsciously reproachful behavior of the depressed patient who, consciously, is aware only of self- reproaches. This is true regardless of the psychodynamic issue of whether the depression is a result of guilt, shame, or a loss of emotional sustenance. The indication for psychotherapy is to help the patient face the underlying anger at the important object who is not providing the patient with what he unconsciously feels he needs. However, after this anger is mobilized, it frequently turns against the therapist because of the underlying shame at having needed the therapist's help. If the therapist cannot help the patient face these feelings, the anger may once again become retroflexed and the patient may become suicidally depressed. When self-

destructive tendencies become ascendant, the therapist may need to "take over" and make suggestions regarding necessary externally imposed or self-protective behaviors. The best of course is to help identify the true object of the retroflexed rage.

After the patient's guilt-or-shame-induced depression is relieved, an *anaclitic depression* may emerge. That is, the patient comes to feel that there is no hope for emotional gratification sufficient to his needs, even when he knows that his needs cannot possibly be met in the therapeutic situation. His hopelessness may elicit hopelessness in the therapist. Treatment cannot then progress until the latter can accept, without guilt or shame, the disparity of which the patient complains.

A subdivision of the depressive character is the *addict:* the person dependent on alcohol, opiates, or any other drug. We subscribe to the oversimplification that such people are in fact addicted to the achievement of pleasure, or at least the relief of pain without effort, but with inevitable self-destructive consequences. When the therapist points this out, the patient may become abstinent to please the therapist. This leads him to believe that the therapist will then be vulnerable to feeling guilt or shame himself, when the addict once again becomes involved with his drug. Our experience in the psychotherapy of addicts is that the patient has a specific fantasy in which he believes that the therapist needs to make the patient become abstinent in

order to alleviate the therapist's own sense of inner emptiness, lack of pleasure, and craving for relief. This fantasy represents a precise projection of the addict's own inner experience. As one supposedly mentally-retarded addict put it succinctly, "You can kill me, but you can't eat me." Both depressives and addicts wish that the therapist were in fact trying to make up to them for what life has perpetrated on them unfairly, because of the therapist's guilt at the patient's suffering. This is in contrast to the hysterical and obsessive-compulsive characters described above.

A related clinical problem is that of the patient who has suffered a *parent Joss* either during or before adolescence. In such a patient there is an arrest of development at the point of the loss." This appears in the form of (a) various forms of denial of the loss, or (b) recreating, by living out in the transference, some aspect of the relations (real or fantasied) from the time preceding the loss. Frequently the patient's way of life subsequent to the loss has been totally organized around resisting acknowledgment either of the parent's death or its significance. This often is manifested in therapy by the patient's propensity to leave and then return. We understand such behavior as an effort both to flee from the recognition of the painful longings that have been reawakened in the transference and, simultaneously, to master the trauma of the loss by turning passivity into activity through leaving and returning. The therapist needs to exercise flexibility and patience in order not to confront the patient prematurely with the pain he is denying. In this way,

the therapist allows himself to be used as a real object for the purpose of helping the patient experience a missing developmental relationship. We regard as an important curative factor in this treatment the patient's recognition that he *is* being treated in a special way; he correctly perceives this as the therapist's effort to make up to him for the blow that life has dealt him.

Paranoid Characters

With paranoid patients, the task is the opposite of the way in which one works with depressives—namely, one helps a paranoid individual realize his passive longings beneath his presenting attitudes of self-sufficiency and arrogance. This is a delicate task, because a paranoid individual, when confronted with such issues, becomes intensely anxious and prefers to hold the position that he needs nothing from anyone. He experiences any awareness of longing with humiliation and fear of annihilation, which may be specifically experienced as castration anxiety. In addition, he frequently has the potential to react to such a frightening possibility with violence. The therapist is frequently puzzled by the fact that such a patient continues to come, since he seems to do so for the sole purpose of using the therapist as an object of contempt. In addition to the therapist's fear of the paranoid's potential for violence (and his aversion to being the object of contempt), there is little gratification in any other aspect of the treatment as well, particularly

when the patient cannot admit directly to feeling any relief as a result of coming. Thus, like obsessional patients, the paranoid patient also makes the therapist feel the way the patient does: helpless, vulnerable to humiliation, and afraid of violence.

