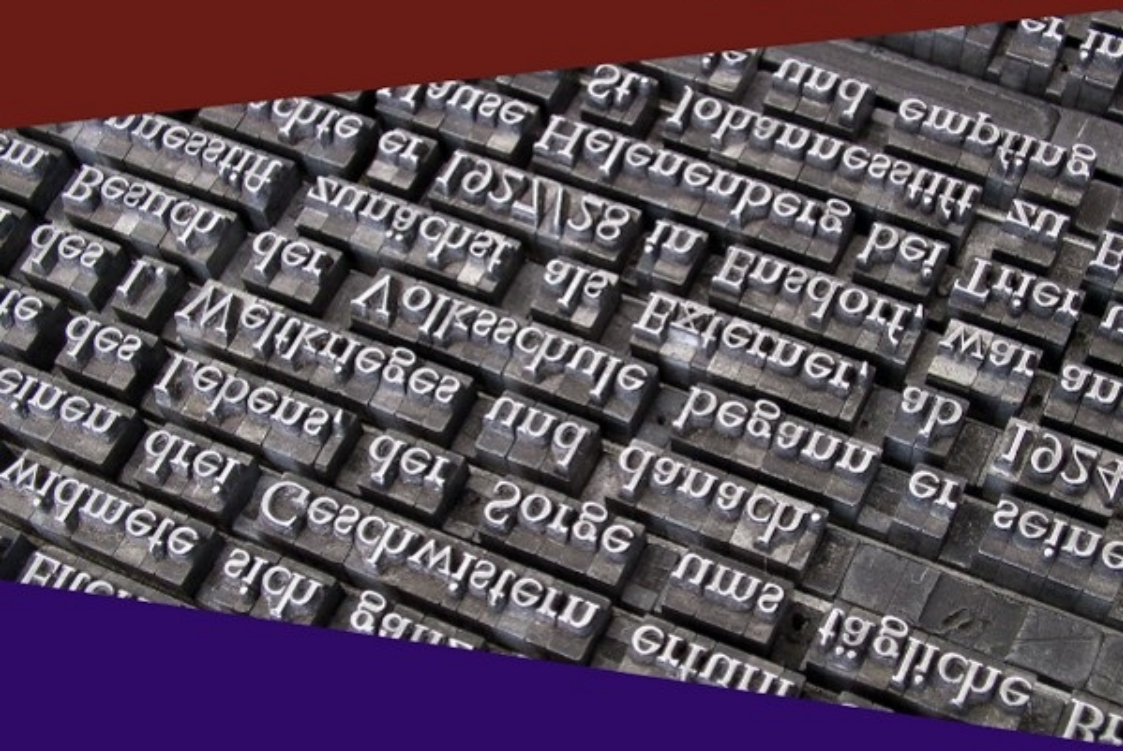
Psychotherapy with Bilingual Patients



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Let us go down, and there confuse their language so that they will not understand one another's speech. For this reason the tower was called Babel, because there the Lord confused the speech of all the earth.

Genesis 11:7-9

I shall be sharing with you experiences with patients of multiple cultural backgrounds and of different languages whom I have encountered in more than 25 years of psychotherapeutic practice in Puerto Rico. Although the English-speaking population in Puerto Rico is small, 30% of my patients are English-speaking and 50% of the 70% who are Hispanic or of other origins have, at one time or another, lived in an English-speaking culture. All of my patients are bilingual to some degree.

Bilinguality in psychotherapeutic practice is not new. Freud recognized bilinguality and sometimes multilinguality in the analytic situation. What is unique, however, is that my patients live in a bilingual society that has a continuous bilingual input: in the streets, over the radio, in the newspapers, etc. Most of my patients are able to start treatment with equal facility in one language or in another.

The birth of language is the dawn of humanity. We are born into a world of sounds. The sound changes to language, the language to communication. If psychotherapy is defined as the intent of changing behavior, feelings, and emotions by psychological means, language is the core of that transference. In the *General Introduction to Psycho-Analysis*, Freud states that: . . in psychotherapy nothing happens but an exchange of words between the patient and the physician. The patient talks, tells of his past experiences and presents

impressions, complaints, and expresses his wishes and his emotions. The physician listens, attempts to direct the patient's thought processes, reminds him, forces his attention in certain directions, gives him explanations and observes the reactions of understanding or denial thus evoked" (11, p. 61).

