

Closeness and
Distance in Psychotherapy

NEAR AND FAR

Martin S. Livingston, Ph.D.

NEAR and FAR

CLOSENESS AND DISTANCE IN PSYCHOTHERAPY

By
Martin S. Livingston, Ph.D.

CONTENTS

• 1 • THIS IS NEAR AND THIS IS FAR.....	3
• 2 • THE ROOM	13
• 3 • SPECULATIONS ON TREATMENT OF MASOCHISM AS AN EGO DEFENSE	28
• 4 • WORKING THROUGH IN RELATION TO MASOCHISM AS A REFUSAL TO MOURN	40
• 5 • HATE, LOVE AND THE HUMAN CONDITION (A PSYCHOANALYSTS REFLECTIONS UPON READING ROMAIN GARY'S <i>WHITE DOG</i>)	51
• 6 • CONTENDING WITH CONTEMPT (CONTEMPT, MASOCHISM AND WORKING THROUGH)	61
• 7 • SOME THOUGHTS ON WORKING THROUGH IN THE LIGHT OF MY GRANDFATHER'S DEATH.....	76
• 8 • ON STRUGGLING TOWARDS TERMINATION	84
• 9 • ON BEGINNINGS	88
• 10 • ON BARRIERS, CONTEMPT AND THE CONCEPT OF THE "VULNERABLE MOMENT"	91
• 11 • JONATHAN AND THE PSYCHOANALYTIC TORCH (THOUGHTS ON THE SUPERVISORY PROCESS).....	122
• 12 • MANNIE.....	135
• 13 • OFF TO CONNEMARA (A REPETITIVE TALE OF RESISTANCE, RESENTMENT AND REFUSAL TO MOURN).....	139
• 14 • RECALCITRANT WORKING THROUGH, NARCISSISM AND THE QUEST FOR IDENTITY ..	150
• 15 • SPLITTING, PROJECTIVE IDENTIFICATION, AND CONTAINMENT AS COUNTERTRANSFERENCE ISSUES IN THE TREATMENT OF BORDERLINE PATIENTS	181
• 16 • MIKAIEL AND MESHA (An Addendum)	225

• 1 •

THIS IS NEAR AND THIS IS FAR

Psychotherapy, like life, is inherently a rhythmic pulsation of closeness and distance, of near and of far. Looking back over thirty years of studying and waiting about the psychotherapeutic process, I recently realized that the underlying focus of my journey has been an attempt to come to terms with two sets of paradoxically opposed human needs: From birth to death, we all, in our deepest hearts, yearn for love and connectedness. Yet, also from birth to death, we all, again in our deepest hearts, yearn for individuality and freedom. The two yearnings appear to be bipolar and opposed, still they are intimately interwoven. The development of a cohesive separateness—of a sense of individual identity—cannot proceed in a void.

Many recent psychoanalytic writers, including Mahler (Mahler et al 1975) and Kohut (1971), have described the need for a symbiotic relatedness as a formulation for individuation. Kohut, in fact, describes a lifelong need for empathic ties with self-objects in order to nurture self esteem and a sense of identity. Ulman and Brothers (1988) state, even more clearly, that trust in self-object relationships is the very “glue” which allows a cohesive self to develop. They describe damage to such trust, as, for example, in incest trauma, as threatening to produce fragmentation (the dissolution of the organized cohesive self) unless efforts at restoration are successful.

On the other hand, true closeness and intimacy are only possible when the individuals are separate enough to recognize each other's individuality. In fact, in order to be a good-enough mother or self-object in the sense we are talking about (that is to provide sufficient stability and nurturance within a close empathic relationship), a mother must be enough of an individual with her own separate cohesive identity. Separateness allows closeness and closeness

allows individuation. A lack of either ingredient becomes problematic for further development of both abilities.

As I realize how important this dimension of near and far is, both developmentally and in the therapeutic process, I am reminded of my then-teenage son's rediscovery of Grover (a character from the very popular "Sesame Street" television show of his childhood). Imitating the character's mannerisms and his voice, my son repeatedly illustrated Grover's conception of near and far to anyone who would pay attention and it was almost impossible not to do so.

Standing at a distance, he would state; instructively: "This is far." As his listener looked in his direction, he would come closer and declare with some enthusiasm, "This is near." Then he would suddenly dart to the furthest point readily available and call, with mounting excitement, "This is *very* far." Finally, as his audience began to warm up to his humor, he would approach once again. This time, with great exuberance, he would get intrusively as close as he could, and, still maintaining his Grover-like intensity and simplicity, exclaim in an imposingly loud voice, "this is very near." He delighted in continuing the game as long and as often as new "pupils" appeared. It was very funny, if at times repetitious and uncomfortable.

I remember it now, about ten years later, very vividly, and occasionally find myself using it in a therapy group to stimulate an awareness of patients' needs for closeness and for boundaries and distance. It has a definite sense of life and meaningfulness in my recall. I think that must be because; the preschoolers watching "Sesame Street", the teenager reliving that experience, and adults in psychotherapy groups are all engaged in the working through of conflicts surrounding closeness and distance.

Even in my writing, I am aware that I tend to shift from a near-sharing of personal experience (as I was doing here), to a far-position of theoretical conceptualizing as I will do in some of the papers later in this book. As with closeness and distance in a face-to-face setting, I believe there is a need for both aspects in a learning process as well. Near experience sharing stimulates and conveys attitudes and feelings as well as information. Far experience sharing provides perspective and allows a conceptual framework to be developed. Theory helps to organize experiences into meaningful patterns; however, it is of most value if it enables the clinician to return once again to his face-to-face experiences with an enhanced ability to be present and to be a participant in the process.

At this point I would like to underline the importance of near and far as a central dimension within the psychoanalytic process itself. From a classical analytic viewpoint, psychotherapy centers around the establishment and working through of transference distortions. Resistances are explored and analyzed in order to allow a transference attachment to unfold. Early resistances may tend to relate to the patient's wish to remain far. If he does not experience his irrational wishes to be taken care of and protected, if he does not become attached, then he will not have to separate, to relinquish and mourn these wishes. Once the closeness and deeper derivatives of these wishes becomes conscious, then resistance may relate to the patient's wishes to remain close and not to individuate. So the working through and relinquishing of transference wishes is, in essence, a working through of near and far.

Kohut (1971, 1977) is a good example of more modern thought, especially with regard to narcissistic personality disorders which are much more commonly seen these days than the psychoneurotic personalities with whom

classical technique was developed. He sees the essence of the therapeutic process as the working through of self-object transference, in which the therapist through an intense empathetic connection serves as a missing part of the patient's psychic structure. Through the establishment of this empathic tie and the repairing of breaks (or failures to maintain it), the patient's developmentally-arrested self once again proceeds toward cohesion and more mature relationships. Once again, therapy is a process of closeness and distance. The patient must, like Grover's pupil, learn to live with near and far.

An anecdote from an eastern writer (Trungpa, 1973) is relevant here to highlight further the centrality of the patient's learning of Grover's lesson. The story is of a guru and his disciple. The disciple enters the guru's cave and sits with him. He experiences the guru as a fire, off at a great distance. He is cold and complains of the distance. Then, at another point, the fire comes, like Grover, too close. The disciple screams in fear of being burned. If the fire comes too close, it is too hot and it feels very dangerous. If it retreats to a distance and demonstrates Grover's, "This is very far", then it does not provide enough warmth. Day after day the disciple lives out this representation of his object until he begins to sense that the fire is stationary. It remains in the center of the cave. It is he, himself, who has been moving near and far. Once this transference distortion has been worked through, then he can begin to find, day by day, what Mahler (1975) calls his "optimal distance." The papers that make up this book have been written over a period of more than 20 years. In the final chapter, my focus on closeness and distance is crystal clear. In the earlier papers, I was not aware of the developing theme. Nevertheless, by stepping back now, overall patterns and a cohesive sense of development are clear. I will present them in the order they were written for two purposes: One is that concepts and ideas build upon previous ones, and a deeper understanding of the last—and probably most important—paper, will be

facilitated in this manner. The other value in presenting them in sequence is that my interest in writing, like all the other processes I'm talking about, moves from near to far and back again. In fact, following the most theoretical and conceptually sophisticated paper at the end of the book, I close with an image I awoke with, in the middle of the night, shortly after having finished the paper I just mentioned. I sense that it summarizes most of what I have written (in a symbolic cryptographic way), as well as serving as the forerunner of what is to come. It is a very-near experiencing of a message from my unconscious depths. It seems natural to return to that level of experience at the end of a fairly conceptual period of thinking and writing. It is a beginning as well as an ending. Perhaps, in later years, I will be able to get some distance and further perspective as to its meaning.

Before closing these introductory remarks, I would like to mention a few themes these papers develop and to point out their relevance to closeness and distance. The underlying central theme, perhaps, is the issue of near and far in the countertransference (in the therapist's experience). Classical psychoanalysis places the analyst behind the couch stressing a sense of separateness. From that relatively far position, the analyst can more easily maintain an analytic neutrality and objectivity. That enhances his ability to alternate between free floating attention and the development of an organized understanding of the patient's dynamics. Accurate, well-timed interpretation requires a relative freedom from countertransferential involvement. Returning to a home base of neutrality preserves an accepting, non-judgmental atmosphere within which the patient can experience and, eventually, resolve his or her transferential demands and distortions. Neutrality does not mean aloofness or lack of warm positive regard. The classical analyst, through understanding and accurate interpretation, provides what Winnicott (1965) refers to as a holding environment; however, the stress

is on non-gratification—particularly of transferential (often libidinal) needs. Also, the analyst sees himself as a transferential object (a relatively blank, anonymous screen on which the patient projects his distortions), as opposed to a real object satisfying developmental needs.

The overall thrust of the classical position thus is to avoid "drowning in the countertransference." It cautions against the pitfalls of too much or inappropriate closeness. That is a valuable position and the cautions provided must be well taken. I want to also clearly repeat that the position allows, in fact depends upon, a degree of closeness and caring. It is, still, a relatively far position. It also happens to be the position of my early training (as well as my personal analysis). It provided me with an invaluable understanding of analytic process and is clearly the foundation of the conceptualizations I am presenting. I have found that any theoretical approach which doesn't build from basic psychoanalytic psychology lacks sufficient depth to lead to real working through and structural change. This influence is clearest in my early writing, and it also carries through to my later work, which has been very responsive object-relations theory, and ego psychology (for example, Blanck and Blanck 1974, 1979, 1986) and self psychology (Kohut, 1971, 1977). But, like the guru's disciple, I often experienced myself (both as patient and as analyst) as too far from the fire.

With its observation of mothers and babies, object-relations theory stresses pre-Oedipal dynamics and considers the possible efficacy of closer ties between therapist and patient. In addition to being a transference figure, the analyst also serves as a real object fulfilling developmental needs. He is more available if, like the guru's disciple, the patient wishes to huddle closer to the fire for a time. Stress is still on separation-individuation following Mahler's outline (Mahler et al 1975) of developmental steps; however, also following

Mahler's observations, the process unfolds out of a normal (developmentally-appropriate) symbiotic relatedness. Yet, at the same time, the therapist is seen as "the guardian of autonomy" (Blanck and Blanck 1979). It is quite clear that really meaningful treatment must invoke near and far. It is not a choice of one or the other, but an attuned sensitivity to questions of how close and how distant and when. Flexibility, risk taking, and freedom are needed more than rigid rules or boundaries. Kohut (1971, 1977, 1984) goes even closer to the fire at times. He clearly maintained a separateness and enough of a far perspective to develop what may be some of the most thorough and exciting conceptual breakthroughs of our time.

With that conceptual clarity, however, he clearly emphasizes the essential healing processes in analysis as stemming from empathy and the empathetic tie between therapist and patient. He presents the concept of the analyst as a "selfobject"—a missing piece of the patient's psychic structure. Through the allowing and working through of selfobject transferences, the therapist functions himself. He provides the "mirroring" empathy that was missing in the patient's childhood. The restoration of damaged trust (especially through the repair of breaks in empathy experienced with the transference experience) is the heart of "cure" for Self Psychologists. This perspective, in itself a far experience, provides a framework for therapy, at times to become a very near experience.

The theme of the analyst's need to integrate both near and far, and an interest in countertransference, is clearest in the last two papers of this book ("Recalcitrant Working Through, Narcissism and the Quest for Identity" and "Splitting, Projective Identification, and Containment as Countertransference Issues in the Treatment of Borderline Patients"). There are seeds of it, though, in the earlier papers as well. "Working Through in Relation to Masochism as a

"Refusal to Mourn" is a concise presentation of a basic psychoanalytic formulation of transference and working through. Subtly planted through it is the idea that this mourning process needs to be shared. So, within a distant perspective, I can look back and see that I was trying to find my way closer. In fact, my emphasis on questioning barriers and my interest in analysis of resistances to vulnerability and to the human condition are clearly the germination of these ideas. Masochism and contempt, two patterns to which I find myself returning repeatedly, are, on their deepest level, the use of excess closeness and merging on the one hand (masochism), and excessive distancing and disowning (contempt) on the other, in order to avoid uncertainty, vulnerability, and fears of fragmentation.

Intimately embedded within the paradox of closeness and distance is the human struggle to come to terms with death. Death is the ultimate mystery. It is, at the same time, a return to transcendent oneness and the final separation. The mourning of lost loved ones, as well as other losses (both fantasied and real) that are inherent in growing up, is one of the key processes in psychotherapy. In fact, resistances to growth may all be conceptualized as a "refusal to mourn." Even the basic concept of transference can be seen as a refusal to relinquish archaic wishes and to mourn. Mourning, especially as a therapeutic process, includes both closeness and distance. It involves an attempt to incorporate or introject the loved object—to internalize its qualities and its functions, and then, after (to use Kohut's terminology) transmuting these internalizations and thus making them an integrated part of the self, separating from the loved object. This separation is not total. Close self-object relations (in increasingly mature rather than archaic forms) are needed from birth to death; however, the archaic (developmentally no longer appropriate) objects must be mourned.

In other words, what I want to convey here is that the content of earlier papers appears varied. Yet, if you read them with an alternating near-sharing of experiences and a more-distant conceptual thought process, I believe you will be rewarded with a rich sense of the integration of these poles in the therapeutic process as well as in life itself.

I will close this introductory chapter concerning the therapist's need to be, to experience, and to relate to one's patients from near and from far with a quote from Kohut (1978, page 174): "The capacity for an inner counterbalancing of contrasts, the capacity for integration and synthesis, has always struck me as being one of the most essential constituents of human strength; it is the unifying force that lies at the center of our being—the concealed knot' in the deepest recesses of the personality, to which Goethe once referred in a letter to his friend Knebel. In our professional lives as physicians and as psychiatrists, this strength manifests itself in our ability to remain one and the same, even though we have to apply varying methods in order to adjust to different or changing circumstances." It is this unity or cohesive sense of self that must underlie the analyst's position, be it momentarily near or far.

REFERENCES

- Blanck, G. & Blanck, H. (1974) *Ego Psychology Theory and Practice*. New York, Columbia Univ. Press.
- _____(1979) *Ego Psychology II Psychoanalytic Developmental Psychology*. New York, Columbia Univ. Press.
- ____ (1986) *Beyond Ego Psychology: Developmental Object Relations*. New York, Columbia Univ. Press.
- Kohut, H. (1971) *The Analysis of the Self*. New York, Int. Univ. Press.
- ____ (1977) *The Restoration of the Self* Madison, Conn., Int. Univ. Press.