Frequently the crucial psychotherapeutic method with the paranoid character is to let him maintain his distance from the therapist, who is experienced as an authority figure whom he consciously holds in contempt while denying his strong unconscious attachment. Enormous patience while awaiting the occurrence of very small changes is crucial with such a patient, because he is prone to believe that the therapist will exploit any progress he makes for his own pleasure. The therapist's patience enhances the possibility for identification with the therapist and his self-control.

There is a group of patients in this category whose primary symptomatology we call *true hypochondriasis.* They respond well without medication despite the fact that they are on the spectrum of extremely serious disturbance, between suicidal depression and paranoid schizophrenia. We are excluding from this group those patients who are basically hysterical, with multiple complaints that are usually amenable to suggestion. We are also excluding patients whose narcissistic personality disorder makes them vulnerable to a reversible hypochondriacal regression (see p. 203). Our approach to these patients is to legitimize and dignify their

suffering by taking it extremely seriously; however, the price for this is our demand that they continue functioning. They have usually been told either that their pain is imaginary or that it is the result of emotional conflict; both of these comments humiliate them. We do not take either of these positions. Instead we offer explicit verbal acknowledgment that their suffering is indeed as severe as they say, no matter how grandiose their claim may he. When they believe that we are sincere, we are then able to take the next step of empathizing with their distress when they realize they must nevertheless carry on their daily activities.

When these patients begin to function better, our experience has been that it is an error to reveal any pleasure we might feel at their success, because this often results in an exacerbation of the symptom. In addition, we encourage them to continue therapy past the time when they are less troubled by their complaint.

We have no adequate theoretical understanding of the primary symptom in these patients, although their separation anxiety is prominent if they are confronted with our pleasure at their loss of the symptom. We are able to find evidence to support either of the two hypotheses with which we are familiar. The first is Freud's, that hypochondria represents the patient's effort to theorize about an internal state in which object representations have lost their investment of psychic energy for the patient, and "objectless libido"

is instead attaching itself to body organs. The second hypothesis is Rado's, that hypochondria is a symbolic expression of unconscious guilty fear of punishment for a variety of sins. Our own hypothesis is a partial one, based on an overt characteristic behavior of therapists who have treated such patients successfully. When they describe to us the effort involved in convincing the patient that his suffering is comprehended, they often chuckle sarcastically. We infer this to be their sadistic response to a patient with whom they have previously behaved in a way that convinces the patient that the therapist is suffering along with him. In addition, the therapist has listened to the endless recital of the patient's complaint. Thus, we infer that the therapeutic effect comes from a pleasurable discharge of hostility for the patient, and that the effect is maintained when the therapist neither retaliates, nor takes pleasure for himself as the patient improves, nor interferes with the patient's pleasure by interpretation.

Another particular subdivision of the group of paranoid characters is the one we call *schizoid characters.* Such a patient is intensely dependent. He protects himself against these dependency longings—which are an even greater threat to him than they are to the paranoid patient—by maintaining emotional distance, with a sense of isolation and detachment. The therapist frequently reacts to the schizoid individual's unconscious attempts to infect him with the patient's fear of his own longings and consequent fear of disintegration under their impact. The chief difference between such a patient

and a paranoid is that the latter is expressing a fear of his own violence and engendering a defensive reaction or counter-fear in the therapist. The schizoid patient is instead afraid of his own intense libidinal demands, which again provokes a defensive reaction in the therapist. As a result, the therapist may feel little gratification from working with such a patient, because of the belief that his importance to the patient is nil. Such a therapist is avoiding the awareness that behind the wall of isolation and detachment, the patient actually is intensely involved with him.

We view *borderline characters* as a decompensated form of a previously stable schizoid state. We believe this decompensation occurs after the patient has been frightened by a close relationship with a potentially gratifying and frustrating object. The result of such closeness is that the patient's ego has been flooded by primitive impulses, both sexual and aggressive. This is a reexperiencing of the traumatic circumstances of the patient's childhood. Formerly the patient had adapted to that state by withdrawal and distancing. Now, however, that earlier adaptation is abandoned and a further regression occurs, accompanied In a specific loss in the function of reality testing. For such patients, the acute episode should be managed in the way described in the following section on schizophrenic reactions. During the interim phase the treatment approach will differ, depending on whether the patient presents a stable schizoid character or whether paranoid, hysterical, or anaclitic depressive features are dominant.