Thus, Freud establishes that psychotherapy is structured on verbal intercommunication. It is through language that the patient reveals himself to the physician who, in turn, exerts his therapeutic influence upon the patient by the same media. The work of Felix Deutsch on analytic posturology (6), of Sullivan on body language (24), of Jackson, Bateson and Haley on nonverbal communication, and of Weakland on double bind (2) has added significant dimensions to the understanding of communication. Yet, in the final analysis, the psychotherapist and the patient rely on the security of the spoken word.

The security of the verbal arena is not without complexity. Words have both an intellectual and emotional meaning: Few words are devoid of any emotional meaning. The individual's history of the acquisition of a word gives the matrix for the emotional response that is evoked by its use. Words may actually be repressed as concepts disassociated from their meaning.

Differences in the patient's emotional reaction to the recollection of even the most hypercathected objects or events in the environment are revealed by either his use of semi-technical/transitional terms that he has newly acquired or by his use of words that he had early in life—with their personal or family oriented particularities. It is within the realms of sexual, micturative, and evacuative behavior that such highly cathected words appear. At all stages of development the spoken word is cathected differently depending on whether it is said or heard, read or written.

I was treating a professional of Spanish parentage. He was raised in a Spanish-speaking country but had lived in the United States for a few years. He kept talking about *axilas* or arm pits, and gave recollections of an extremely

personal nature regarding his early interest in this part of the human anatomy. He related it to a symptom of anxiety that he experienced while riding in the subway where women stood with their arms on the railing exposing their *axilas*. He went into early recollections of smell, meaning of hair, etc., and seemed to exhaust the possibilities of exploration without any change in his anxiety. After what appeared an exhaustion of the theme, it became apparent that he was always using the technical term *axila* (arm pit), undoubtedly of later acquisition. I asked him if he knew any other word for *axila*; his brusque answer was that there was no other word in Spanish for arm pit. He left it at that. Upon insistence, he reacted with bitter, half concealed rage. I finally asked him if he ever knew the word *sobaco* which is *axila* in autochthonous Spanish. He was silent for a moment, recognized the word, then continued to talk at length about the same recollection that he had brought to previous sessions, now accompanied by body motion and voice fluctuation. The recognition of a personal word and the continual discussion allowed him, in time, to subdue his anxieties in regards to the subway.

I also had a female patient who would use exactly the same word *fundillo*, which in Spanish is a jovial term for the buttocks, interchangeably for female genitalia and anal region. I became aware of this double meaning and its ensuing confusion. She finally recognized that she had never established the word distinction for these parts of the anatomy and further claimed that in her household, even as a child, this "confusion" was familiar. This patient suffered from severe menstrual pains and very severe constipation. After word clarification and therapy, both problems disappeared. With these examples in mind, and the complexity of language nuances, you may wonder how I dared to treat patients in languages which were not mine from the cradle. I was not particularly brave, but was sustained by the knowledge that more than 90% of the psychotherapeutic work done in this country from the thirties to the fifties was practiced in very similar circumstances and with the thickest of mid-European accents. This interest in linguistic studies had a glorious start, yet faded

rapidly from the psychiatric literature, as pointed out by Spitz, Rosen, Ekstein, and others.

Freud's linguistic observations were recorded in “The Psychopathology of Everyday Life” (12). He illustrated mistakes, slips of the tongue and pen, memory lapses, etc. His examples were primarily from slips in a foreign language, as the cases of “Signorelli” or the quotes from Latin verse, etc. He generated the idea that slips of the tongue occurred more in a foreign language. He analyzed many foreign patients, was extremely interested in the translation of his own work, and personally supervised some of his own translations. With such an auspicious start, it is strange indeed that the psychotherapeutic literature is particularly undeveloped in comparative linguistic studies.

After 25 years of experience, I can assess that the therapist practicing in a foreign language can produce very rapid transferential cures which are seldom seen when dealing with the native tongue. After all, God does speak in a foreign tongue. Patients of different cultures and languages are difficult to categorize under sweeping generalities. Yet, residents treating exclusively Spanish-speaking patients on a face-to-face psychotherapeutic situation do not report occurrences of silence. On the other hand, in many classical books, the generality that silences are more frequent in Latin people is expressed. This can be seriously questioned. By analogy, if Latins are loquacious at a social level, they should be garrulous in therapy. Silences, although not frequent in psychotherapy, are very frequent in psychoanalysis and maintain a very profound type of resistance in the Spanish-speaking population. Silences are prolonged and resistive to interpretation or intervention.