____ (1978) "Natural Science and Humanism as Fundamental Elements in the Education of Physicians and Especially Psychiatrists, by Henry von Witzleben. Discussion In Ornstein, P. (ed.) *The Search for the Self. Vol 1.* Pages 171-176.

____ (1984) *How Does Analysis Cure?*, Chicago and London, Univ. of the Human Infant. New York, Basic Books.

Trungpa, C.: (1973) *Cutting Through Spiritual Materialism*, Berkeley, Shambala Publ.

Ulman, K. & Brothers, Doris (1988) *The Shattered Self*. Hillside, New Jersey, The Analytic Press.

Winnicott, D.W. (1965) *The Maturation Process and the Facilitating Environment*. New York, Int. Univ. Press.

THE ROOM

In the Spirit of near experience, I would like to share a fictionalized version of my first therapy group. The character of the leader is based upon my co-therapist rather than myself. I guess that when I wrote it (about 25 years ago) I wanted some distance—which, as a new Ph.D., I called objectivity. The other characters are based upon a group of college kids home for the summer. Their struggle to find an “optimal distance” is evident. It is fascinating to see that in this piece, written long before I began to conceptualize about near and far, almost all of the themes I want to develop in later chapters are presented. Narcissistic defenses against vulnerability, particularly contempt as a distancing mechanism, are clearly illustrated, along with the search for closeness and empathy. My intent is that sharing this near material will give the reader a feeling for the “trees.” In the following chapters, there will be ample stress at times on providing a more conceptual perspective and an increasing view of the “forest ” as well.

A Frightening Room

He ambled coolly into the room, his long legs carrying his slender frame smoothly to a corner seat. He sat down, gently pushed his hair back from his forehead, and took out a slightly crushed pack of butts. Without a word, he offered one to the chubby fellow next to him. His whole outer appearance was calm, in fact, indifferent, but inside he was scared and excited. As he held out the pack, all he could feel was an overriding hope that they would like him and a fear that they wouldn't. “My name is Jack, Jack Haines,” he said with as suave a tone as he could muster.

“Mine’s Bud,” answered the chubby fellow with a friendly smile. He seemed so comfortable! Somehow, Jack felt he had to look up to Bud. He knew nothing about him. In fact, from what he could size up, he didn’t seem like much of a ballplayer or even a ladies’ man. Nevertheless, maybe because of the way he seemed to be at home in this frightening room, he made Jack feel one down.

They were both silent. Jack looked around the room and wondered how the hell he had let himself into it. It wasn’t so much the room itself that scared him, as the reason he was there. Not the room itself, but what it represented. He glanced around at the chairs placed almost in a circle and bit his lip as he realized he had chosen one that was more or less in a corner and not really a part of the circle. An arrangement like that made it hard to stay safe. He wanted to get up and run, just as he had done a few weeks ago when he couldn’t face the fraternity bitch session. He wondered if he would ever have the guts to go back to school. It wasn’t that his grades were so bad, just that he felt one down too often. That’s what he hoped to gain in this room—courage to go back. “No, not that so much,” he thought, “as to learn to be one up—to be cool.”

As each of the others came into the room, Jack wondered why they had come. There was Gilbert, short and sort of soft with a high voice. He seemed to be posing as he waltzed in. No need to fear him. Then, there was Ellen, dark haired with soft eyes that betrayed a timidity and gentleness beneath the tough, seductive appearance of her form-fitting Levis and black sweater, which clung tightly to her firmly-shaped breasts. Jack felt a mysterious excitement about her as she sank softly into the easy chair across the circle and glanced in his direction.

Ted and Sally came in together. They seemed to know each other as they chatted quietly and sort of ignored the rest of the kids. From the way Sally

pranced in with her head held high, Jack surmised that she felt one up. Ted, on the other hand, struck him as one of those intellectuals who always tried to be one up but didn't really feel it at all. He was sort of fooling everybody—mostly himself. Jack felt an instinctive alertness. Like a dog catching the scent of his natural adversary, he noted Ted's lithe manner and his quick, sarcastic wit as he described an acquaintance to Sally.

The last to enter the room was Laura, a neat blonde with an overly-sweet manner, who sat herself primly on his left. Her flashing blue eyes seem to suggest a liveliness, but Jack was disappointed at the overly proper way in which she placed her smooth, shapely legs. Her whole manner said, "One up, hands off!"

The whole room reverberated with a long pause. Jack lit another cigarette, his third already and, again, brushed the hair gently back from his forehead. The kids looked across at each other. Finally, Bud broke the silence, "Well, welcome to Kookesville. The men in white will be along in a minute." The group laughed nervously.

It seemed like ages til Dr. Mason came in to get things rolling. He wasn't as tall as Jack, and really seemed rather young. His Texas drawl was relaxed enough, but he wasn't quite the image of fatherly authority that Jack had expected. Once the doctor drew attention to the discomfort that everyone was feeling, and they talked about it a bit, the whole room seemed to relax. Conversation came easily for a while. Bud took the lead and drew everyone into a discussion of summer plans. School was over for a few months, and everyone was eagerly looking forward to a chance to enjoy life with the academic pressures of finals behind them. Even Jack began to loosen up a bit. He really admired Bud though, and wished he could be more like him. He was so boss! Even here in the room that seemed so frightening, this freckle faced

redhead seemed to be right at home. He was majoring in psychology and planned to write a term paper on group therapy in the fall. He certainly knew what it was all about!

As the group talked, Jack looked around the room and wondered what would take place there in the next few months. He wasn't afraid now. He hadn't been in the center. He hadn't been one up like Bud, but then, he hadn't been rejected either. No one laughed when he told them about his not being too popular at school, although he did think he sensed a smile from Ted. He wondered, too, when the doctor would speak up and help them—when he would figure things out and give them the answers they needed.

Before long, the session was over. As Jack rose to leave, he wished the group would stay together longer. He wanted to suggest that they go for a few beers, or, at least, to ask someone. He felt that maybe if he got to know one of them better, maybe Ellen, it would somehow help him feel one up. If only he could speak up!

As Ellen walked off with Sally and Ted, tears came to Jack's eyes. He left the room quickly, without losing his composure. He told himself that it didn't matter, that he didn't care, he fantasied getting Ted on a basketball court where he could show him he was the better man. He told himself it didn't matter, and he bit hard on his lip.

The Icy Pool

It seemed like ages til Wednesday rolled around again. Each day Jack went to the office job his dad had arranged for him. Each day he played it cool and made sure everyone saw him as a one-up guy. He knew that he was well thought of; in fact, several girls seemed to be giving him the come-on. Nevertheless, somehow, he just didn't feel part of the gang.

When he punched out early to go to the group, his hands felt clammy and his heart seemed to be skipping beats. He looked quickly behind him to see if the others had noticed, and slipped out the door. He wondered what the gang would think if they knew that he was going to see a psychologist. Also, he was nervous about going to the group again. Last time, everyone had been new, and it was easy to make small talk. However, somehow, he felt that today, or sooner or later, they would all find out. They would realize that he wasn't as cool as he made out.

When he got to the room it was empty. For a second he thought he had the wrong day. Then he realized that it was only a quarter of. He sat down in the same corner seat and looked around the room. He looked at the empty green blackboard and wondered if the doctor ever used it. He thought for a moment about the book he'd read. It said that patients who come early are usually very anxious and unsure of themselves. Boy, they sure had him pegged! Patients come early because they are over-anxious and concerned with pleasing others and with being liked. "Yeah, that pretty well sums me up!" he thought. It was much easier to be there before the others arrived. Then you could feel like the oldtimer and be one up.

Jack's train of thought was broken when Bud came bounding in, confidence in his every step. He seemed so cool, puffing calmly on his smart briar. "How's the boy, Jack?" he asked, with a vigor that made Jack a bit uncomfortable. "Just fine," Jack responded, barely stilling the "sir" which came to his lips. "How's yourself," he added with an outgoing tone of his own. "I guess I carried it off okay," he said to himself as he nervously brushed the hair from his forehead.

"What's a cool guy like you doing in here with a bunch of psychos?" Bud asked, only half jokingly. Jack wondered what he really meant. It felt good to know that Bud thought he was cool, but the comment about the group made

him sort of uneasy. He chuckled and cracked back, "Here comes the head shrinker now." They both laughed, but Jack felt puzzled beneath his cool exterior.

Jack's "good morning, Doctor," drew a friendly "Howdy," and the wiry Texan sat back comfortably in a soft chair. He pulled up a smaller chair and set his feet on it. Jack nervously reached for his butts as he timidly asked, "Cigarette, Doctor?"

"Thanks, but that Doctor bit is sort of formal. The name's Mike," he replied with a warmth that momentarily caused Jack to lose his practiced indifference and to smile back. This young doctor was a bit of a riddle. Not only didn't he seem to be playing it cool, but he was, in a way, giving up his inherent one-up position. It seemed awkward to call an adult by his first name, especially someone he expect to change him—to help him be one-up. "I'm a people, too," Mike added as if he knew just what Jack was thinking.

The others drifted in, and Jack felt an awkwardness and an excitement as he realized that the only chair left was the one on his left, and that the remaining member yet to arrive was Ellen! A dozen opening remarks ran through his head, but, when she finally arrived, all he could manage was a cool, "Hello there!" She sat down and angled herself somewhat in his direction (or at least he interpreted her action that way). He could feel his heart jump as she seductively crossed her lightly-tanned, well-displayed legs and smiled at him.

Ted was talking, something about his alcoholic father, who never seemed to accept him, but Jack wasn't much aware of anyone but Ellen. Her soft brown eyes seemed to be alive feeling, with compassion and interest in whoever was speaking and also somehow with an invitational glance at Jack just enough to keep him entranced.

Gradually, each of the kids began to reveal a little of themselves and their backgrounds. Jack realized that Bud and he were the only ones who hadn't told much about themselves. Even Mike, as everyone was calling him, was willing to talk about his feelings and attitudes. Of course, Ted's conversation was a calculated attempt at being cool, but the others seemed to be trying to get to know each other.

"How about you, Jack? What's your family like?" Mike asked.

"Just fine, a typical family," Jack replied. He probably would have gotten away with this defense, but Ellen smiled and egged him on.

"Come on Jack, that kind of answer will keep you on the edge of the pool all summer," she said. Somehow he knew what she meant. The room was just like a swimming pool. Some of the kids had jumped in and seemed to find the water fine. They were able to let their hair down and talk about some of their problems. He could see through Ted's phony superficiality, but Ellen had opened up and told how she got thrown out of school after a series of affairs came to the dean's attention. Gilbert had spoken with sadness about his constant unhappiness and his feeling that nothing was really worthwhile. Each of them had at least got his feet wet. Only Bud and he still remained on the water's edge.

"Come on Jack," Ellen urged, "We want to get to know you and we can't if you won't let us." Jack felt that, more than anything, he wanted to jump in, to be part of the group, to take a chance and see how they would feel if they really knew him—but the risk seemed too great. "I haven't any real problems," Jack responded. "A cool guy can't let his guard down," he thought to himself, but somehow he had a vague suspicion that the guard didn't make him feel one up. In fact, if the risk weren't so great, he thought he might drop it a little and let these kids a bit closer.

"Our time is up for today," Mike pointed out. "Let's not expect Jack to jump in so quickly. Don't forget that most of you have been in psychotherapy groups before. That water can look pretty icy to someone who hasn't been in all winter."

The Security Room

Jack found himself taking stock as he walked towards the clinic. Half the summer was over and he still wasn't sure if he would be able to face those damn make believe Ivy-Leagues in the fraternity. A lot had happened in that room and inside him. He felt more comfortable than he had in a long while. It was nice to be heading for the room again. If only he could feel as safe at his job or back at school. Mike was always warm and friendly. Even when he criticized or got mad at someone, and he certainly wasn't timid about letting you know when he was annoyed, you still felt sure he wouldn't throw the guy out. "Boy, if only I could feel that way outside!" Jack thought. "If only I could carry the room around with me for security, sort of like the way that kid in the comics carries his blanket, then I could lick the world."

When Jack got to the room, Bud was already there. "How's the boy, Jack?" he asked.

"Pretty good, Bud," Jack replied. He chuckled to himself as he thought about the first few times he had met this "cool character!"

The others arrived soon afterward and a pretty hot discussion of the advisability of premarital sex relations in college got underway. Bud once again tried to play discussion leader, but Ellen pinned him to the wall. "You know Bud, I'm sick and tired of your acting like you were the doctor. You've been just as great at asking us things and then jotting them down somewhere

in that Goddamned book of yours. Don't you think its time you jumped in the pool already?"

Bud started, but came back smoothly with, "Well, I told you that I felt that in certain cases sexual intercourse between unmarried students might be advisable if they considered the consequences and that in many cases—" "Oh boy, there he goes again with that textbook dribble!" Ellen gasped.

"Well, what the hell do you want from me?"

"We want you to join us, to be a person, to stop behaving like you're filling a Goddamn role."

"If you're going to be so emotional about it, I won't discuss it. You don't really bother me you know. I'm just here to gather material for a paper."

"Mike, will you tell him already?"

"You're doing fine Ellen. What about the rest of you?"

At this point, Jack was seething. He wasn't sure quite why, but he just wanted to go over and wring Bud's fat neck.

"You stupid bastard, you can't just play it cool all the time. If you expect to be more than a shell you've got to let yourself feel. You've got to react!"

"But you people aren't important; you just don't matter. If you all want to scream and carry on, go ahead, I don't mind. I'm here to learn."

"Don't you feel at all annoyed or angry with the group, Bud? They are being quite nasty," Mike interjected.

"No, that must be part of their problem" Bud answered, as he nervously reached for his notepad.

"Well I'm angry," Jack spoke up forcefully. "Why the hell don't you tell this schmuck that his cool shell just fell off? Why don't you tell him that he doesn't really fool anybody? Why don't you just tell him to get the hell out of here if he's so damn cool he can't be one of us?" Then, turning to Bud, he shouted, "If you have no problems, if you're so cool, then why are you here? What's a cool guy like you doing in here with us psychos?" Jack continued, throwing back Bud's own words, "And don't give me any of that crap about a term paper either."

"Gee, Jack, I thought you were a cool guy," Bud responded weakly.

"Maybe he was," Mike threw in. "In fact, maybe that's why he is so angry at you now. We often tolerate least our own feelings."

"Well, it doesn't matter. I've got enough material now and I'm leaving right now," Bud said as he got up to go.

"Aren't you going to stop him?" several kids asked at once. Mike smiled, the same warm smile with which he had answered so many of their demands and questions. The smile sort of said, "You're a big boy now. I'll help when I can, but it's really best for you to find the answer yourself. I'm rooting for you, but I respect you too much to take over and deal with your problem." Then he turned to Bud and told him that leaving was his choice. "I really would like to see you stay, and, from the last comment about stopping you, I think the group does too. Being a real person isn't easy, but if you try, I think you might find it worthwhile." Bud gathered a bit more courage from this, but made it clear that he "hadn't really planned on staying any longer," and turned to go.

"So long, Bud. Give me a call if the paper gives you any trouble or if you feel like chatting sometime," Mike said as Bud walked out the door.

"Thanks, Doc," he said with more feeling than he had shown all summer and the door closed softly.

"Gee, I didn't really mean for him to go. I feel awful, like I threw him out. Should I go after him?" Jack asked.