Schizophrenic Reactions

We are in agreement with the current prevailing view, that schizophrenic reactions probably represent a response that is differentially available to many people. We further agree that there is a core group throughout the world for whom the genetic contribution is sufficiently powerful to result in a predisposition toward schizophrenic reactions in the face of stress. The psychotropic drugs, by reducing the disorganizing effects of anxiety on the thought processes, have been extremely useful in re-socializing a large number of these core group patients. However, we address ourselves here to therapists who are specifically interested in the psychotherapy of schizophrenics beyond the extremely important but limited goal of getting them to function outside a hospital. Our opinions are based on personal successes and failures that are appropriate to this framework of "folk wisdom."

For such patients, the disorganizing effects of acute anxiety may be countered by the therapist's willingness to be available at times outside the regularly scheduled office appointments, rather than by the use of medication. During the acute phases of the illness it is important to help these patients learn that behavior occurs in sequences, and that minor grades of anxiety frequently pass unnoticed because they are immediately followed by characteristic defensive activity. When powerful feelings such as rage, guilt,

or fear have been part of the sequence, the patient is better able to regulate these tensions when they are identified with the therapist by the use of words. As a consequence of viewing behavior as occurring in sequences, the patient may begin to substitute psychology for morality as a frame of reference. This substitution again is made possible when the patient identifies with the therapist's value systems, and can move from notions of good and evil into the understanding of anxiety as a prime mover in human relationships. This procedure enhances identification with the therapist and sanctions covert dependence on him.

During the periods between crises, schizophrenics induce feelings of helplessness and inadequacy in the therapist by their fear of their vulnerability to the frustration of emotional involvement. If they are treatable by psychotherapy at all, they make themselves available by trying to live up to what the therapist wants and expects of them. They make such a commitment with great ambivalence, because they greatly fear failure of any kind; its resulting shame devastates them. Thus their commitment to treatment is so inconsistent that it effects their ability to communicate thoughts and feelings in a way that the therapist can readily follow. Unlike the situation with the obsessional, where the therapist frequently has the conviction that the patient w ill destroy his understanding as soon as it is uttered, despite its correctness, the therapist has an endless sense of groping with the schizophrenic. Our experience over a number of several-year courses of

successful outpatient treatment of different schizophrenics has been characterized by the following: (1) no anticipation of termination; (2) complete honesty on the part of the therapist about his own emotional reactions to the patient; and (3) explicit verbalized faith that the patient will eventually function adequately—which is no contradiction to (1) above. Following such a period, a schizophrenic may reveal the secret pleasures of his existence, the foremost among which may have been the pleasure of having frustrated the therapist to the point of helplessness, as he himself had always felt defeated and humiliated.

Manic Depressive Reactions

Our position in regard to the etiology of this illness is the same one we held, above, in regard to schizophrenia, with this difference: lithium carbonate seems more precisely useful in decreasing the sense of internal pressure that ushers in the manic phase than do any of the psychotropic drugs in controlling the disorganizing anxiety of acute schizophrenia. We have a verbal report from one experienced psychotherapist who finds that lithium is useful as an adjunct because it "damps down" the patient's libidinal, aggressive, and narcissistic (grandiose and exhibitionistic) tensions, thus making it easier for the patient to collaborate in serious psychotherapy.

Our own experience in psychotherapy with manic patients provides us

with the following tentative formulations. Preceding the onset of a manic episode there was always, in retrospect, a specific instance of adaptive failure, followed by a feeling of emptiness and despair. Then there was a downward spiral in response to unrealistically severe self-punitive tendencies that destroyed the patient's selfesteem still further. The manic episode that followed was characterized by attempts to deny his shame by striving for grandiose achievements. He attempted to accomplish this by various forms of extreme behavior, often of a tremendously provocative nature. The purpose of this provocativeness was to force others, especially the therapist, to become indignantly angry, defensively set limits, and reject the patient, thus behaving in compliance with the patient's projection onto them of the patient's self-punitive superego.

We have no way to decide at present whether or not this exaggerated reaction of our patients, which seems to be the essence of mania, is constitutionally determined. One reason why this question is difficult to answer is that these patients uniformly deny the existence and the significance of any psychologically meaningful events, such as the prior adaptive failure mentioned above. The result of this denial is to increase the puzzlement of the therapist who is trying to treat the patient etiologically by understanding the biological and psychological threads of his behavior. Such patients are empathically in tune with the therapist's ego-ideal. Therefore they are able to exploit his discomfort when he cannot meet his own

standards and avoid becoming provoked or confused by the patient's behavior. This is in contrast with the schizophrenics, who take a more detached attitude toward the therapist's ambitions; they have been so thoroughly defeated in the past that they are less willing to attack directly than are the manic patients.