Language, on the whole, can be seen as the principal characteristic of the ego in its performance of communication. When the ego cannot perform well in the role of communication, anxiety results. We have cases of neurotic depression, compensatory overreaction and transitional paranoid reactions, mostly from wives of English-speaking executives who ate catapulted both geographically and

hierarchically from the mainland into a Spanish-speaking situation. The psychodynamics of such a situation is very complicated indeed and could include competition with their husbands, anger reactions, etc., but the sudden language change is an added stress in the appearance of the pathology. Strangely enough, complaints are not voiced along the lines of language difficulties. Instead, many complaints reveal an intolerance towards differences of non-human physical surroundings. These complaints do not pertain to the man-made physical environment which would, indeed, be pertinent (breakdown of appliances, lack of adequate services, etc.). Rather, most complaints are noncontrollable areas such as rain, heat, light and lack of non-inhabited spaces.

Some people come into the country with a rationalization regarding the acquisition of the new language. These people keep alive the fantasy of eventually becoming very knowledgeable and efficient in the new language and its literature. Yet, they stress the differences in pronunciation and the usual use of localisms. Their fantasy is that some day they will learn "pure" Castilian, like Oxford English—it is as if a Spaniard going to Minnesota would decide not to learn English until he could go to Oxford, or at least to Boston.

Another example of ego conflict with language difficulties was a patient referred to me from the mainland, who presented, during a short period of treatment, particular language characteristics and ego confrontations. He was a tall, good-looking, amiable, 37-year-old, single, engineer, born and raised in Berlin. He had served in the German Army during World War II, after which he had migrated to the United States, where he had learned English and worked for two years. He had then been transferred by his company to Puerto Rico, and given the customary raise in salary. Although he was unhappy about the transfer, he accepted it because of the raise.

He had been seeing a psychiatrist on the East Coast, who had referred him to us because of insomnia, anxiety, and indecision regarding getting married. The patient started his treatment completely in English, four times a week. After a

short period, he abandoned the island in a state of panic and returned to the United States. Later, when I looked over the protocol, I found two striking things: 1) His regressive behavior at the beginning of treatment was greater than any I have seen in such cases; 2) He immediately started dreaming in German exclusively, his dreams dealing with his previous experience in the German Army. There was no direct day residue, to speak of, detectable in the dreams.

It seems that having only recently carried through such a formidable job of adaptation into the English culture and language, the capacity of his ego was depleted for further adaptive compensation. Upon being faced too rapidly with a second new situation, in both language and culture, he suffered deep regression at a clinical level, and defensively went back to his original familiar grounds every night in his dreams, in an attempt to ease his tensions.

Language preference in psychotherapy is a commanding phenomenon. Many factors influence the acquisition of a foreign language. Studies have been made on preferences of second generation émigrés, identification difficulties, and tendencies to protest the parental figures. Many Puerto Ricans, by reasons of their multiple geographical and cultural upbringings, come very close to bilinguality—a perfect command of both languages.

In Puerto Rican émigrés, rarely does language identification become so clearly and completely categorized as in this case quoted by Greenson, "I would like to cite some material from the analysis of a young woman who developed a great aversion to speaking her mother tongue, German. She described her predicament as follows: 'In German, I am a scared dirty child; in English I am a nervous, refined woman.' As long as she spoke English, her picture of herself was the English-speaking refined lady. The moment she spoke German, her self-image changed, and she became a 'scared dirty child.' The English identity was a screen against the German identity. It served the purpose of maintaining in repression the painful German self-image, as well as offering an opportunity to exhibit a more pleasing aspect of the self" (14, p. 247).