"Still want me to decide for you?" Mike answered softly. "I can understand just what you're feeling. In fact, I thought about going out myself, to try to reassure him and to perhaps bring him back, but I decided that maybe he had come as far as he could for now and that all we could do for the time being has been done. Let's get back to us though. Jack, you were pretty mad there. Do you have any idea why?"

Jack was quiet for what seemed like ages. Suddenly he felt as though he had been hit by a ton of bricks. "Bud was me, or I was Bud," he rambled, not really quite sure just yet of what it all meant. "When I first met him I thought that he was the greatest. He was just what I always wanted to be—a cool guy who never would be hurt." Tears flowed down his cheeks as he began to understand. "All my life I've worked to be the best at things, the best at basketball, the top student, the best at anything, just so I'd be in a position where people would look up to me. I kept telling myself that friends didn't matter as long as I was cool." He could hardly go on. His throat was choked, his nose was running, and he heard himself sobbing. He felt as if he ought to be terribly embarrassed, but he looked across at Mike, who nodded as if to comfort him and at the same time urge him to go on. He looked at Ellen. The tears in her eyes somehow let him know, without a word being said, that he wasn't alone.

"Cool, hell!" he went on through the tears, "all this time I was kidding myself about not having any need for friends, I was just keeping them away, hiding my head in the sand. I've sunk so many baskets hoping somebody

would think I was great. Think I was great, hell; all I ever really wanted was to be liked—to belong—to be able to take off the Goddamn cool mask and be Jack Haines. Not the coolest guy in town but a real one.”

“A very real one, and a real fine one,” Ellen said as she placed her hand gently on his. Jack looked up through his watery eyes and smiled. Ellen smiled back warmly and sat back in her chair, hesitantly removing her hand.

For a moment, there was silence. Everyone seemed to be electrically together, and the feeling was wonderful.

“Spilling your guts out is painful and frightening. I could never have done it outside the security of this room, but somehow I feel as if I can see the whole world for the first time—or I guess I should say feel it.”

There was another long thoughtful pause, and then Jack voiced a frightening thought. “I’ve always been cool. Now I know that that’s not it, but what should I be? I wish Mike would use that blackboard and let me know. Why won’t you tell me, Mike? Why didn’t you tell me about not being cool? Why did I have to find out like this?”

Mike smiled that same warm smile again and said, “Maybe we need to feel and experience, maybe a diagram on the board wouldn’t really have meant much to you.”

“I think I follow Mike, but if I can’t be cool, then should I be impulsive, outgoing or what?”

Ellen placed her hand on his again, in that same tender way, sort of like a big sister and said, “You don’t be cool, Jack. You don’t be impulsive or anything else. You just be!”

The Outside: Epilogue and Prologue

The office crowd was working busily as Jack got up to leave. "I'll see you guys in the morning. It's my afternoon for that group I was telling you about," he said with a smile, recalling the first few times he had had to punch out early.

When he got to the room, most of the group was already seated. They stopped for a second to exchange greetings and then Laura continued: "I'll be staying on with Mike individually for a while. I'm still not sure that college is for me. I think I'll get a job for a few months and see how I like the business world. It sure will seem funny not coming to group every Wednesday."

Mike came in at that point and the last session was underway. Jack found his mind wandering. He looked around the room, and his glance fell on the blackboard. "A Goddamn symbol!" he thought. "A symbol that Mike isn't ever going to write out the answers."

His wandering thoughts were interrupted when he became aware that Mike had thrown a question in his direction. His hand started reflexively for his forehead, but he stopped it and chuckled, "There goes that nervous gesture of mine again. I'm sorry Mike, I was off somewhere."

"We've all been talking about how we felt about leaving the group, and we wondered about you, Jack. What feelings have you been having?"

"Well, I think that a few weeks ago I would have felt that there were too many questions unanswered, and I would have been waiting for you to give us all the solutions. Now, I guess I'm still pretty scared, but I realize that you really don't have the answers. At least, I have a better idea of the questions though."

"You seem to be running away from feelings about the people in the group," said Mike.

"I suppose I am. It's awfully hard to finally, after all these years, feel that I have some real friends, and then to have to leave. I'll miss you all, even Ted. I think that he's a little phony at times, but I realize that he's just trying to be part of the group. I still don't like the way he does it, but I don't feel as though I have to be afraid of him and ready to strike back anymore. In fact, I've come to enjoy his witty cracks. Most of all though, I feel like I want to take Ellen along with me, to take her around like a big sister (although in several sessions I've thought of her quite differently).

"I'm rambling and maybe monopolizing, but there is something I need to think out loud on. Now that I know that the cool business was a blind, I feel that I ought to be more aware of just who I am. I've always felt that I was someone special. What I mean is that I always felt that I had a meaning, that I had been put here to achieve some purpose, to be something. But who, or what will I be? Ellen once said, 'You just be!' That's been haunting me all month. I know that you can't tell me how to just be; that somehow I've got to find out myself; but how the hell to go about it is driving me nuts! No! Don't cut in on me just yet. Let me ramble a minute."

"I say I constantly, but what do I mean? Who am I? I know I'm Jack Haines, but who in God's name is that?"

"Here in the group I somehow feel I know. I can't put it into words, but it's as if by being part of a whole I feel meaningful. Then, I wonder if the only way to feel whole is paradoxically to be a part—part of a group, a nation, the universe. Can't I just be, without having to be in relation to?"

At this point Jack seemed to be in a cold sweat.

"It can be painful to search, Jack," Mike said, "Painful to keep looking, to keep striving, but no one can make it easy for you. That's about all the time we have left together. I really feel that we all have to face Jack's questions in one way or another. I only hope that in some way our sessions have helped in at least clarifying the questions and in helping everyone to see themselves a bit better. Now I'm afraid that I'm rambling a bit. I guess that's it. Let me hear from all of you."

Slowly each of them exchanged addresses and goodbyes, and left the room. As Jack and Ellen walked out, they looked back around the room once more and thought back over the months they had all been together. "Parting is such sweet sorrow," Ellen quoted, trying to lighten the mood, but Jack was lost in thought.

He stepped outside the room to face life, and a frightening thought crossed his mind: "What if. . .what if, after all this search, there really is no meaning, if death just ends a meaningless decay?" It crossed his mind, but his lips were still, not daring to voice it. "How does a guy go on then? How' do you keep searching," he thought to himself, "If you can't really be sure of there being anything to search for?"

"I don't know," Ellen said softly, as if she could read his thoughts and had wondered the same things herself. "I don't know how you go on. I only know that I must."

"And that somehow we can!" Jack added.

As they parted, Jack was again lost in thought: "I've left the room now. I'm on my own. To just be, or at least, to become!" . . . But to become what? . . . and how? . . . and what if? . . ." The lingering doubt remained.

SPECULATIONS ON TREATMENT OF MASOCHISM AS AN EGO DEFENSE¹

Many theorists have considered masochism the core of neurotic character structure. Freud (1924) asserted that the length and difficulty of treatment was closely related to the amount of "unconscious guilt involved." Bergler (1949) even went so far as to state that there is only one "Basic Neurosis": orally-based psychic masochism.

In accordance with its importance, the concept of masochism has been thoroughly discussed at conferences and in the literature. Diverse viewpoints have existed about the clinical picture and its genesis. Surprisingly relatively little has been said about the therapeutic handling of the many patients who, in varying degrees, fit the syndrome. The present paper is a summary of my understanding of the dynamics usually involved in masochism and an attempt to outline some specific approaches to treatment stemming from this viewpoint. Material from the analysis of one patient will be presented in order to clarify these approaches. He was chosen because he clearly illustrates the dynamics and interaction involved, but a multitude of similar examples are readily available.

The Clinical Picture

The basic element in the masochistic syndrome is a denial of strength and self assertion. The masochist demonstrates his fear, suffering and helplessness

¹ This chapter first appeared in *International Mental Health Research Newsletter*, Spring, 1970

to the therapist and often to the world, in return for a bargain in which he will be fed without moving from his safe place.

One patient, Larry, a 29-year old lawyer, who constantly asserts his fear that he is unable to earn a living, function sexually, or compete in any way, clarified the nature of his masochistic bargain through his reaction to a motion picture. He was extremely moved by "The Bible," and, upon leaving, felt that becoming religious might answer his problems. When asked which part of the movie had been most moving, and with which character he felt identified, he described Abraham's willingness to sacrifice his son. With a look of power he quoted the angel: "Now that you have shown that you truly fear the Lord, He will make with you a covenant." Power through submission and suffering—or as Heik (1941) puts it, "Victory through defeat"—is a good one-line summary, or motto, for many of these patients.

The clinical picture is often confused by secondary defenses which Henry Grand (1967) describes as "double mask" and Bergler (1949) refers to as "pseudo-aggression." The masochist acts as if he were attempting to hide his helplessness and immaturity from the world. However, beneath this defense is the wish for passive gratification and the attempt to keep any real adult potency concealed. In fact, in many cases the masochistic helplessness cloaks an underlying attitude of grandiosity (which, in turn, is a defense against injury to infantile narcissism).

The lawyer mentioned previously sees himself as having worked hard to get through law school so that people will not realize his inadequacy. He reassures himself that his high grades and appointment to the staff of "Law Review" were just his ability to "fool others" and that since he never actually wrote an article it wasn't a "real" (adult) accomplishment. In other words, it is

alright to succeed in order to please mama, as long as the achievement is seen as a sham and does not represent real self assertion or potency.

Theoretical Background

I view masochism as an ego defense and not as an instinctual tendency. This process is a symbiotic defense against anger at a disparaging love object. It is an attempt at avoiding the anxiety of separating from, first real, and later, introjected parents. Instead of expressing anger or self assertion openly, the masochist seeks gratification through passivity. His helplessness becomes both a demand to be fed without responsibility and a subtle means of revenge on the disparaging parent. The price of gratification is paid in advance through submission and suffering, and the anxiety of separation, competition and self assertion is avoided.

Masochism thus can be seen as an early defensive formation (basically oral, but with further components added at each level). The passive, apathetic denial of assertiveness and appetite is a response to early frustration—which is felt as an injury to the infant’s feelings of omnipotence. Edritia Fried (1969) describes this as a process of drive extinction.

The masochistic pattern is also often copied from a guilt-inducing, controlling, binding mother, who encourages the child to present specific accomplishments but to remain in the symbiotic bind because of her needs.

Speculations on Treatment

Much of the following may apply more generally than just to the treatment of masochism. Naturally, many treatment attitudes and procedures are generally of therapeutic value to diverse patients. This paper will focus only on those attitudes and approaches which are of value, especially with those

patients whose major defense picture is masochistic. To provide some organization, treatment approaches will be considered under the following headings: Attitudes of the therapist and specific content to be dealt with. Therapist attitudes include a stress on less verbal communication, promotion of activity, maintenance of separateness and no "rachmonos" (pity). Specific content which must be dealt with includes the legitimization of anger, rivalry and asserting oneself or taking, the unveiling of grandiosity and perfectionism, the realization of the price paying or "suffer now, fly later" orientation and the analysis of the guilt-controlling symbiotic bind with parent surrogates.

Therapeutic Attitudes

Cryptic or Non-Verbal Communication:

Since masochism is an early formation, it is largely a non-verbalized attitude and can thus be dealt with through non-verbal, or (if verbal) cryptic, symbolic interventions. Words are learned later in life and often serve elaborate defensive functions. Masochistic patients frequently request detailed clarifications and draw the analyst into, at best, an anxiety-reducing, vague explanation. The explanation is then heard as an undoing of the less-wordy, anxiety-arousing intervention. At worst, the intellectualizing masochist can engage the analyst in a prolonged theoretical discussion. Larry is an expert at this technique. Before the analyst caught on, many sessions were spent in responding to his "eager and sincere" efforts to gain some more of an understanding of the "important" communication which had been offered. The masochist's willingness, at convenient times, to listen intently (even reverently) to the authority sets an elegant trap. The more the analyst talked in these situations, the wordier the explanation, the more Larry was able to pick whatever he needed to undo the original intervention, to reassure himself

that he was in a safe, submissive position, and thus to maintain his fantasy of a safe symbiotic maintenance of the status quo.

An often effective technique in coping with the masochist's skill in this regard is making a pointed remark at the end of the session and postponing any further elaboration. This leaves the patient thinking, often productively, between sessions and helps maintain a workable level of anxiety. The parting shot technique is actually something such patients often utilize themselves in a less constructive manner.

Promotion of Activity:

Due to the severity of his separation anxiety, the masochist fears activity and clings to the safety of passivity. The analyst must provide a model who is not afraid to enjoy (even his work), who takes a strong active position and who is not threatened by the patient's growth and activity. More concretely, activity is encouraged by refraining from advice giving and requiring the patient to struggle with questions rather than providing answers even in the face of lengthy and impressive demonstrations of helplessness.

Maintenance of Separateness:

The masochist's expertise also extends to pulling people into a symbiotic fusion. If he can succeed in getting the analyst to neglect his own needs with regard to such things as fee and length of sessions, or get him involved in "reality problems" like working out a budget, then the lines of separation blur.

This is reassuring to the patient and will often feel like good relationship building to the therapist, but it serves primarily as an avoidance of facing the purpose of treatment—the furthering of growth towards separateness and maturity.

The lawyer patient went through about two years of being at first passively aggressive and depressed, and later angry, when the analyst failed to gratify his demands for concrete advice on such things as writing law briefs and “managing” on his income (\$15,000). Once he dreamed of being in a swimming pool and after getting most of the way across, calling for help. He feared he would drown, unless someone swam with him. He was furious with the lifeguard who merely offered a hand at the end of the pool, but he also had the feeling that he might make it to the other end. His associations in the session ran to being annoyed with mother’s constantly doing things for him.

The most important tool the analyst has is his own separateness, his willingness to assert independent feelings and opinions, to demand a fee, to maintain his own mood and activity in the face of the patient's passivity and depression and, most importantly, to determine in what manner and at what times he will offer his help (with regard to real needs and not in response to demonstrations of submission and helplessness).

No Rachmonos (Pity):

This most basic attitude is closely related to the maintenance of separateness. It does not mean that the therapist is to be cold, distant or unresponsive. It means that the basic stance, though warm and accepting, must not be overly involved. The masochist is a past master at drawing compassion and pity. Its purpose is largely a divergence from facing separateness and separate feelings, particularly aggressive ones. It is an excellent diversionary tactic, especially because it allows for some outlet for the aggression through rendering the would-be helper impotent. To extend pity or attempt to provide comfort and aid to such a maneuver only adds to the patient’s investment in suffering and his guilt at wanting to hurt such a nice parent figure. A denial of pity, on the other hand, is in effect a genuine

respect for strength and a confrontation with the patient's real potential effectiveness. The therapist must represent not only a nonpunitive authority, but also nonindulgent one.

The patient's self denigrating demands for pity must be viewed as part of a sequence. They are often a response to anxiety provoked by progress in treatment, by some assertive step on the outside or by a closer awareness of his aggression. Larry's characteristic response to any sign of strength or growth which slips out is to sit slumped in his chair and, with a quiet halting tone, to embark on a depressed (and, if the analyst is not careful, depressing) monologue. The content is varied. Often it deals with his inability to write his law briefs or to earn a living. However, the underlying message is always something like, "I'm helpless and hopeless. Thus you must do it for me or at least feel impotent and guilty for not being able to. Also, don't take the sign of capacity seriously." If this maneuver succeeds to any degree in eliciting pity or help, then the status quo is again maintained. A good rejoinder to the monologue must cryptically get across an accepting but nonsympathetic skepticism. An example of one which worked well with Larry was, "Gee, you are too good a lawyer for me to argue with, but why are you presenting such a strong case of helplessness today?"