Narcissistic Personality Disorders

These patients are described in several publications by Kohut (1968; 1971), who emphasizes their suitability for psychoanalytic rather than psychotherapeutic treatment. Although we agree that psychoanalysis is the treatment of choice for them, we have several reasons for including them in this chapter. First, in our experience, every psychotherapist is confronted not only by narcissistic personality disorders as such, but also by identical narcissistic problems within a number of other conditions as well. Second, the diagnostic criteria that simultaneously indicate the presence of the pathognomonic narcissistic transference and guide the therapist in treating it are as evident in psychotherapy as in the "trial analysis" that Kohut recommends (1971, p. 4). Third, our experience has been that psychotherapy provides these patients with symptomatic relief, which, while it falls short of the results we have seen from the psychoanalysis of similar cases, nevertheless provides many patients with results that satisfy them. It achieves this primarily by providing the patient with an opportunity for a

stable, narcissistic transference. The patient's self-esteem is restored by means of this transference, through the use of the therapist either as a "mirror" or an "idealized parental image." The use of the therapist in each of these ways represents a reactivation, in the transference, of a particular developmental phase in the patient's life that had been cut off from normal maturation. If it is a "mirror transference," then an archaic, grandiose self-image has been reactivated. If it is an "idealized parent" transference, then a somewhat later, hut still very early, merging relationship with a "perfect" admired parent has been reactivated.

In Kohut's framework, the normal developmental sequence from infantile to adult narcissism is as follows. During the first two years, "the child's original narcissistic balance [i.e., feelings of euphoria and perfection] . . . is disturbed by the unavoidable shortcomings of maternal care, but the child attempts to save the original experience ... by assigning it, on the one hand, to a grandiose and exhibitionistic self-image: the (cohesive) grandiose self; and, on the other hand, to an admired you: the idealized parent imago." (Kohut, 1971, p. 86)

"Under optimum developmental conditions, the exhibitionism and grandiosity of the archaic grandiose self are . . . tamed, and the whole structure ultimately becomes integrated into the adult personality" (Kohut, 1971, p. 87). There it is manifested by our healthy ambitions and the self-

confidence to achieve them; enjoyment of our activities; humor, characterized by an ability to laugh at our own shortcomings; empathy; and important aspects of our self-esteem. "Under similarly favorable circumstances, the image of the idealized parent also becomes integrated into the [healthy] adult personality" (Kohut, 1971, p. 87). It provides the sense of pleasure we derive in obeying the dictates of our conscience as well as in living up to "the guiding leadership of its ideals." Eventually it provides us with the capacity for a mature form of admiration for others, and for enthusiasm about our own achievements.

Kohut describes the developmental sequence of the future candidate for a narcissistic personality disorder as follows. "If the child suffers severe narcissistic traumata, (particularly at the hands of parents who are un-empathic, depressed, or self-preoccupied for other reasons), [and thus unable to provide the child with a mirroring, echoing presence], then the grandiose self-image is [unconsciously] retained in its unaltered form [into adult life] and strives for the fulfillment of its archaic aims. Similarly, if the child experiences traumatic disappointments from the admired adult, then the idealized parental image, too, remains in the unconscious [in adult life] as an archaic transitional-object that is sought for, for the maintenance of the patient's homeostasis in regard to tension regulation and self-esteem. When such patients . . . become involved in treatment they form one or the other of a pathognomonic narcissistic transference.

"When the grandiose self is [re]activated in the transference, it is a replica of the way in which the child attempts to retain a part of his original . . . sense of perfection by [experiencing the] power and perfection [of his] grandiose self-image: 'I am perfect,' " (Kohut, 1971, p. 28) and assigning all imperfections to the outside. This occurs in three forms, and Kohut's description of its most mature form, the "mirror transference'' per se, is instructive. He calls it "the reinstatement of the phase in which the gleam in the mother's eye which mirrors the child's exhibitionistic display and other forms of maternal participation in the child's narcissistic enjoyment, confirm the child's self-esteem and . . . begin to channel it into realistic directions" (Kohut, 1971, p. 96).