Puerto Rican émigrés, especially the teenagers, go through intense language shifts. In general, I can say that most teenagers, as partial émigrés, would accept only a therapist who was fluent in both languages. The preference shifts at different stages in the therapy. Sometimes it is by deference to the therapist that a language is chosen. In only two cases of prolonged treatment have I seen a definite sequence which sharply demonstrates an analogy with their genetic development. Both cases were females in their late twenties, with social and sexual maladjustments, who had been transplanted to the mainland at around the age of 4½ years. Both had been raised on the mainland up to age 25, and had experienced sharp increases in their socioeconomic position. Both returned to the island from highly paid jobs. Both started consultation and undertook the initial phase of analysis in Spanish, with occasional shifts into English. In both cases, at about the fourth month, they shifted to English completely, remaining thereafter in that language, with very few mixtures. By the end of the third year, they both used English and Spanish interchangeably, and then made a final definite reintegration to the Spanish language.

Language tendencies are selected by patients. Some express their thoughts in what can be called a "progressive insecurity." Example: "It was Monday, no, Tuesday, no, Wednesday," or: "A hundred, two hundred and fifty, three hundred. …" This is in contrast to the patient who will express the same idea in a decreasing type of dialogue. "It was the 23rd, no, the 22nd, no, the 21st…." Whether this gives some inkling into the emotional matrix "progressive or depressed" as characterological aspects should be the subject of further studies.

During a chance encounter, a friend reporting failure in his attempt to establish telephone communication could verbalize this in many different ways, as follows:

I called your house…	and there was no answer.
	they did not answer.
	there was nobody in.
	you did not answer.

the telephone did not answer.

the phone seemed to be out of order.

The choice seems to depend on the *emotional* state involved in the selection.

Strange and complex language usages were revealed by a patient who did not exhibit neologism proper, but who showed new logistics in language usages and word meanings. On a consultation at a V.A. facility, I saw a 22-year-old, single Korean War veteran with a diagnosis of paranoid schizophrenia. This patient's education was up to the second year of public high school in Puerto Rico; he was exposed to very little teaching of English which was followed by a two-year period in the Army, mostly in a Spanish-speaking milieu. Among his many complaints, he mentioned a "pressure on the right side of his head." He had a history of having painted his room totally black where he secluded himself for long periods. He stated that all his troubles were due to the fact that both his father and his brother, who were truck drivers, had their trucks painted red. Now, every time they drove their trucks, he could detect it from afar, which produced feelings of unpleasantness and discomfort. He claimed that if his father and brother would paint their trucks another color, preferably blue, his feelings of unpleasantness would subside. Not knowing really how to proceed, I asked him, I think by intuition, why was it that the right side of his head bothered him (right in Spanish is *derecho*). Immediately he answered, without hesitancy, that right (derecho) was made out of *der* and *echo*—that *der* was really the letters rearranged to spell RED, which was the color of the trucks. At his command was rapidity of both translation, word division, and letter rearrangement, meaning link of the phoneme from one language to another in the middle of a psychotic state. The opposite phenomenon of retranslation of visual stimuli into reconstructed words also occurred.

A Latin female patient[1] in the third year of her treatment revealed a dream. She was married to an English-speaking European and had previously been in treatment for two years in the United States during which she spoke English. The dream was: "I am standing on a balcony in a house by the seashore. The sea has

receded, leaving a big empty beach. As I was preparing to investigate this dream, she exposed a linguistic association that made the meaning of the dream very plain. She said—"sea gone" (marido), *marido* means husband in Spanish. Her husband and her former therapist were both English-speaking, thus the dream in English would be nearly impossible for them to understand. Translated into Spanish, the clarity of the word play is transparent. Her present therapist is Spanish-speaking and, thus, she makes this direct gift of establishing understanding that would be foreign to her former therapist and to her husband. Her father was also Spanish-speaking. Her English world is gone and is being substituted by a Spanish-speaking world.

"Sound language" in the sense of awareness of grammar and syntax is more evident to the child than to the adult. Sometimes, apparently, the foreign word acquires sound meanings which are more feasibly explored in the bilingual situation. Children can imitate foreign utterances more readily than adults. This represents more "sound meanings" than actual meanings. A four-year-old English-speaking girl living in Puerto Rico in a bilingual household was asked what name she wanted to give her newly acquired puppy. She answered rapidly, "*Jayuya*," which sounds like "hau hau" in Spanish, or the English equivalent of "bow-wow." This is the name of a small town in the interior part of the island, which in all probability this little girl may have heard mentioned a couple of times. It seems to be evident that she was struck by the sound of a barking dog, which is present in the word Jayuya.