Bergler (1949) has described this guilt-inducing diversionary maneuver as "injustice collecting." Patients often seem to strive not to get, as they claim, but to set up a situation in which they are frustrated and thus once again demonstrate the bad (nongiving) mother. Bergler attributes the aim of this maneuver to the "enjoyment of psychic masochism." I see it more as the attempt to force the parent or therapist to feed the patient and to overlook his real capabilities and his aggression. The masochist thus is able to remain passive and to avoid the anxiety of separation and self assertion. The therapist

must be free of guilt in this area and not need to be a “good parent” in the sense of a giver or a nice guy.

A still further attitude (of no rachmonos) is not allowing the masochist to present himself as completely blameless while offering his symbiotic partners as responsible for his plight.

Specific Content: The Legitimization of Anger, Rivalry and Asserting Oneself or Taking

Masochism serves originally as a defense against aggression directed at the parent upon whom the infant is dependent. The masochist fears that destruction of the object would leave him to perish and also fears retaliation. He also seems, in fantasy, to equate any self assertion or attempt to take something for himself with an effort to destroy, or at least to harm, the parental object. This is perhaps a result of earlier wishes or of an awareness that the parent interpreted any sign of potency or growth as a threat to the symbiotic dependence and responded by “returning” the threat of withdrawal of love. Parental induction of guilt for any more towards separateness forms the basis for what Freud referred to as the “negative therapeutic reaction.”

The analyst's task is to show the patient that he is aware of the resentment and aggression subtly, and often not so subtly, disguised in politeness and submission. The basic position is to point this out with the message that the feelings are legitimate, that they can be expressed and that the analyst will not allow himself to be harmed (will protect himself).

Pointing out that the patient is far from ineffectual, and is actually expressing much of his feeling indirectly, is often quite ego strengthening. A dramatic experience of this type occurred with Larry when he, while walking behind the analyst, whistled to get his attention (the way one might whistle to

call a porter). Once in the office, the analyst wondered why he had chosen to whistle rather than call out. Larry explained, politely, that he had wished to save the analyst the trouble of walking all the way down the hall to the waiting room to discover that he was already at the office door and that he was "too meek to speak loudly enough to be heard at the other end of the hall. The therapist's intervention at this point was to reflect "you are so meek, polite and thoughtful. I couldn't possibly think that your whistle meant screw you." We both laughed and Larry went on to discuss his resentment of his boss' authority.

Unveiling of Grandiosity:

The contemptuous whistle mentioned above is closely related to the masochist's fantasies of complete power and revenge against those who have made him feel helpless. He wishes to maintain a grandiose position from which he can contemptuously control people as objects to gratify needs. As long as he desires this omnipotent control, the patient will remain helpless.

It is thus important to try to reduce some of these demands. A good technique for doing this is the drawing out of the patient's statements to their apparent (often blatantly absurd) conclusions. A related attitude is the feeling that rules shouldn't apply to him unless he decides that they are reasonable. Cryptic titles often get across the absurdity of this position nicely. Larry, for example, speaks of how he sits in his office like a tyrant and complains that all his colleagues don't come in regularly to say good morning, or to ask him to lunch (to pay homage). After many failures at explaining that he ought to stop in their office sometimes, the following intervention got through nicely: "You don't want to be seen as a *schmuck*, but as King *Schmuck*."

The Price Paying Orientation:

Masochistic suffering does not seem to me to be a real enjoyment of suffering as Freud, Bergler and others have described it. I prefer Reik's (1941) view of the suffering as a flight forwards. The masochist is not giving up pleasure. On the contrary, he is defiantly and stubbornly persevering toward a fantasy of future gratification for which he is paying the price in advance. He sees the world as perfectly balanced and expects an equal reward for his pains, just as he fears punishment for any pleasure he allows himself. One useful technique here is a joking view of the absurd conclusions, but also demonstrates the analyst's willingness to enjoy. The hostility in the wit must always be directed at the pathological defenses and felt as two equals laughing together. The patient should not be able to use it masochistically. One patient, after several remarks on the analyst's part, explained that the trick was, "You suffer and you suffer and then after years and years you finally reach a point"—and here he burst out laughing—"where you are just miserable."

Analysis of the Guilt-Controlling Symbiotic Bind with Parent Surrogates:

After a real working relationship is established, and this may well take a year or two, the major task is to enable the patient to see how he repeatedly sets up relationships in which he feels secure but gives up self assertiveness and independence as a price for this security. The exact qualities of these relationships vary from patient to patient, but they usually include a guilt induction contest, an exclusiveness that doesn't allow a third party and a great deal of unconscious resentment involved.

Larry has reiterated situation after situation in which he entered into what he now calls "Abraham's bargain" with his mother or his wife. After many repetitions, he became aware of and was able to verbalize the resentment

involved. A more difficult task has been to get him to accept his role in bringing them about and to take the risk of a separate existence.

Conclusion

Treatment of masochism is a long and at times frustrating process. After two and one quarter years, the patients on which this paper is based (including Larry) have made varying degrees of progress. With Larry, the progress has been very gradual, but clear. He is now quite aware of the binds he gets into and is no longer free to enjoy them. His previous masochistic depressions are fewer, last only briefly and do not reach the suicide-threatening proportions they did originally. However, much more work will be necessary before he ventures more than slight tests at self assertion and responsibility. The very clarity of the masochistic pattern for which this case was chosen is predictive of a very long course of therapy.

My speculation is that once the pre-Oedipal material is worked through, and the patient begins to feel more potent, father will come into the discussions in a more meaningful way. Oedipal conflicts will need to be worked through as well, but the real disablement seems to be an earlier fixation. The difficult task in analysis is the removal of blocks to separation from the symbiotic bind with maternal introjects.

References

- Bergler, K. (1949) *The Basic Neurosis*. New York: Grime and Stratton.
- Freud, S. (1924) *The Economic Problem in Masochism. Collected Papers*, 2:255-268. New York: Basic: Books, 1959.
- Fried, E. (1969). Personal communication.
- Grand, H. (1967) *The Concept of the Double Mask*. Paper read at Postgraduate Center for Mental Health. New York.

Reik, T. (1941) *Masochism in Modern Man*. New York: Grove Press.

WORKING THROUGH IN RELATION TO MASOCHISM AS A REFUSAL TO MOURN

This paper first appeared in the International Journal of Group Psychotherapy in 1971. It is written in a more technical psychoanalytic language than my later papers and requires some studious attention in comparison to most of them.

At this point in my emotional and professional development I was most comfortable communicating in this fashion. It lends itself well to the purposes of the paper which were: (1) to present a concise digestion of a Freudian understanding of mourning and its central importance in the working through process; (2) to show that since mourning is traditionally a shared experience, it appears useful for working through to also proceed as a shared experience; and (3) to publish in a prestigious journal.

Mannie Schwartz (my own analyst) urged me to postpone publishing until I felt comfortable enough (or at least willing enough) to be more vulnerable by including my own working through (mourning) experiences which led to the formulation of the ideas in the paper. He felt that, although he never wrote so personally himself, it would become a valuable trend in the next generation.

A few years later (in Chapter 11) I did write briefly about my own experience as a therapy patient; however, at this point, risking such personal openness seemed too "unprofessional" (frightening). In addition, the paper had already been accepted and I was impatient to see my work in a real journal.

The ideas in the paper actually stem from a very painful period in my own analysis. About the time I was planning to discontinue individual treatment, I found myself in an intense, frustrating struggle to get my group to understand me. I felt very much a part of the group and was quite active in talking about anyone else's feelings. However, whenever I wanted to talk about myself I hit a stone wall. People seemed to turn off and I felt horribly inadequate.

Finally, one morning, I was in a sweat about some problem I thought was important. Once again no one listened. I couldn't explode, and the fury turned to a tearful loneliness. One woman related that although she wanted to listen to me she couldn't seem to stop her mind from wandering to thoughts about her father's death.

"Don 't you see? Marty has been trying for years to talk about his father's death and how he felt," my analyst pointed out. I began to bawl like a baby. I relived those years around my father's illness and death with a new family. This time, for the first time in my life, someone shared my grief and knew about my fury. The woman next to me cried and told me about a loss of her own. We put our arms around each other and shared the feeling of loss the way my family had been unable to do. For months I felt like my father had just died, but this time I was not alone.

In time, I came to realize that I had a lot of feelings about leaving treatment, about leaving my one-to-one relationship with Mannie. It meant not only giving up the relationship, but also the transference yearnings which were tied to it. I began to understand analysis in terms of the working through of transferences (in terms of mourning

losses, both real and imagined from childhood). Now I knew why it takes so long.

In the published paper I left out the personal background. I want to include it in this book for two reasons. One is simply that it brings the dry theory alive. The other is related to the whole theme and style of the book. Personal style, involvement and openness communicate and are potent forces for change. I have shared my feelings with students and with patients at very selected moments when I felt they needed to know that they were not alone. Mourning, and for that matter, joy also, need to be shared and lead to a growth process when they are.

The value of patients sharing with each other in group therapy is clearly accepted. The question of the therapist sharing such personal material is more controversial. It is related to the issue of closeness and distance, which is at the heart of this book. To what extent does it interfere with the unfolding of transference material? When does it place an inappropriate burden on the patient and when does it encourage vulnerability and risk taking? Does it enhance empathic bonding and promote "transmuting internalization" or is it experienced as a break in empathy? These questions all relate to the issues of near and far. The answers, for me, are not written in black and white. I think the complexity of each patient and therapist combination, with a focus on the developmental needs of the patient at a given moment, should guide the therapist in allowing the patient to find his "optimal distance. This chapter focuses simply upon the working through of transference and resistance in the patient and its relationship to mourning as a shared process. It speaks of the patient's merging and separating and the value of his sharing with other

patients. Countertransference issues and the therapist's closeness and distance will be considered in later chapters.

The ‘working through’ of resistances was described by Freud (1914) as that “part of work that effects the greatest changes in the patient and that distinguishes analytic treatment from every other kind of suggestive treatment.” According to Glatzer (1969), it is the “warp and woof of analytic therapy” and is as essential in analytic group psychotherapy as in individual analysis.

However, very few articles have been devoted directly to the subject of working through in group psychotherapy, with the notable exception of Glatzer (1969), Wolf and Schwartz (1962) and Leopold (1959). The present author views working through as a process of mourning for, and thus relinquishing, introjected objects, with masochism and the repetition compulsion being seen as a refusal to mourn. Against this background, this paper explores some of the advantages of a group setting for implementation of the working-through process.

Working Through Defined

Freud (1914) pointed out that the naming of a resistance does not result in its immediate suspension: "One must allow the patient to get to know this resistance of which he is ignorant, to work through it, to overcome it, by continuing to work according to the analytic rule in defiance of it." Fenichel (1945) states that, "Analysis consists, not of one abreaction' but of a gradual summation of discharge of less and less distorted derivatives." From these observations, it is clear that the core of analytic work is not simply the releasing of an affect or the gaining of an insight. It is the repeated demonstration of the same defensive or instinctual behaviors in differing

contexts. A consciously planned effort to resolve the compulsive repetition of transferences defines the working through process (Fenichel, 1941; Wolf and Schwartz, 1962).

Mourning

According to classical libido theory (Fenichel, 1945; Freud, 1917) the sudden loss of a heavily-catheted object through death or disappointment releases a flood of unattached libidinal strivings. If a child's ego threatens to be overwhelmed by the emotions involved, it might well repress the experience in an attempt not to give up the object, in which event regression takes place from love to an oral incorporation, from an object relationship to an identification, in an attempt to regain infantile omnipotence and safety. In an adult, or in a child whose ego is not overwhelmed, the flood of libido is controlled by retarding the loosening of the tie to the object. The tie is represented by hundreds of separate memories, and each dissolution must take place separately. Freud referred to this slow dissolution as "the work of mourning." Identification with the deceased or disappointing object is part of trying to retard the unpleasant process by not relinquishing the illusion that the person lives, if only as an introjected object. Many cultures have funeral feasts which symbolize this incorporation, or fasts which deny the wish. The tendency of mourners to take on symptoms of the lost object is also commonly seen (Abraham, 1927).

Mourning thus consists of two acts: (1) the establishment of an introjection, and (2) the loosening of the binding to the introjected object. It is characterized by ambivalence toward the object (the incorporation being both an attempt to preserve the loved object and to destroy the hated, disappointing or abandoning object).

Working Through as a Mourning Process

Rado (1925) was the first to compare working through with the work of mourning. He described the representation of the tie to a lost friend by hundreds of memories and the nature of the work of mourning as the dissolution of each of these in turn. In each complex of memories and wishes, in each situation he and the friend had shared, he had to make clear to himself that his friend was gone and that a renunciation was necessary. Again and again, he had to realize and re-experience that “there too and there again” the object was lost. Fenichel (1941), in discussing this, shows that in analysis the patient must, in like manner, be repeatedly confronted.

Most, if not all, patients have experienced severe disappointment in their original libidinal objects (parents). Perhaps there was no actual loss through death or other reality changes like divorce or dethronement by a sibling, but some strong disappointment in parental figures is inevitable. Illusions of the idealized, omnipotent protector are shattered, and the disappointment of the Oedipal phase must be dealt with. While healthy development calls for the completion of the mourning for lost objects during the latency phase, many children are unable to carry out the work of mourning. Because of earlier fixations or a lack of support from the environment, the withdrawal of libido is overwhelming. The result is that the first step of the mourning is carried out—the loved and hated object is introjected (thus forming the harsh superego)—but the work of loosening the binding to introjects is aborted. The carrying out of this second part of mourning, the separation from parental introjects and the dissolution of their projection in the transference, is the substance of the working through process. Its completion involves the relinquishment of illusion and the acceptance of a separate life without omnipotence or an omnipotent protector and provider.

Masochism as a Refusal to Mourn

As discussed in a previous paper (Livingston, 1970), masochism is often the core of neurotic character structure and must be an essential focus in treatment. This is particularly true in the later working through phases because, as Freud (1923) asserted, the length and difficulty of treatment is closely related to the amount of "unconscious guilt" involved. Additionally, Freud (1924) pointed out that treatment may well be subverted by a 'negative therapeutic reaction' if the patient's masochistic fear regarding the enjoyment of therapeutic gains is not dealt with. Thus, masochism is obviously closely related to the working through process.

In fact, masochism may be viewed as the tendency to resist working through. Many theorists have defined masochism as an effort to maintain an illusory relationship with a parental figure or an introject. Glatzer (1959), for example, views masochism as the repetitive seeking of refusal in order to maintain a pre-Oedipal fantasy of the bad mother," with working through of the masochistic patterns being the relinquishing of this fantasy. Further examples are Bergler (1949) and the Kleinians (Segal, 1964), who see the masochistic pattern as an attempt to maintain a symbiotic tie through submission and the presentation of suffering. Briefly, then, masochism may be said to be a stubborn refusal to separate from parental figures or introjects and an insistence on maintaining fantasies of security and omnipotence. It is a refusal to complete the second portion of the mourning process, the loosening of ties to the introject.

Refusal to mourn the loss of the parents who were wished for but never possessed masochistically keeps the patient from utilizing the insights he has obtained. Working through is the repetitive and tedious process of completing the mourning by confronting the patient with progressively less-distorted

derivatives, again and again, in one area and then in another, until the ties to the introject are loosened sufficiently to allow growth and separation.