When the idealized parent is reactivated in the transference, the patient has an experience of the therapist that can be summarized as "You are perfect, and I am a part of you." As Kohut describes it, "Since all bliss and power now reside in the idealized object, the patient (like the child) feels empty and powerless when he is separated from the therapist, and attempts to maintain a continuous union." (Kohut, 1971, p. 37) This can be especially noticeable over weekends when the patient is not depressed but feels empty, drained, and powerless.

For the informed therapy of these patients, it is crucial to grasp that narcissism is *not* the antithesis of object relationships. The fact is that

narcissistic objects are ones with whom the patient is deeply involved. The differences are in the nature of the relationship with the object. For example, when the therapist is a narcissistic object for a patient, he may feel tyrannized by the patient's expectations and demands, and have the sense of not being in control of his own initiative. As Kohut says, "The [patient's] control over such (selfobject) others is . . . closer to . . . the control which a grown-up expects to have over his own body and mind than to . . . the control he expects to have over others." (Kohut, 1971, p. 27) Thus, the therapist may feel himself to be the object of admiration or contempt, rather than of the love or hate that are more likely to emanate from a patient with a "well-delimited, cohesive sense of self, and whose impulses are directed toward . . . objects which have . . .become fully differentiated from the self" (Kohut, 1971, p. 19).

The technical implications of this difference between object-instinctual impulses (love or hate) and narcissistic impulses (admiration or contempt) are exemplified by one of Kohut's patients (1971, p. 252). When his comments were couched in terms of "affectionate longing or angry resentment and destructiveness" toward the therapist, they "fell flat." Progress could be made only when the therapist ceased to regard himself as a separate, distinct person, but rather as a mirroring, admiring parent, an alter ego, or a literal extension of the patient. The progress was manifested by spontaneously confirmatory memories, shifts in self-perceptions (for example, dreams in which machines were replaced by people), and evidences

of an increase in functioning associated with the increase in the patient's self-esteem.

Kohut suggests that idealization is the more usual transference at the start of therapy and that, as it recedes, the mirroring transference may emerge as the more basic one. These patients are particularly vulnerable to a regression of either the idealizing or the mirror transference when the therapist is physically absent, such as over weekends, or emotionally absent, such as in a failure of empathy. There then occur what Kohut has described (1971, p. 97) as "typical regressive swings" to: (a) fragmented and archaic forms of grandiosity (manifested by imperious behavior, affectations of speech, or unrealistic grandiose fantasies); or (b) archaic forms of idealization (manifested by mystical or ecstatic religious feelings such as a merging experience between the true believer and God or some other, more vaguely experienced outside power); or (c) autoerotic tension states (manifested by hypochondria or perverse fantasies and activities).

What many psychotherapists have found and our own experiences have taught us is that these patients respond favorably with amazing rapidity when the therapist explicitly recognizes the effect that his literal absence, or his lack of empathy for the patient's need for either a mirroring or an idealized presence, has had on the patient. Another requirement of therapists treating such patients is the ability to comprehend the primitive

developmental nature of (rather than simply reacting to the contempt expressed by) the patient's vengeful rage at small disturbances in his control over the therapist, whom he experiences as an extension of himself. This rage occurs particularly in the form of over-reactions to small slights, which are experienced as enormous insults. The rage's developmental nature is analogous to the experience of helpless anger when a part of one's own body or mind does not function as one wishes it to.

Another way to approach the difficulty in treating these patients is to understand the vicissitudes of the therapist's own narcissism. These are manifested, in the mirror transference, by the vulnerability of his self-esteem to the demands of a patient who uses him without recognition of his characteristics as a real person. As a result, the therapist may feel bored and emotionally distant from the patient. In the instance of an idealizing transference, the therapist may feel embarrassed by the patient's gross admiration of him. Psychotherapists who can recognize the underlying developmental nature of the patient's needs are better able to tolerate these transferences and to help the patient either terminate in narcissistic equilibrium or go on for further psychoanalytic work.