While treating patients in different languages and adjusting my ear from one language to another at least four or five times a day, I became aware of an impossibility. I was unable to follow if the patient shifted suddenly from one language to another in a word or perhaps a phrase. This is not prominent when "tuned in free floating awareness," "listening with the third ear," or as Sullivan states, "deep in selective inattention" (24, p. 12). The sudden shift left me completely unaware of the meaning of the word or phrase. Usually I could not remember the word or phrase even though it was a completely familiar term. The

sound was completely alien as if I had never encountered it before. After a number of observations of this sort, and certain tribulations regarding my own countertransference in these particular situations, I received personal communication from another therapist in town which corroborated my observations. At the time, I also wondered whether I was subjected to special pronunciations on the part of the patient which would have made it difficult to detect the meaning of the pronounced word. This was not the case at all; such "language unawareness" happens even when treating completely bilingual patients whose pronunciations are perfect in both languages. This phenomenon appears whether the word is a name, title, a familiar phrase, or even a verse. The key to the matter is the fact that verbalization is the message from the preconscious into the conscious and such processes happen within the framework of grammar, syntax, etc., which is particular to each language. Pick states, "grammar and syntax are not something added to the words chosen, but a matrix into which the words are embedded." It follows that one is, so to speak, tuned in to a certain grammar and syntax; the falling of a communication from a foreign language into such a matrix would be lost to understanding. "Deverbalization precedes verbalization," as stated by Rosen (21, p. 471). The same thing happens in the patient when faced with the task of free association: "the patient regresses to earlier stages of communication." The therapist on his own, when faced with the task of listening with his "third ear," regresses also and his deverbalization processes happen in a subconscious state of mind. If we see a patient or meet a person who by physical characteristics we expect to speak in one language and who does the opposite of what we expect, we suffer a similar sense of disorientation. I want to point out that the same feeling of loss does not happen in social conversations when our interlocutor shifts suddenly to a different language. Somehow the selective "third ear" never emerges in the nonprofessional situation and thus this particular idiosyncrasy never occurs.

The matrix of continual verbalization is characteristic of mothers taking care of infants in a Spanish-speaking culture. They accompany their child-rearing

practices with a continuous verbalization during the process of food preparation, diaper changing, etc. This is in contrast with the historical case quoted by Edelheit, “Salimbene, in his twelfth-century chronicles. He describes a linguistic experiment that has been made by the Emperor Frederick III: ... he wanted to find out what kind of speech and what manner of speech children would have when they grew up, if they spoke to no one beforehand. So he bade foster mothers and nurses to suckle their children, to bathe and wash them, but in no way to prattle with them or to speak to them, for he wanted to learn whether they would speak the Hebrew language, which was the oldest, or Greek, or Latin, or Arabic, or perhaps the language of their parents, of whom they had been born. But he labored in vain, because the children all died. For they could not live without the petting and the joyful faces and loving words of their foster mothers” (7, p. 409). Continual verbalization is also necessary in taking care of catatonic regressed mute negativistic patients. If the nurse or attendant keeps communicating during the minutiae of their activities around the patient, it is an observed fact that the patient’s response is better.

The child, not only imitates the mother's tongue, gestures, etc., in the prestages of language, whether in the first stage of echolalic repetition or in the second stage of naming, really communicating conceptual language. He also imitates all the other noises in the house, animals, cars, wind, seashore, etc. With the advent of popularity of radio, TV, phonographs, and tapes, sometimes on during the whole day and part of the night, children of today are subjected to a barrage of noises that at some level constitute an example of overstimulation or “emotional overload,” according to Spitz.

Dream phenomena, whether in one language or another, have, in my experience, not presented themselves readily to cultural distinctions. Their composition of elaboration, symbol formation, and the aspects of the day residue are similar. I have been unable to assess the much valued and expressed idea of dreaming in Spanish, dreaming in English, or dreaming in German. Except for a few exceptions, verbal utterances are usually indistinguishable and confused.

When thoroughly explored, the patient is seldom sure about the language of utterances, thus pointing out the power of secondary elaboration and to the presence of perhaps some functions of the consciousness mind which seems to be very resistant to any influence by the subconscious. As I expect some arguments on this observation, I want to make it clear that if I were to quote dreams from my protocols, I do not see how anybody could appoint them to English or Spanish patients except by guessing.