Analytic Group Psychotherapy and Working Through

Three papers mentioned previously as notable exceptions to the dearth of papers on the topic of working through in group psychotherapy all conclude that the group setting holds many advantages for the working-through process. Each stresses different aspects. Leopold (1959) emphasizes the availability of multiple channels of communication which, by evoking conflicts not stimulated in a one-to-one setting, reveals more of the individual's total personality. With repeated opportunity to identify the same defensive patterns in various situations, the individual becomes aware more quickly of distortions and contrasts, and he is, of course, aided in this by both the group and the therapist pointing out again and again his neurotic interactions. Glatzer (1959, 1969) notes that such interpretations coming from peers who are not invested with a pre-Oedipal witch-mother transference, are less anxiety-provoking in the group, and that when the interpretation comes from the therapist, the narcissistic hurt is lessened by similar interpretations to fellow members of their defensive patterns. Wolf and Schwartz (1962) observe that since the group provides multiple interactions, repeated confrontations, and a variety of alternatives, there is easier relinquishment of authority projections because the disparate views and the differing ways other patients deal with the analyst force re-examination by the individual of his own projections.

There is a further importance to the group setting if working through is considered as the completion of a mourning process and the giving up of fantasied objects. The child was unable to "grieve effectively" (Wetmore, 1963) and, through introjection, attempted to bind the anxiety involved.

Mourning, which involves tolerating gradual doses of anxiety, is a group activity, a shared experience, in many cultures. Those who are under less stress, or whose egos are stronger, keep the child, or the adult with an undeveloped ego, from being overwhelmed. Similarly, a group setting in which several members are mourning the autarchic omnipotence of infancy, or the parents who disappointed them, can provide strength for each other, much as do a group of mourners.

Frequently, discussion of a death or disappointment by one member will set off similar feelings in other group members which can then be shared and worked through. Also, the departure of members from the group can become a part of this process by arousing feelings of loss.

The presence of other patients also faces group members with a current loss, the loss of exclusiveness with the analyst. The mourning for, and eventual acceptance of, this loss is in itself a step in the direction of working through toward separation.

A psychotherapy group both confronts the patient with an onslaught of his refusal to mourn and lends support to the mourning process by not leaving him alone to be overwhelmed as he gives up his many neurotic ties and defenses. To be sure, the individual analyst can do much of this confronting, and the patient need not feel alone on the couch. However, since mourning and its role in working through are best carried out as a shared experience, and the analyst cannot share in it as fully as can a co-patient, the group setting offers a decided advantage for implementation of this process.

Summary

Working through can be viewed as the process of mourning idealized parents who never existed. Through repeated, planned presentation of less

and less distorted derivatives, the patient is confronted with the necessity of again and again relinquishing his illusions of omnipotence and ties to introjected protector's and providers. The multiple interactions in the group setting provide opportunities for repeated confrontation of defensive patterns, especially the masochist's refusal to mourn his lost objects.

Since mourning is traditionally a shared experience, it appeal's useful to utilize a group setting to implement the working through of separation from illusions and introjected objects in analytic work.

References

- Abraham, K. (1927) *Selected Papers*. London: Hogarth Press.
- Bergler, E. (1949) *The Basic Neurosis*. New York: Grune and Stratton.
- Fenichel, O. (1941) *Problems of Psychoanalytic Technique*. New York: Psychoanalytic Quarterly.
- _____(1945) *The Psychoanalytic Theory of Neurosis*. New York: Norton.
- Freud, S. (1914) Recollection, Repeating and Working Through. *Collected Papers*, 2:366:376. New York: Basic Books, 1959.
- ____ (1917) Mourning and Melancholia. *Collected Papers*, 4:152-172. New York: Basic Books, 1959.
- ____ (1923) *The Ego and the Id*. New York: Norton, 1960.
- ____ (1924) The Economic Problem in Masochism. *Collected Papers*, 2:255-268. New York: Basic Books, 1959.
- Glatzer, H. (1959) Analysis of Masochism in Group Psychotherapy. *International Journal of Group Psychotherapy*, 9:158-166.
- ____ (1969) Working Through in Analytic Group Psychotherapy. *International Journal of Group Psychotherapy*, 19:292-306.
- Leopold, H. (1959) The Problem of Working Through in Group Psychotherapy. *International Journal of Group Psychotherapy*, 9:287-292.
- Livingston, M. (1970) Speculations on Treatment of Masochism. *International Mental Health Research Newsletter*, Spring.

Ratio, S. (1925) The Economic Principle in Psychoanalytic Technique. *International Journal of Psycho-Analysis*, 6:35-44.

Segal, H. (1964) *Introduction to the Work of Melanie Klein*. New York: Basic Books.

Wetmore, R. (1936) The Role of Grief in Psychoanalysis. *International Journal of Psycho-Analysis*, 44:97-103

Wolf, A. and Schwartz, E. (1962) *Working Through. Psychoanalysis in Groups*, Chapter 8, pp. 162-178. New York: Grune and Stratton.

HATE, LOVE AND THE HUMAN CONDITION (A PSYCHOANALYSTS REFLECTIONS UPON READING ROMAIN GARY'S *WHITE DOG*)

There is an inherent bond between novelist and psychoanalyst. Though their manifest ways differ, there is an identity in much of their underlying motivation. Both analyst and writer are deeply concerned with the human condition.

A writer struggles through his creative effort to deal with, or at least to shed some light on, his approach to the human condition. His philosophy of life, (his sense of values and points of view, as well as his style of dealing with them) is conveyed in his story. Each story is both an attempt to deal with his own inner conflicts and to reach, to have some impact upon, the reader. This communication is greatly enhanced through technical skills, but is ultimately conveyed by who he and his characters are. Even without or beyond his conscious intent, the writer's style of life and points of view are sensed and responded to.

An analyst's creative effort and motivations are also quite related to his or her concern with understanding and coping with the human condition. His responsibility is to aid his patients in their struggle to deal with being human and its stresses, in becoming more fully themselves, more fully whole unique human beings. His chances of carrying out this responsibility are like the writer's, greatly enhanced through the use of technical skills and theoretical knowledge. But, again like the writer, his work and its effectiveness are as dependent upon who he is and the statement he makes of his own understanding of, and approach to, the human condition, as it is on his training or theoretical position, like the author, and his characters, he makes this

statement of his values and style of life more by actions and attitudes than by preachments—more by who he is than what he says (often beyond or without conscious intent). This takes place much the same way a mother imparts more to her children by what she does than what she says. The attempt to recover by a "Do as I say, not as I do" approach is disastrous.

These similarities in the way analysts and winters carry on their quest for meaning and attempt to touch others is especially striking and deeply meaningful to me at times when a writer and his story have managed to touch me—to stir up my emotions by confronting me with an aspect of the human condition and make me wrestle with it. I often use such stories with my patients in order to communicate an understanding or to confront them with a hidden part of themselves. Sometimes we share our thoughts or feelings about a story and thus struggle together to sense and deal with the writer's depth of experience, to shed some light on life.

One such story is Romain Gary's *White Dog*. It impressed me deeply. It is a beautiful example of a writer's attempt to work out for himself (and at the same time to stir up in the reader) an awareness of one of the basic challenges of being human. It helped me to deal with, to struggle towards coming to terms with a part of myself and of mankind. Such is, I feel, the highest purpose of literature.

I would like to share my reflections on *White Dog* with you as I will with my colleagues and patients (in a much less organized manner and with a sense of just what part might be most meaningful to the individual). I will describe the sequence of the novel as I experienced it so that you can have some idea of what I am responding to; however, I urge you to read the book, or the excerpts from it published in the October 9, 1970 issue of *Life*, in order to get it's full

impact. I will try to convey some of Gary's creative skill, as well as a sense of his style and who he is, by using extensive quotations.

White Dog is about "a graying German shepherd, aged about 6 or 7, a beautiful animal whose strength and air of intelligence were striking." Gary, who is himself the central character in this basically true story, took him in one rainy night. He called him Batka which means little father in Russian, and he was soon considered a member of the family.

Gradually Gary realizes that the dog had been trained in the south as a police attack dog—trained to a terrible purpose, to hate and viciously attack blacks. Because of the love which has developed between man and dog, and because of his sense of identification between Batka and a part of himself, Gary becomes possessed with curing the animal, against all odds. He takes him to a kennel where he finds visiting quite painful. "I had been seeing the animal everyday: I wanted to know how *I* was doing, if something could be done about me, about that hard core primeval savagery in all of us. . . I pressed my cheeks against the wire netting and felt his cold nose and hot tongue. It is not difficult to recognize an expression of love in a dog's eyes and I thought of my mother, because of this faithful dog and because of love."

Keys, the black keeper who cares for Batka also becomes obsessively involved with him. Driven out of hate for those who trained White Dog, as he comes to call him, Keys ingeniously succeeds in winning him over.

At first, ". . . it went against the grain, against years of training, conditioning and an inbred sense of what he was all about, against the very meaning of his dog devotion and loyalty toward his people. I could tell by those self pitying whines and half-hearted attempts at menacing barking, that the animal no longer believed in himself. . . an agony of split personality . . . the two parts clashing with each other, the new and the old, with the bewildered

uncomprehending look in the dog's eyes becoming a dumb, anguished 'Why?' Keys lit a cigarette, glanced at the dog and laughed."

Gradually though, Keys and the dog become closer and closer. Gary is made to feel like an intruder. Then, after six weeks travelling, he returns to find that Keys had left the kennel, taking the dog with him. Lloyd, a friend who knew the neighborhood, and Gary set out to find them from an address left at the kennel. They split up to make inquiries and then, "I heard a scream of terror behind me, then a long animal howl, followed by a burst of short rapid furious barks and another silence, while the animal had his mouth full . . . I could hear the throaty murderous growls of a dog at his quarry."

When Gary found them, 'Lloyd was on the floor, his face and hands were covered with blood . . . The dog's fangs were aimed at Lloyd's throat he mercilessly plunged them again and again into Lloyd's outstretched hand . . . I threw myself on top of Batka and instantly got his fangs in my hands, again and again, again and again, like deep slashes from a knife, and the dog kept growling still trying to get at Lloyd's throat.

"Keys was standing on the stairs laughing: "Black Dog! It's Black Dog now! Batka was coming at me. He had bitten me several times, but they were blind bites in the thick of battle, and with Lloyd unconscious, with his arms folded limply over his face, the dog had now singled me out for attention. In a second he was on me. The first two rapid bites were for my wrists, and then, kicking, I rolled back with the back of my neck hitting the wall . . . I waited, with my face hidden in my arms, my eyes closed, my knees up . . . Nothing happened."

"I raised my head. What I saw in front of me were my mother's eyes, the eyes of a loving faithful dog."

'Batka was looking at me. I have seen friends wounded and dying next to me, but whenever I try to recall what an expression of total human despair, incomprehension and anguish, the expression at the end of everything is like, I shall look for it in my memory of that dog's eyes.'" "He raised his head high and gave out a soul rending howl, full of all the sadness and hopelessness of the earth's darkest nights. Then he was gone."

That is Roman Gary's statement. He tells us he writes as a "way out of the suffering of other people, you don't write books to help people. You write to get rid of them. To help yourself. I cannot resist human suffering: I fill my books with it and the books bring me a great deal of release, esteem and material comfort—and do nothing for the world, nothing in terms of solutions, changes, help." Here is a man who senses the frustrations and at times agony of the human condition. He feels and experiences deeply and struggles to resolve his own discomfort.

Ralph Graves, Managing Editor of *Life* points out that Gary "believes that gestures, even futile ones, are important, and that they give man a precious dignity, win or lose." Both *White Dog* and Gary himself, as the main character, lose, "but something important survives is Gary's willingness to struggle and feel intensely against odds, with little hope of solutions and no attempt at providing himself, or us, with a false sense of certainty. His ending, as well as his limited statement of intention in writing, is a bit pessimistic, even cynical, but in the very act of writing them he continues to feel and to struggle.

Despite his cynicism, he breathes the world around him in deeply and shares his experience of it with us. He shares it so beautifully and poignantly that he achieves far more than he intended. He confronts the reader with a sense of the agony and struggle of his characters, with the suffering and the joy

of his own struggle. *White Dog* is the author's approach to the human condition. It is both a presentation and an action.

White Dog made me uncomfortable. I cried aloud with pain. These reflections are really my attempts to resolve for myself the discomfort it stimulated in me. My need to write it, and to communicate it, is also in part my way of dealing with the human condition. In sharing my thoughts and feelings (with Gary and with you), I am not alone. In addition though, I am more optimistic than Gary.

I consciously hope to set off some thinking in you, some willingness to struggle a bit even though we won't find any simple answers.

The main theme I experienced was that we are all White Dog and share some of his agony. Gary brings this out clearly in his identification between the dog and that hard core primeval savagery in all of us." We are all White Dog in that we all have, either by very early learning or because of some inborn, instinctual inheritance, experienced intense feelings of hatred. In the young child, as in *White Dog*, this hate is unlimited and not subject to reason. When our hate feelings persist, only unconsciously as adults, they are still (as feelings) not subject to adult mental processes.

We are all White Dog in that we love and feel deep devotion. Often these opposite feelings of love and hate are directed most strongly towards the same people. Originally, the child's hate for the parent who frustrates is unbounded, and so is his love and attachment to the parent who feeds. Since some frustration is inherent in life, and the child won't survive without some nurturance, the intense love-hate ambivalence is inevitable.

The agony White Dog feels on being hit by inner contradiction is intensified, because (like a child) he can only see things in black and white. He

can not discriminate between friendly whites and an enemy white. Also, again like a child he has only a limited ability to control his actions, thus increasing the agony of his predicament. He responds reflexively to his conditioning, and instinctively to his breeding. He is in the end, a victim of his inability to make a choice.

The reason the story is more chilling than most of our childhood experiences is that, unlike the child whose momentary hate and wish to kill is also unbounded, White Dog had the physical strength and weapons to viciously attack and kill. This capacity is not even mitigated by conscience or a sense of fear of consequences as it would be in an adult.

However, keep in mind that to children, and to our unconscious feelings, the difference between wishes and deeds is not at all clear. The child's feeling that his thoughts are omnipotent and magical often leads him to fear, or at times to hope, that wishes come true.

Thus we are all White Dog and must all cope in some way with the painful love-hate ambivalence inside us. People approach this core aspect of the human condition in diverse ways—many of them destructive.

Some individuals accent one side of the conflict in order to set it to rest. If the hate is intense (perhaps because of the child having been used and controlled as an object to satisfy his parents' needs rather than treated in relation to his own needs) the person may become cynical about ever caring for them as themselves—without intentions of exploitation. All hopes of love may then be relinquished in a search for power. Such a person might become a sadistic hater, controlling and exploiting others as Keys does in the story.

If the hate is intense but the parent is too threatening, then the sadistic wishes are repressed. They are maintained in fantasies (partially

unconscious). In order to deny these fantasies, to maintain their repression, we might well see a submissive, masochistic person. Such a person attempts to seek love and protection from authority figures and relinquishes any wishes for independence or power. Competition and assertion are shunned, while underneath (perhaps with some awareness, perhaps not) grandiose and sadistic thoughts of revenge smolder.

Essentially, pathological reactions to the love-hate ambivalence emphasize either the sadistic side or the masochistic side; however, one is never present without the other. Even a completely dominating dictator like Hitler felt an underlying submission to the "fates." In like fashion, the most submissive, ingratiating servant must harbor much hate and resentment. Most often we see people play both roles. For example, the captain who is a harsh, rigid authority with his subordinates is also likely to be meek and submissive with the major who is his superior. Sometimes the picture is one of a very passive person, as if the two forces are neutralized in a compromise.