A brief case vignette from the psychotherapy of a narcissistic personality disorder may illustrate some of these issues, with particular reference to the consequences of a psychotherapist's embarrassment at being

grossly idealized. At the end of the first month of therapy a patient made out his check to the therapist instead of to the institution, as he had been instructed to do by both the billing form and the therapist. The therapist did not endorse it over to the institution and wait to approach the event the following month, with the understanding of the patient's need to idealize him. Instead, he returned the check to the patient and suggested that perhaps the therapist had not been explicit about the need for the check to be made out to the institution. Within twenty-four hours the patient was convinced that the bright red blood on his toilet paper was evidence of cancer of the rectum, although he had had adequate previous experience with his own hemorrhoids to be capable of recognizing the true probability. This kind of sequence characteristically follows a therapist's embarrassment and subsequent lack of empathy for a patient's need to idealize him. In this case the patient's need for a merger with the powerful object (the idealized parent imago) had been frustrated, following which there was a disturbance in the transference equilibrium, with a regression to an "autoerotic tension state:" hypochondria. Subsequently the therapist was able to explain the sequence to the patient in terms of the latter's feeling of loss when the therapist had failed to comprehend and accept the check as an expression of admiration and of the sick feeling that followed this loss. As is so often the case, the explanation was followed by relief for the patient and the spontaneous recollection of his admiration for, desire for closeness with, and wish to be like his father, who

had returned from serving in World War II when the patient was five.

This anecdote also illustrates the problem of differentiating between a narcissistic problem and one in which object instinctual strivings (love or hate) are at issue, on the basis of a single example. Thus the check could be seen as a gift of love, which, when spurned, caused guilty rage in the patient. The rage was then symbolized by the experience of an internal disease. However, the check could also be seen as a hostile act, intended to discomfort the therapist in his relations with his administrative superiors. In that case its return might have been experienced as retaliation, and a guilty fear of further punishment might again have been symbolized as an internal disease. As in any psychotherapeutic situation, the correct treatment derives from a correct diagnosis; and in this instance, the crucial data were: prior evidence for the idealizing transference, the confirmatory memories, similar fragmentation phenomena that occurred subsequently when this transference was similarly disturbed, and the eventual transformation of the patient's primitive narcissistic impulses into more mature ones.

Thus it may be stated that with these patients, the diagnostic criteria that appear during the treatment process rather than during a diagnostic interview are: (1) the pathognomonic idealizing or mirroring transference; (2) the subjective response of the therapist to feeling himself a narcissistic object; and (3) the characteristic forms of more archaic idealization or

grandiosity that occur when the idealizing or mirroring transference is disturbed by a lack of empathy from, or the temporary physical loss of, the narcissistically loved therapist.

Concluding Remarks on the Patient-Therapist "Fit"

In several places we have referred to the therapist's anxiety, which derives from a variety of sources, and to the particular problems that may arise from his sexual or aggressive feelings (see pp. 190-191) or from the vulnerability of his self-esteem (see p. 202). These are background issues that may present occasional difficulties for a therapist with almost any patient. We wish to conclude by suggesting several other considerations that every competent psychotherapist needs to consider about his relationship with particular patients. First, if a patient reminds him specifically of a significant object from his own past life, he is likely to have trouble establishing the optimal cognitive and emotional distance. Second, he needs to he able to empathize with the patient's experiences. If these are alien to him, this creates a problem similar to the difficulty involved when a patient is unable to identify with the therapist's attitudes. Third, there are predictable consequences that follow from the interactions of certain character types. Hypo- manic therapists often do well with depressed patients. Obsessional therapists do well with hysterical patients, if they are not made anxious by the patient's emotional storms; conversely, hysterical therapists often do well

with obsessional patients. In these examples, the therapists are all assumed to be operating from the base of their raw character and its stylistic derivatives in their treatment behavior. It is equally true, however, that a therapist who has faced and integrated the relevant conflicts within himself is in a much better position to empathize freely and correctly with patients who are similar to the way he once was. From such a base he can provide the patient with an object for identification in accord with the basic tenet of this chapter. It has been our experience that the optimal level for this kind of functioning is rarely achieved solely through the educational process, without the help of personal therapy.

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Notes

1 Throughout this chapter we use the word "object" as though it were interchangeable with "person," in the social-psychological sense of a figure in the external world. This is not what we intend. First, we follow the original German usage, in which "object" is distinguished from "subject" and the word therefore has no dehumanizing implications. In classical psychoanalytic usage, "object" refers to feelings and attitudes towards "internal representations in the mind" of figures (including oneself) in the external world. This is of particular importance later on, when we rely heavily on the explanatory power of " identification" to account for the changes that occur in psychoanalytic psychotherapy.