There is, in my experience, examples that show a difference in the culture but because of the lack of statistical value I am hesitant to communicate them. I do so only in the hope that it will stir some discussions and observations from other sources. In a few instances, some Spanish-speaking patients discussed what I call “mini-dreams,” which were uttered in the shortest way possible. There does not seem to be a counterpart in English. The smallest meaningful word, almost a phoneme, constituted a whole dream. I am purposely avoiding the word condensed as there is a question in my own mind as to whether these particular dreams are the product of hypercondensation. Do these dreams pertain to the interminable as far as dream exploration and analysis are concerned or do they represent a special direct utterance from the unconscious with very little elaboration or dreamwork? These “mini-dreams,” or psychotherapeutic snapshots, usually were revealed in the second year of treatment. Dreams such as a name, a word, a neologism, were reported as "night,” or “raining.” The best example was a patient in his second year of treatment who had a dream of “ants.” He was, by then, well oriented in reporting dreams, developing associations, and analyzing them. In his particular dream he could say very little—just “ants.” He did not know whether he had seen or felt the ants. As an association, he said, “crablice.” He then proceeded to talk at length of the significance of this in his sexual development. This same patient had had another dream with an “ear” which I again consider within the range of a “mini-dream.” Mini-dreams have also been in sequence repeated with a change in only one word. A patient in his second year of treatment had, within a span of two

weeks, dreamt of the following sequence: first dream, “I was walking with an erect penis”; second dream, “I was walking with an ‘inspoon’ (ponzoña)”; third dream, “I was walking with a small knife.”

I come at last to perhaps one of my most controversial statements. It has been my experience that bilingual patients, though not particularly loquacious, do present a great avoidance of the expression of verbal aggression in the therapeutic situation. Direct verbal expressions of anger are practically nonexistent. Even the raising of the voice is rare. The panting, raving patient is an infrequent occurrence. Patients are usually extremely polite. Even indirect verbal expressions of anger, long tirades against psychiatry, commentaries on adverse publicity, etc., are unusual. The use of foul language, even when encouraged, proves a formidable barricade. Quoting disparaging remarks about the therapist is done with extreme hesitancy. Nevertheless, indirect expressions of anger are evident: wanting more time, delaying payment of bills, accidentally throwing ashes on the rug, stumbling on chairs, banging doors when leaving, etc., are indeed to be found. What is worthy of consideration is that, upon very careful evaluation, it is evident that English-speaking Anglo-Saxon patients who have lived in the local milieu for some time acquire similar characteristics.

Rothenberg (22), Fernandez Marina, Mehlman, Ramirez de Arellano, et al,, (10), Maldonado Sierra and Trent (19), have commented on aggression in Puerto Ricans, hyperkinetic-like seizures, musculoskeletal expression of anger, rage, etc. —the so-called Puerto Rican syndrome. It seems to me that these superficial differences in dealing with aggression (I consider them “self” characteristics rather than ego characteristics) can be better explained by the smallness of the local geographical situation and population characteristics, the immediacy of the relationships (by familiar groups) and the inevitability of neighbors. A verbal insult could realistically establish an eventual vendetta. It is easy to insult a neighbor whom you do not see often or will never encounter again. But to do that with somebody whom you are sure you are going to meet twice a day, 365 times a year, is different. This would lead to tremendous amounts of pent up rage and

could only be released by the musculoskeletal expression, always of a psychotic-like flavor.

Rosen states that, “the prestages of language are seen as a development of a systems of signals between parent and infant,” and later, “in the gestural system, the development of forefinger pointing is said to be a milestone in human evolution” (21, p. 479). It would seem to follow then that the increase of gestural language or its reappearance in psychotherapy could be either a sign of regression and a deeply embedded type of defense or an actual part of the self. The perseverance of sign language, gesture language, pointing, etc., could be interpreted as a lack in command of exclusively verbal communication. We know that verbal communication is always accompanied by certain aspects of gesture language, modulation, pitch, accent, etc., which form the core of the communicative process. Again, patients submitted to the bilingual situation, but more frequently Spanish-speaking patients, have a tendency to keep their hands occupied during the therapeutic session with toothpicks, lighters, pieces of paper, bags, etc., which are kept in their hands, caressed, played with, etc. This method of keeping their hands occupied makes gesturing difficult and complicated to assess. The patient submitted to the bilingual situation has a tendency not to express verbal hostility easily. He tends to be too courteous or correct. Keeping his hands occupied assures him that even in extreme bouts of anger, the hands will never be used for the expression of anger.