One fact stands out. The denial of either side of this basic conflict leaves one with a feeling of incompleteness, even unworthiness, and a lack of true strength.

Thus we are faced with a challenge. We are all White Dog. We both love and hate, even the same people. We must accept the ambivalence, the contradictory emotions. We must acknowledge, and even draw strength from, the animal within us.

We are all White Dog, but unlike White Dog, as children grow up they become capable of learning several essential mental emotional skills.

An adult learns the difference between feelings, fantasies and wishes on the one hand, and actual actions on the other. The word or thought does not equal

the deed. Our inner feelings, including the sadistic and irrational ones, are part of us. They are not meaningfully to be judged as good or evil, they just simply exist. On the other hand, actions can be controlled and we must be accountable for them. I can wish to seduce or kill and choose not to. I can rise above my instincts and my conditioned reflexes.

Another adult capability, which neither a child nor White Dog possesses, is the ability to make discriminations. Feelings are not black or white. Shades of grey, contradictions and ambivalence must be faced (as well as other imperfections in ourselves and others). People are not good or bad (black or white). Each individual is a unique combination of many facets. True love must include a respect for such uniqueness, for differences of feelings, values and ideas. A really loved child is one who is encouraged to grow to be continually more himself. As children are treated as unique and separate individuals with respect for their differences, from each other and from their parents, the amount of hate in the world is lessened. Perhaps this is the most meaningful way we can carry on the struggle Gary is involved in in his *White Dog*, by accepting ourselves and others in all our facets, including our “core of primeval savagery.”

To move in these directions, adults can call on another ability children and White Dog do not have, the capacity to tolerate frustration and losses. When White Dog can't get at the object of his hate and kill, he is extremely frustrated and goes into a wild frenzy as if his very survival depended on carrying out his wishes. So too, a child cries frantically at minor frustrations as if they are life and death matters. A mature adult, though, has experienced frustration and probably severe loss, and has seen that he can survive. He has come to accept this as part of life. He does not give up struggling but maintains a sense of perspective, or at least regains it after a period of time. Like Gary and many of

his characters, the adult can maintain his dignity, his sense of who he is and that he will continue to be. White Dog could not do this. He could not give up one wish to order to obtain gratification of another. Maturity is in part this ability to tolerate frustration, to relinquish some gratifications in order to obtain more important ones. For example, the adolescent must at some point give up his wish to always be close to a safe, warm home base in order to become independent and to achieve more mature satisfactions. Among the most difficult of the wishes that must be relinquished is the desire for omnipotence and perfection, for absolute control over our world. The people around us, especially the ones we love most, cannot be controlled and manipulated without generating resentment and hate (and the magic words “for his own good” do not carry any weight).

Responsibility can be, and must be, taken for one's own values, decisions and actions. This freedom was not available to White Dog.

These reflections amount to the statement of a direction, a goal. It is also a statement of the difference between an animal like White Dog and an ever-maturing human being who is striving to actualize his own potential and to seek meaning in a conflicted existence where contradiction is clarity. It is an approach to the human condition. We are all White Dog and feel his agony, but, fortunately, we are also much more.

CONTENDING WITH CONTEMPT² (CONTEMPT, MASOCHISM AND WORKING THROUGH)

"I don't know what you mean by 'glory,' " Alice said.

Humpty Dumpty smiled contemptuously, "Of course you don't—till I tell you. I meant There's a nice knockdown argument for you!" "

"But glory" doesn't mean a nice knockdown argument,' " Alice objected.

"When I use a word, " Humpty Dumpty said, "It means just what I choose it to mean—neither more nor less. "

"The question is," said Alice, "Whether you can make words so many different things."

"The question is," said Humpty Dumpty, "which is to be master—that's all."

Lewis Carroll

Humpty Dumpty is difficult to contend with. He refuses to contend openly—to engage. He must remain high upon his wall for fear of being shattered if he ventures off his protective perch. Yet Alice finds herself feeling inferior and frustrated. If Humpty Dumpty is as skillful as some group patients who have mastered the art of contempt, Alice will not even be able to spot the subtle yet pervasive verbal and nonverbal techniques of contempt. Confrontation is even more frustrating because, when threatened, Humpty

² An abbreviated version of this paper first appeared in *Voices*, Summer 197:5.

Dumpty will simply look down smugly from his wall, and once again point out Alice's failure to comprehend. Then, with little or no sense of his own feelings of fragility (his fears of a "great fall"), he can remain above the confusion beneath his wall. He feels a bit superior, rather serene, and very, very lonely. Contempt is often very difficult to contend with, especially in a group setting. Even Humpty Dumpty is not yet a Black Belt. A true master of the fine art would not allow himself to feel lonely, and would never be so lacking in finesse as to comment directly about "who's master." Also, his wall would be much more camouflaged.

Claire, for example, an extremely attractive young woman who relates in a warm and relatively direct way when alone with the therapist, remains rather aloof and quiet in group. When she talks, it is usually to the leader, often referring to the group members as "them." She feels no desire to be known or to be part of the group and expects "them" to be incapable of understanding her. These feelings were at first communicated only subtly through intonation and facial expressions. She had little or no awareness of the implied condescension, and any attempts by group members to confront her were met with comments like, "This is what I was afraid of, they misunderstand me." She felt accused and defensive, and became more distant. The group felt uncomfortable, careful and after an annoyed silence left her alone once again upon her wall.

The most difficult aspect of contending with contempt in a group is the group's reaction to the contempt master. Rather than seeing contempt as a sign of insecurity, other patients frequently are antagonized and provoked. Instead of trying to understand the fears involved and the reasons behind the distant stance, they feel judged and discarded. The usual response is either

anger or a readiness to let the contempt master keep his distance with an equally condescending, "Well fuck you too—we have no use for you ."

A Psychodynamic Picture

Obviously, the first step in working through with patients who present an outer picture of contempt is viewing their defensive maneuvers in a context of the whole patient as a struggling human. This is, in effect, just what the defense has most skillfully prevented in the patient's prior experiences. He feels that at all costs he must hide his struggle, his weaknesses and his pains. Yet these are an essential part of his humanness. In fact, in a way, it is only through allowing himself to be seen as vulnerable that he can be related to others (in group and in life) in a fulfilling way.

Contempt, as an intrapsychic mechanism, is a defense against a devastating feeling of being damaged and inadequate. On an Oedipal level, it relates to a denial of castration. It is a "cock-sure" position. On a more primitive level, it is an attempt to maintain an infantile narcissistic omnipotence (Freud, 1914).

Both these levels relate to avoiding what Perls (1969) refers to as impasse followed by implosion. By maintaining a smug, omnipotent position, a cool distance is preserved, not only from other people, but also from inner impulses which are feared as overwhelming. In a Freudian sense, the essential nature of danger is helplessness, a condition in which one has strong impulses which are completely impossible to put into operation. Castration or death is seen not as a state of nothingness, but as a state in which one is intensely bombarded by stimulation both from inside and out. The feared result is that an immense inner disturbance and flood of impulses will be experienced, which the individual, being paralyzed in a motor sense, will be totally unable

to carry out. This inability to discharge excitations, to restore a balance (homeostasis), is imagined as totally devastating (Silverberg, 1952).

One boy's first reaction to an awareness of cemeteries and death was an unperturbed curiosity, until he pictured the dead person under the ground getting thirsty. "But there wouldn't be any drinks Daddy. They couldn't get a drink!" With this, his whole tone changed.

Debbie, a pretty young social worker, through a good deal of analytic work, began to be aware of how often she utilized a contemptuous denial of sexual desires and needs for people, along with a neat controlled facade, to avoid her own impulses. In the course of discovering this contempt and the underlying anxiety involved, she began to associate at first to a movie (*Johnny Got His Gun*) in which a wounded soldier is armless, legless and unable to communicate, yet remembers and feels. Then she began to remember feeling armless and legless herself as a child—"round and plump, like an egg, and also an empty feeling in my stomach." She also remembered nightmares of being "taped like a mummy." In other words, analysis and acceptance of her use of contempt enabled Debbie to face previously avoided feelings of helplessness.

Contempt also functions as an interpersonal defense. Fears of being abandoned or rejected as valueless and unlovable are hidden behind a front of "not only don't I need them, but they are valueless" It is closely related to Nydes' (1963) description of the paranoid-masochistic character who gives up love for power and judges others in order to prevent being judged himself.

Thus contempt is a defense against feeling inadequate and helpless in the face of overwhelming feeling, and also serves to hide any vulnerability or need from others. The cost is tremendous. Fulfilling interaction with people becomes near impossible, even avoided, because it would threaten the contempt mastery feeling. In addition, a great deal of intrapsychic energy is

required to maintain the cool distance. The result is a lack of spontaneity, liveliness and creativity.

A Developmental View

Contempt is originally related to an attempt to provide some distance from an overstimulating parent. In the very early stages of development, it is a response to a fear of being swallowed or fused. It is a desperate effort to preserve a sense of self in the face of infantile buzzing and booming confusion. It thus becomes closely related to a denial of dependency needs which would re-arouse fear and confusion. Sexual overstimulation can also set off an intolerable flood of impulses which the child is not capable of discharging. In addition to its other defensive functions, contempt can then be seen as a device in a "quest for certainty" (Schwartz and Wolf, 1959), an attempt to see things in black and white, thus maintaining a cool distance from ambivalence and struggle.

These multiple determinations of contempt tend to begin to crystallize around a quest for certainty at about age four in "the phallic state of mind." Freud's (Silverbert, 1952) formulation was that at this age children feel, think and behave as if there were only one genital organ—the penis. Thus the world can be divided, with a neat and orderly sense of certainty, into the "haves" and the "have nots." This conviction leads to other important conclusions in both sexes. It is a highly determining factor in their attitude towards themselves and others. Girls tend to see themselves as intrinsically inferior and boys frequently regard themselves as superior. As Thompson (1942) and others have pointed out, these attitudes are not solely determined by biological factors and reactions to them. They are related also to cultural advantages and values.

The boy, in this manner, compensates for any fears of inadequacy in relation to father (or mother who is often experienced as a powerful and phallic witch on a broom during this period). Contempt also serves to deny any castration anxiety (as discussed earlier). He then adopts an attitude of contempt, scorn and, on occasion, pity for these inferior beings. The smug refusal to play with girls so often seen during latency is closely related to these feelings.

Of course girls can also adopt a position of contempt for inferiors as a reaction formation in a similar way. Debbie, for example, felt above all the "dirty" things boys did. She was a "lady," neat, clean and (above all) cool. She learned to act weaker and dependent as a way of disarming and controlling the boys she was frightened by. She remembers being afraid to play with boys, except the ones who had a crush on her—"they were safe, like little girls." At the same time, she also identified with her father as the superior one. At about nine or ten she remembers that mother and sister wore bras, "but father and I were the only ones with undershirts."

In this phallic period the judging and devaluing tendencies of the disciplinary struggles (anal problems), and the need to deny the dependency and confusion of the oral period, are crystallized into a disparate attempt to remain above it all.

Conflict, failure to understand, anything "childish," "silly," or "dirty" (including dependent, sexual and aggressive desires) are all looked down on. Superiority, certainty and omnipotent control are valued. Humpty Dumpty's contempt position high on his wall becomes an attempt to remain above (distant from) what is in essence the human condition. Acceptance and love of himself or another nonperfect person has become very difficult.

Contempt and Masochism

At this point in our discussion, the intertwining of contempt (as a sadistic or at times paranoid maneuver) and masochism becomes apparent. A contemptuous grandiose attitude is hidden behind every piece of masochistic submission. Also, woven subtly into every bit of contempt are threads of helplessness and inadequacy. Whenever you find a “hole in the head,” there’s always grandiosity and contempt.

A previous paper (Livingston, 1970) focusing on the treatment of masochism, pointed to the necessity of unveiling the underlying contempt and grandiosity. Larry, a young lawyer who is presented as a masochistic character, frequently masked his contempt behind assertions of timidity and unworthiness. For example, one time he was walking behind the therapist and whistled to get his attention (the way one might whistle to call a porter). Once in the office, the analyst wondered why he had chosen to whistle rather than to call out. Larry explained, politely, that he had wished to save the analyst the trouble of walking down the hall to the waiting room to discover that he was already at the office door and also that he was “too meek to speak loudly enough to be heard at the other end of the hall.” The therapist’s reaction at this point was to reflect, “You are so meek, polite and thoughtful. I couldn’t possibly feel your whistle meant ‘screw you.’ ” They both laughed heartily and Larry went on to discuss his resentment of his boss’ authority.

Larry’s whistle was closely related to fantasies of complete power and revenge against those who have made him feel helpless in the past. His aim is to maintain a subtle grandiose position from which he can contemptuously control people as objects to gratify his needs. As long as he struggles to maintain this contempt (whether it is veiled by politeness and submission or not) he will remain helpless.

Contempt is a major aspect of the sadistic and paranoid sides of sado-masochistic and paranoid-masochistic (Nydes, 1963) character structures. Masochism and contempt may thus be understood as two sides of the same coin. They disguise each other, lead to each other and alternate within the same person. One may be more prevalent (obvious) than the other in a particular patient at a particular time but, just as night follows day, they are inherently related.

Contempt, Masochism and Working Through

Working through can be viewed as the process of mourning idealized parents who never existed (Livingston, 1971). Through repeated, planned presentation of less and less distorted derivatives, the patient is again and again confronted with the necessity of relinquishing all illusions of omnipotence and ties to introjected protectors and providers.

Many theorists have defined masochism as an effort to maintain an illusory relationship with a parental figure or an introject (Glatzer, 1959), or, in other words, to maintain a symbiotic tie through submission and suffering (Bergler, 1949; Segal, 1964). Briefly, then, masochism may be seen as a stubborn refusal to separate from parental figures and an insistence on maintaining fantasies of security and omnipotence. It is a refusal to complete the working-through process.

In a very similar manner, contempt is also a refusal to mourn. It is essentially a position which denies human desires and needs for love and nurturance. The contempt master insists, in a disparate pressured way, that he does not yearn for loving parents or even for closeness. As long as a facade of contempt prevents him from being aware of his own inner feelings of helplessness and longing, the pain of mourning can be avoided. However, as

we have seen, the price for spontaneity, freedom and the capability to love is a high one.

Working through can now be understood as an unfolding, tedious and repetitive process of mourning. The patient must be confronted with progressively less distorted derivatives, in one area and then in another. With each discovery of alternating contempt and masochistic helplessness there is anxiety and pain, but this is balanced by the excitement of discovery and the freeing of energy previously tied up, and most of all by feelings of being accepted (perhaps even loved) as a fuller human being by analyst, group members and, most importantly, by himself.

This process of mourning must obviously include some seriously felt yearnings and a sense of loss. It is, at times, a heavy, sad feeling (quite different, however, from the dulling absence of feeling in a defensive depression). At times though, the sudden release of energy which was previously bound in resisting the mourning, and sudden spurts of real self-esteem, lead to lighter periods of laughter and enjoyment. If working through does not lead to an increased freedom to enjoy, even the work itself, then of what value is it? Humor, in fact, may be one key tool which can cut through a good deal of the taking oneself so seriously which is often seen in contempt masters. The Humpty Dumpty caricature can, for example, become an enjoyable confrontation technique. If the basic atmosphere is warm and accepting and people can laugh together (not at one another, but together), then the terrors of coming down off the wall are lessened.

Time, repetition, acceptance, patience and a sense of understanding the tedious alternating of feelings of helplessness and contempt; of heaviness, longing and sadness and then elation, excitement and lightness are the essential means of really working through towards autonomy and maturity.

Therapeutic techniques are really very unimportant compared to the patient understanding and accepting the process of working through. The repetitive, tedious alternating between two poles is not simply an annoying side feature of analytic work. The gut level experiencing of these ambivalences is part and parcel of the essential nature of the process. Patients are thus gradually enabled to tolerate increased doses of anxiety and confusion. These forays into the unknown are increasing tests of relinquishing the quest for certainty. The very swings from searching for masochistic and symbiotic dependency to a contemptuous denial of any such yearnings build up ego strength—if the patient is enabled to discover how they function. Becoming aware of and knowing that he can survive these contradictory impulses is the means by which infantile wishes can be tolerated and eventually mourned and relinquished. The repetitious unfolding of swings in an atmosphere of understanding and acceptance is the process of working through. An understanding of this process, which has been referred to as the "warp and woof" of analytic therapy (Glatzer, 1969) is essential to any psychotherapy with reconstructive goals. It is that "part of the work that effects the greatest changes in the patient" (Freud, 1914b).

Contempt, Masochism and Working Through in Group Psychotherapy

A group setting is, at the same time, the most difficult and the most effective one in which to contend with the contempt master. It can be a very threatening place and force Humpty Dumpty even higher on his wall. A psychotherapy group confronts him with an onslaught of his refusal to mourn and his precious distance above being less than omnipotent. If the group is to be effective, the threat posed by this onslaught must be balanced in some way.

If Humpty Dumpty is to relinquish his safe and certain position on the wall, he must sense that he will not be left alone without getting something of value

in return. This is precisely what a group can provide. The something of value is essentially a feeling of intimacy and belonging, an opportunity to experience himself as a fuller human being in an accepting, nonjudging atmosphere. As was discussed in detail in a previous paper (Livingston, 1971), the relinquishing of wishes for omnipotence and security in the working-through process is best carried out as a shared experience. Mourning has always been a shared experience in many cultures. Those who are under less stress at the moment can lend support and keep the impulses (including rage and grief) from being overwhelming.

The subtle task of the group therapist is to promote an atmosphere in which the working through can unfold. The contempt master has, in the past, managed to repeat experiences of feeling put down and rejected or else of being allowed to feel that he is above needing to belong or to be related to others. Early responses to him in the group are likely to be similar to these previous experiences. The first key to "contending with the contempt master" is that contention itself may somehow be avoided. The leader, and eventually the group members, must learn not to become embroiled in the subtle forms of a "which is to be master" contest. This can be done with surprising ease once the defensive aspects are understood rather than responded to with one's own contempt-masochistic defenses. Obviously then, the leader's personal analysis and his openness to accepting residuals of contempt in himself, are a prerequisite for dealing really effectively with such patients. The patient who is allowed to remain separate from the group often represents a rejected part of the members' (or the leader's) sense of themselves. In understanding and accepting Humpty Dumpty they are actually integrating, in a Gestalt sense, and accepting a part of themselves. Often the first step along these lines is pointing out to the group as a whole that contempt becomes a two-way interaction. The role the other group members play in perpetuating

the defensive system must be interpreted. The other group members are often less defensive at the moment. Then as they accept the two-way nature of what is going on, without feeling a need to fix a blame, Humpty Dumpty may begin to venture off his wall and join in.

Pairs of patients who are relating to each other in such a subtle sadomasochistic manner can often be confronted in a way which frees not only the pair, but the whole group. They both expressed a good deal of warmth for each other and looked to each other for support in the group session. In individual sessions, Debbie expressed a good deal of contempt for Morris as being like the little boys whom she remembered seeing as harmless once they had a crush on her. She felt he was in some way controlled by her and dreaded his reaction to realizing it. She expected him to despise her as a "low worm-like thing" and feared losing his affection. At the same time, Morris felt that, although he liked her and in many ways saw her as bright and attractive, Debbie was very dependent and easily controlled. He often felt guilty for "pulling her strings" and getting the responses he wanted. At the same time he felt that if he were direct and sexual with her, she would despise him as physically unattractive and no longer respond warmly.

Both Morris and Debbie feared that they would be rejected if their thinly veiled contempt were discovered. When they got up the nerve to explore these aspects of their relationship, there was a good deal of anger, but each was eventually able, with the group's help, to see the two-way nature of the interaction. No one was blamed or found guilty. The group was interested and excited by their openness and the working relationships in the group were greatly enhanced. The friendship between the two patients deepened also, but this is a frequent side gratification and not necessarily the result. The essential result was that in working through their contempt along with fears of being

discarded as worthless or bad, they both were able to accept additional parts of themselves and to give up a bit of the need to maintain a controlling contempt toward each other.

It is difficult to give detailed examples of working through because, by its very nature, it is a process which occurs over and through time. The above interaction took place gradually over many months and in itself was only a small part of the alternating phases of moving towards a more separate, non-sadomasochistic way of relating and then retreating which both patients had been going through. It is a part of a process of tolerating the anxiety and confusion of giving up contempt, or its masochistic other side, and then jumping back up on the wall again for awhile. Each clarification, each sense of real ego strength liberates energy, provides some sense of worth and, in turn, also enables the patient to get involved in further confusion and to face other feelings of helplessness. Here again a familiar piece of contempt is discovered hidden in some other area. And there again . . . and again. Through this repetitious confrontation and mourning, Debbie and others in her group have dealt more and more effectively and openly with their needs and desires. They have also become gradually more sensitive to other s pains and desires. More centrally, she has begun to really value and enjoy people. Her capacity to give and receive love has steadily unfolded, along with an ability and willingness to face the lifelong continuing process of the human condition. Sharing this process in group with other struggling, emerging individuals was an important factor in her ability to mourn her "wall," to accept herself and others as less than perfect, and to grow.

Summary

Contempt is a pervasive, at times subtle, defensive position. It can, if not understood, lead to a patient remaining isolated even in a psychotherapy

group. Intrapsychically, it is a defense against a devastating feeling of being damaged, inadequate and helpless. It also functions as an interpersonal defense. Fears of being abandoned or rejected as valueless and unlovable are hidden behind a front of "not only don't I need them, but they are valueless." Contempt thus attempts to hide vulnerability and to provide a safe certainty and a cool distance from impulses which are feared as overwhelming.

It is integrally related to masochism, which can be viewed as a refusal to mourn, to relinquish ties to introjected parental figures, thus maintaining a sense of security and omnipotence. Working through is seen as a process of mourning this omnipotence in the form of idealized parents who never were. In this process, contempt for imperfect humans who don't replace these introjects must also be repeatedly confronted and relinquished.

The group setting can be a potent force in both confronting patients with their contempt for self and others, and in providing something for which it is worth giving up the safety of their defensive position. What the group provides is an example of human intimacy and belonging. In this way it enables the patient to gradually tolerate increasing doses of uncertainty and anxiety—to accept himself and allow himself to be seen as a vulnerable, less than omnipotent, human being.

References

- Bergler, E. (1949) *The Basic Neurosis*. New York: Grune and Stratton.
- Freud, S. (1941a) On Narcissism: An Introduction. *Collected Papers*, 4:30-59. New York: Basic Books, 1959.
- _____(1914b) Recollection, Repeating and Working Through. *Standard Edition*, 12:145-156. London: Hogarth Press, 1958.
- Glatzer, H. (1959) Analysis of Masochism in Group Psychotherapy. *International Journal of Group Psychotherapy*, 9:158-166.

- ____ (1969) Working Through in Analytic Group Psychotherapy. *International Journal of Group Psychotherapy*, 19:292-306.
- Livingston, M. (1970) Speculations on Treatment of Masochism. *International Mental Health Research Newsletter*, Spring.
- ____ (1971) Working Through in Analytic Group Psychotherapy in Relation to Masochism as a Refusal to Mourn. *International Journal of Group Psychotherapy*, 21:339-344.
- Nydes, J. (1963) The Paranoid Masochistic Character. *Psychoanalytic Review*, 50:55-91.
- Perls, F. (1969) *Gestalt Therapy Verbatim*. Lafayette, California: Real People Press.
- Schwartz, E. and Wolf A. (1959) The Quest for Certainty. *Archives of Neurological Psychiatry*, 81:69-84.
- Segal, H. (1964) *Introduction to the Work of Melanie Klein*. New York: Basic Books.
- Silverberg, W. (1952) *Childhood Experience and Personal Destiny*. New York: Springer.
- Thompson, C. (1942) Cultural Pressures in the Psychology of Women. *Psychiatry*, 5:331-339.

• 7 •

SOME THOUGHTS ON WORKING THROUGH IN THE LIGHT OF MY GRANDFATHER'S DEATH

The “working through” of resistances was described by Freud (1914) as that “part of the work that effects the greatest changes in the patient and that distinguishes analytic treatment from every kind of suggestive treatment.” Rado (1925) compared this process to the work of mourning. He described the representation of the tie to a lost friend by hundreds of memories and the nature of the work of mourning as the dissolution of each of these in turn. Again and again he had to realize and to re-experience that “there too and there again” the object was lost.

The first step of mourning is the establishment of an introject. An attempt is made in struggling toward separation (in accepting a death and in moving towards termination in psychotherapy) to incorporate attributes of the valued person. This stage of the mourning thus consists of the reminiscing and re-experiencing of some of the many contacts which occurred during the relationship. The establishment of a transference and the re-experiencing which goes on in psychotherapy is related to this stage.

The second part of mourning consists of the loosening of the binding to the introjected object. The later stages of working through in psychotherapy can be conceptualized as the carrying out of this second part of the mourning, the separation from parental introjects and the dissolution of their projection in the transference. Its completion involves the relinquishment of illusion and the acceptance of a separate life without omnipotence or an omnipotent protector and provider.

In previous articles (Livingston, 1971 and 1973) I have discussed the central role of this mourning-working through process in psychotherapy and some of the many resistances (especially contempt and masochism) which are, in essence, a "refusal to mourn". I have also stressed the importance of deeply personal sharing of such experiences in group psychotherapy as an important element in enhancing the process. My experience with such sharing has convinced me of its growth value both for the mourner and for those with whom the experience is shared—for we are all, in a sense, mourners. We are all struggling to grow in coping with blows to our infantile wishes as well as with any recent losses. We are all struggling to accept and to experience more fully the human condition, which includes an awareness of helplessness in regard to our own finitude.

Thus, I have judiciously shared personal experiences with students and with patients, and consider it a major means of getting across my conceptual thinking in a teaching sense and more importantly as a stimulus to growth through facilitating the process I have outlined. Other chapters (particularly 4, 6 and 8) deal with the conceptualization of mourning in relation to resistance, termination and the essence of the psychoanalytic process. At this point, in a more intimate (new) moment, I would like to share a personal mourning experience with you, as I might share it with patients or students when I sense that they are ready to deal with such stimulation. (As with allowing my children to share in the mourning of their great grandparents, I am always alert to what stimulates growth and struggle and at what developmental moments such sharing could become an over-burdening bombardment. Neither extreme protection and strict refusal to share openly, nor a random confrontation with personal material without sensitivity to its impact with optimally facilitate growth). I wrote the following letter upon returning from burying my grandfather. I had no idea of its purpose as I wrote it, but I read it

to my grandmother and some other relatives a few days later when my wife, children and I made a *shiva*(condolence) call. My children (10 and 8 years old) chose not to attend the funeral, which I think would have been too upsetting, but were eager to visit their great-grandmother and very meaningfully expressed their own memories and feelings in the sharing which followed my reading.

Spring 1974

Dear Pop,

One last note to say goodbye; then I will continue to let go. I told you most of what I needed to in the hospital when I knew it was the last time I'd see you . . . I told you how much you meant to me when I was a kid. I remembered with you how your smiling encouragement spurred me to climb monkey bars and bigger ladders. I told you how much you are with me even now. Parts of me I hold dearest I connect lovingly with a part of you I have digested and made mine. The sensitivity to pain in your wizened old eyes, the physical and emotional sense of strength in a man who could fight hard and angrily; yet also cry tenderly with a small boy. Your great grandchildren also remember a man who loved deeply. They felt your patriarchal pride in them as your offspring and they remembered how you played with them and enjoyed them. They asked if they could have the ashtray shaped like a tire to keep on the fireplace because they want to keep a part of you with them and they remember the fantasies you shared with them about horses running around the tire like a racetrack.

I guess the real reason I'm writing is I wanted to share the funeral with you. You would have understood most of it and felt very deeply. I greatly miss the times we shared understandings of life, death and

helplessness. The times you tried to tell me that there were some times and events which we couldn't control or even comprehend. I love you very much, Pop, and I often felt it was alright to not understand when I was with you. Now I can sometimes accept it even when I'm alone.

Grandma kept calling you Pop. I call you Pop because I feel you are much more to me like a father than a grandfather. Grandma, too, loved you very much, and for the first time I could see her as a helpless little girl who needed a Pop the same way that I did when I was a boy. You were often there for me, for Mom, and also for your wife. She was often really more little girl, or at times mama, than wife. In the end she was so real, Pop—so beautifully real—that I wanted you to know, to share her with you. She called, "Papa don't leave me." And as I covered you with the symbolic three shovels of dirt she cried out in pain to your children to "do something. Don't let them take him away." I remembered your great grandson's response. Glenn cried when he heard and he said, "But I don't want him to be dead, I didn't want him to die." The eldest and the youngest responses to losing you were the same. For that matter, I remember on the way to the hospital saying, "But I don't want to say goodbye."

Your daughter Esta, my mother, cried deeply on my shoulder and I felt the screams of protest in her body. Yet we knew that you felt it was time and no longer fought to go on. We shared that moment with my wife who also loved you dearly and we mourned you as if you were my father.

At the very end Grandma turned to my mother and said, "Esta, do something! You always did." The three of us cried as I mumbled something about times when we are ultimately helpless and find it

painfully hard to accept. I thought of some of our talks years ago. I fell once more your loving acceptance of my youthful drive to understand everything, of my desperate urgency to 'know' following my father's death.

As Grandma walked away from the grave she pleaded, "Why did God take him away from me?" "Why a lot of things?" I thought as I kissed her goodbye.

I feel a peacefulness at the moment. These very human treasures I have taken from loving and being loved by you. It was very very good. . . And now, through my tears, I want to say goodbye. It doesn't feel so much as a "have to " anymore. I am ready, for the moment at least, to let go. Goodbye Pop. I loved you very very much.

(After writing that last line, I suddenly cried and screamed in a way that I never have before. I guess that's why I had to sit here alone and write—it was, itself, a struggle to let go. I put this last note in parenthesis because I am no longer writing to Pop. Yet it feels important to share it—I'm not sure yet with whom.)

It has been said that “death does not end a relationship. It continues in the mind of the survivor; striving towards resolution.” The work of mourning continues over a varying length of time. Often intensively for about a year (or sometimes over a lifetime). The heavy pain and sorrow fade in time, to be replaced by acceptance and a peaceful sadness. In the first reactions to loss, mourners often experience a reluctance or even refusal to let go (of their tears and of loved one). As mentioned previously, the first step of mourning is the establishment of an introject. these feelings are evident in my initial reaction. The flood of tears emerged by surprise as part of a struggle to let go. However, in reading the letter I can re-experience my reluctance to do so. The main

purpose of the writing seems to be related to reminiscing in order to feel closer—to establish a sense of identification. In working through this stage of the mourning, I was attempting to take in, and hold on to, the parts of my grandfather which had been so important in shaping who I had become.