Patient behavior in Puerto Rico is markedly distinctive. The tendency of patients to use language proper as a resistance—almost as a weapon—is evident. Some resistances are of content, and others are of form. By the latter, I mean that patients tend to talk in the plural or in the present tense when recollecting, or they use crutch words like “then” and “and” to start every sentence with a phrase such as “I am thinking,” or “it comes to my mind,” etc. These resistances are sometimes impervious to exploration or interpretation. In a few cases, this resistance is maintained through the entire process of treatment. This occurs in English and Spanish speaking patients under treatment who are intensely

subjected to a barrage of bilingual stimulation of radio, TV, newspapers, billboards, directions. Then, the question arises, if their mother tongue is continually subjected to the continuous attack by the bilingual milieu, could defensive maneuvers be raised inadvertently in the native tongue, which appear as resistances of form in the psychotherapeutic process? I am particularly impressed by the imperviousness, the duration and the almost complete opaqueness to interpretation of these real strongholds of defense.

Patients tend to use incognitos such as “my friend” persistently. Proper names are rarely use. Without consistent insistence by the therapist, identification of places, persons, and sources of opinions are rarely given. Patients express themselves in such terms as: “people say,” “one does,” “we do,” “we want,” “we think,” “I am thinking,” “I think,” or “what comes to my mind.” These phrases are repeated cacophonically by patients for months as an introduction to every paragraph. The usage of the past tense, “I was thinking” or “I thought,” precedes the appearance of the “I think.” Starting sentences with prepositions is a type of verbal defense of great consistency. Patients also use “I don’t remember” as a form of defense. Ironically, “I don’t remember” is a formidable denial of recollections and yet it is expressed as if it were a positive attempt at recollection. Patients also tend to start a paragraph with “for example”— examples are not the product of free association.

I find, in borderline Spanish-speaking cases and in narcissistic personalities, the presence of a type of verbal resistance that is extremely difficult to overcome. The patient will repeat in an echolalic form every intervention of the therapist before responding to it. I am talking specifically of material presented to stimulate association. Before the patient gives any association to the stimulus, he repeats it, usually slowly— whether it is a word, a phrase, part of a dream, or part of a sentence. The therapist must be aware that this is a resistance that can be interpreted as a very positive identification with the therapist. When encountered at the beginning of treatment, it seems a manifestation of a budding positive transference. It seems like an expression of

interest, eagerness, and responsiveness. Yet it is a resistance and becomes even more evident when dealing with dream material or even when the therapist's intervention is a repetition of the last word or phrase of the patient. In some cases, the resistance is totally impervious to interpretation and demonstration. I have not seen it in neurotic patients in therapy except at the very beginning. We can theorize that this resistance is a demonstration of an ego defect. The word pronounced by the therapist cannot be received or accepted as a representation of an object or even as a transitional object to respond to. As long as it remains "in the voice of the therapist," it is a strange object to which the ego cannot respond. As the patient pronounces it with his own voice, he makes it his own by placing it in his mouth. The word or phrase as a representation of an object becomes part of the patient's ego or is at least positively cathected. It becomes less menacing and thus his own thoughts and words can come forth and be linked to the ego sound, ego word, and ego phrase. I have seen this happen in some neurotic patients on the couch but it disappears when pointed out and interpreted.

In borderline patients this resistance to words of the therapist is impervious and I have seen it persist in patients who have been in treatment for two to three years. In general, verbal resistances, even when carefully pointed out and analyzed, reappear in the course of the treatment. They become good means of judging the awareness of the transference situation or the stage of the therapeutic alliance.

Sharing experiences is to start the dialogue. I consider dialogue to be both a "hope" and an "end." Purposely then, our dialogue has its beginning.

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Note

1 Due to the limited geographical reality in Puerto Rico if you disqualify for treatment every person that you have met or that knows about you, your practice would become nonexistent. Therefore, because of this reality factor and possible feedback, great liberties have been taken with the rearrangment of personal data. On the other hand the geographical limitation and social inevitability provide us with a built-in follow-up system which proves a deterrent in self-aggrandizement and provides humble and cautious evaluation of therapeutic results.