The second part of the mourning, consisting of the loosening of the ties to the loved one, had really started years earlier as I grew up and became a separate person. However, with his death, another phase of this process was beginning. Through tears I said goodbye, but the heaviness lingered. For about six months I was aware of a lack of zest, especially in my physical pursuits (the areas of athletics and sexuality are where I always felt most connected to Pop). Then slowly, over time, a renewed sense of vigor returned. In fact I began to feel more solid in many ways than I had before. I was integrating deeper parts of myself which were related to him and to those childhood years and which seemed more available to me now than they had before. This second part of the mourning becomes clear in the following letter.

January 1979

Pops,

I woke up in the middle of the night wanting to write to you. I don't know why. I don't understand. Funny, those are the thoughts I always had as a kid about my father's being dead. Only this time they express a peacefulness—not a demanding, searching cry.

I must have had a dream before I woke. I can only

recall thoughts of a red clay-like overlook and the Pacific below. I'm vacationing on the island of Kauai, so the scene isn't hard to place. I hear the ocean now and it reminds me of you.

I haven't written much for a long time. I haven't been aware of thinking of you for a long time either, now they come together—my wanting to write in the middle of the night and some vague wish to communicate with you—to let you know.

It has been about ten years—at least it feels that long. (I sense it's probably more like five.) After you died the family seemed to scatter. By the time of Grandma's unveiling a few years later only Mom and two other of your many sons and daughters showed up. Out of all the cousins I knew as a kid, only I was there. Sherman, your youngest, was a gray-haired grandfather. The scattering and not being there that day was more emotional than geographical.

You held the family together and without you the petty angers spread it in pieces. I think the separate pieces have each done well though—what you began has thrived in its own way (very differently than the way you envisioned, yet I think you would be happy about most of us).

I know you would feel good about where I am and the roads I've travelled. I guess I am wishing I could let you know. I keep wondering why tonight. It would be uncanny if you died in January. The urge seems to clarify itself a bit now. What I want to let you know is that I'm okay now. I feel very tearful as I write this part. I don't know why. I have thoughts about being a grandfather someday. The great grandchildren you knew are growing up fast and beginning to date. They are fine young people—mench, as you would say.

Surprisingly, my thoughts end there. Sadness remains; a sense of peacefulness remains; my urge to communicate seems to be fading along with my image of you. Strangely, what I want to tell you is that it hasn't been a perfect vacation. Laura has pneumonia, I sprained my

ankle and it has rained a lot. We are together though and we are okay. I guess I'm saying I can take it from here Pop, but I have felt that for a good while.

I suppose, undramatically, I'll just say goodbye again. Pop, I love you and miss you—wish I could share my family with you. Bye.

The parallels between these mourning experiences and the working through process in psychotherapy are striking. The establishment and deepening of transferential attachment and the encouragement of regression are similar to the first phase of the mourning. Through the transference, the patient is able to reexperience, this time with increased awareness, his attachment to, and symbiotic incorporation of, his early love objects (thus repeating a process of establishing them as introjects). Then, the unrealistic aspects of his attachment to introjects and his wishes that they provide a magical protection must be confronted and relinquished. This second phase of the working through and resolution of transferential wishes is akin to the second stage of mourning (the loosening of the ties). In this manner, working through in psychotherapy may be seen as parallel to a healthy mourning process.

References

- Freud, S. (1914) Recollection, Repeating and Working Through. *Standard Edition*, 12-145-156. London: Hogarth Press, 1958.
- Livingston, M. (1971) Working Through in Analytic Group Psychotherapy in Relation to Masochism as a Refusal to Mourn. *International Journal of Group Psychotherapy*, 21:339-344.
- ____ (1973) The Economic Principle in Psychoanalytic Technique. *International Journal of Psycho-Analysis*, 6:35-44.

ON STRUGGLING TOWARDS TERMINATION³

Every group deals with its own ending, or the departure of one of its members, in its own style; each separation is a unique experience. To impose any preset order or expectations can interfere with the natural flow of the mourning and joy involved in “such sweet sorrow.” Yet there are several issues which are inherent in any struggle towards separation. It is these common themes upon which I want to focus.

The largest obstacle to a healthy mourning process is the harboring of hidden grudges. These left over antagonisms are often kept secret because airing them leads ultimately towards a relinquishment of the infantile expectation that restitution will be made. As Hennie Glatzer has discussed, a major resistance to giving up fantasies of the witch mother is that it requires at the same time giving up the belief that an all good object must exist somewhere. Helen Durkin expressed a similar concept, “The grievance must be taken out in order to allow the grieving.” Only after the angers and disappointments with the group and its leaders have been voiced, can the members begin to deal with a real letting go.

Once the angers at the bad (less than omnipotent) leaders and the illusions of perfect leadership have been, to a degree, worked through, it then becomes possible for a group to take in the leaders as well as the other group members. This process parallels the displacement of a harsh, unreasonable superego; hopefully, the introject which is formed at this point is a more human and self

³ This paper first appeared in *Group*, November 1974. It refers to comments made at a workshop on “Termination in Group Psychotherapy” at Post Graduate Center in New York during the spring of 1974.

accepting one. Group members deal with this essential first half of the mourning process by striving to make contact with each other and with the leaders. Efforts are made both to reminisce over the meaningfulness of past contacts and to touch each other in a deeply personal manner, in preparing to part.

Group members often express, directly or more subtly, a wish to know the leaders' response to the approaching separation. Two conflicting needs are being dealt with in this behavior. First of all, it is part of the establishing of an introject mentioned above. "Am I important, meaningful, to you? Do you also feel loss, pain and joy; or does a real grown-up rise above such childish feelings?" Such communications are often latent rather than manifest, but have a large effect on the expectations the members will have of themselves. If they incorporate a picture of their analyst as cool and unmoved at such a point, they may retain a larger chunk of grandiosity or contempt in their expectations of themselves.

On the other hand, another latent struggle in the wish to see what the leader is experiencing is the struggle to resolve their own guilt about hurting or damaging their parents in growing and separating. "Does my autonomy cause you pain?" may be the underlying communication. These latent fears must, of course, be analyzed in a treatment group, and at least understood in other settings, if a free letting go is to be accomplished. Patients really need to experience that the relationship has been meaningful and that (if it is so) there is some pain for the leader, too. However, it is essential to differentiate pain from damage and, in an analytic way, to work through the patient's fantasies of revenge and wishes to hurt.

In the same manner, a differentiation must be made between the childhood terror of abandonment, helplessness and death on the one hand, and the

apparent helplessness and finality of the current separation on the other hand. It is this repeated experiencing back and forth, thus separating fantasy and reality, which constitutes the working through process. It is this gradual loosening of ties, as in the second stage of a mourning process, which enables the group to experience a termination fully.

The reason this article is entitled “On Struggling *Towards* Termination” is that—when we observe a termination in our groups—we most often see the work done in preparing for the experience of separation. The deepest part of the experience, though, can only take place when the actual separation has occurred and been accepted. For example, my son and I spent a good deal of time experiencing and sharing our feelings about our anticipation of his first summer at sleep-away camp. However, when the bus actually pulled away, I said to myself, “He’s really gone. That bus isn’t just going around the corner and back. It’s going to New Hampshire. He won’t be home all summer.” Only then did I realize how much I experienced a part of me off along out there. I was surprised, pained and also felt a real joy in his growth. I shared these feelings with my wife and daughter, and someday I will probably tell Glenn about them, but it was not possible to share them with him. In a similar way, we as therapists can never fully terminate their treatment relationship with us. Thus, we concern ourselves with the work aspect of analysis and its heaviness, and occasionally lose sight of its lighter side and its relationship to the enjoyment of life. The role of mourning is to enable the mourners to let go, not to allow their pain and helplessness about death to bind them in sorrow and anger, but to free them to return to life. Or, in the psychoanalytic sense, the role of working through is the process of mourning idealized parents who never existed and the relinquishment of illusions of omnipotence and omnipotent protectors and providers, in order to be free of the burdens they impose.

To the degree that both stages of mourning (first, the establishment of an introject and, second, the loosening of ties to the introjected object) have been carried out, the participants will be free to experience what feelings they experience, or even whether they have feelings at any one moment, without expecting any particular stereotype. There is no right way; it is important for each individual to feel free and unashamed of his own unique experience of terminating.

The essential thing is to go through the experience, as opposed to a “refusal to mourn,” or a compulsive repetition of ritual. The goal of this often painful and tedious mourning-working through process, of struggling towards termination, is autonomy (which includes a sense of joy in experiencing and an increased freedom of choices). If this is so, then must not the whole process be deeply experienced without stereotype because, “means are simply ends in the process of becoming?”

ON BEGINNINGS

Life is a continuous series of beginnings and endings, of coming together and partings, from birth to death. Each of these events is embedded in the past and a future of its own. A group is thought to begin when some number of people enter a room and to end when they depart, but it really has roots in each person's past experiences and fantasies and it often continues to have meaning beyond its formal ending. Also, from its inception, each member of a group is effected by his own growing awareness of the inevitability of eventual termination. From the very first session, conflicting forces, progressing toward and at the same time struggling to prevent or at least to delay separation, are operating.

The most powerful resistance to the experience of parting, of termination, is not to begin (not to form attachments or a cohesive group in the first place). "Why allow myself to get so involved if we will part in three days (or three years)?" Thus one of the main tasks of the group and its leaders, during the phase we refer to as beginning, is the exploration of these resistances in order to facilitate a cohesive growth-inducing atmosphere.

A conceptualization of this task calls for an understanding of the past and the evitable transference wishes and fears which each member carries with him. The group situation stimulates a reliving of early family experiences and patients tend to set up their own networks rather quickly. Ideally, extended individual preparation over many months provides a group leader with a sense of a patient's dynamics but, even then, new dimensions are unfolded as the group begins and the relative safety of a one-to-one setting is left behind. Much of the initial stage of a group deals with the anxieties aroused in this manner and with the avoidance of fantasied catastrophes.

Conceptualization of the beginning of a group also strains one to think out the entire process—particularly the struggle towards termination. From a psychoanalytic viewpoint, the process of psychotherapy may be described as the working through of transference demands. Transference is essentially a demand for gratification of infantile wishes for an omnipotent provider and protector or an attempt to play that role oneself. These wishes must ultimately lead to disappointment. The working through of this disappointment in the struggle towards termination is a mourning process in which the ties to such omnipotent figures are gradually relinquished. The termination of a group is symbolically an experience in parting, once again, from one's childhood family and a step towards freeing oneself from the repetitious nonproductive quest for it.

Even in a short-term group, I accept this involvement and separation as the core experience I want to facilitate. Thus I see the beginning of a group as the forming of libidinal ties, the bringing into awareness of transference as well as fulfillable expectations, and the initiating of a mourning process. The leader's role, then, becomes one of facilitating an atmosphere in which people can risk openness, vulnerability and intense involvement, as well as an awareness of their own separateness and willingness to experience their own unique responses to our coming together and our parting. No two groups and no two individuals will go through this identically. The important thing is always to experience—the group process and life itself.

Concretely, in observing early sessions (and also, incidentally, in the beginning of each session) it is important to be aware of several themes which may be stated as questions: When does a group seem to form, to get off the ground? At what point does each participant become a member? When is deep pain touched and a mourning process begun for each person? What forces are

operating to enhance the formation of a growth-facilitating atmosphere and what forces are working against it (in the individuals and in the group as a whole)? What are your own attitudes and responses to groups in general and to this specific one, as well as to closeness and to separation? How do these attitudes relate to your individual style as a group leader? Such questions can be useful to a leader, an observer or even a participant in a workshop group.

Conceptualization must always provide a flexible backdrop or framework from which to understand the flow of a group's process; however, no rigid expectations or preset order can be imposed, with the unique unfolding of an experience. There can be no one way, no right and certain technique, to facilitate the beginning of a group. A leader must strive toward an ever-increasing awareness of his contributions and his limitations as well as where his group is. Each new group, and even each session, marks the opening of a unique opportunity for discovery and experience.

• 10 •

ON BARRIERS, CONTEMPT AND THE CONCEPT OF THE “VULNERABLE MOMENT”⁴

*Something there is that doesn't love a wall
That sends the frozen-ground-swell under it,
And spills the upper boulders in the sun;
And makes gaps even two can pass abreast.*

*I let my neighbor know beyond the hill;
And on a day we meet to walk the line
And set the wall between us once again.
We keep the wall between us as we go.*

*there where it is we do not need the wall;
He is all pine and am apple orchard.
My apple trees will never get across
And eat the cones under his pines, I tell him.
He only says “Good fences make good neighbors.”
Spring is mischief in me, and I wonder
If I could put a notion in his head:*

*Why do they make good neighbors? Isn't it
Where the cows are? But here there are no cows.
Before I built a wall I'd ask to know
What I was walling in or walling out.*

⁴ This paper first appeared as a chapter in Wolberg and Aronson, *Group Psychotherapy*.
1975

*He moves in darkness as it seems to me,
He will not go behind his father's saying,
And he likes having thought of it so well
He says again, "Good fences make good neighbors."*

Excerpt from "Mending Walls"
by Robert Frost

One essential similarity in the many diverse approaches to psychotherapy is the question of rigid walls (at the very least, within a therapy group). The softening or removal of these barriers, allowing moments of deep openness, facilitates growth. These vulnerable moments, though they are not often a conceptual focus, are central to working through and the entire psychotherapeutic process.

In this paper, I would like to discuss the concept of the "vulnerable moment" and to look at masochism and contempt as two major barriers, or defenses, against the risks involved in such vulnerability. Then, I would like to suggest that a great deal of the group leader's role may be conceptualized as the facilitation and prolonging of vulnerable moments through the removal of rigid or unnecessary barriers. Lastly, I will outline some of the techniques which I have found useful in implementing this concept.

The Concept of the Vulnerable Moment

What I mean by "vulnerable moments" is essentially those brief periods when a person is able to let go of his defenses fully and to allow himself to be open, soft, and very, very human. My first awareness of the power inherent in the sharing of such moments came as a patient in a group. For years I had struggle to express myself and to be part of the group. For years I had hit a silent wall in response to my efforts to share my feelings, and had retreated,

again and again to my comfortable role as understander and empathetic listener. Finally, these frustrations built to an unbearable point and, in one session, following a fruitless attempt to communicate, my limits exploded. In response to my anger at the group's unresponsiveness, one woman said that although she really wanted to be with me, she found herself daydreaming about her father's death (which, of course, was totally unrelated to the content of what I was struggling with). It was at this point that Mannie Schwartz, the group's leader, intervened. 'Don't you see? For years, whatever the surface content, Marty has been trying to deal with what he felt when his father died.' "And no one ever listened," I added. "Not now and never when I was a little kid." These words unlocked the flood gates. I cried, and I remembered, or perhaps relived is a better word, how wretched I felt when my mother and the others all ran from me and my grief. Of course they ran from their own pain, as the group had been doing with my struggle to mourn over those years, but I always felt something was wrong with me and had blocked any time I began to approach these feelings. For the first time I was able really to cry openly, to be helpless and soft—and to mourn. The group shared my grief. Several people cried for some of their own losses. Over the next few months, a tremendous amount of growth took place. We all felt stronger and freer really to be ourselves.

Insights followed. I even wrote a paper about the importance of the shared mourning of transference wishes as an aspect of working through in group psychotherapy (1971). These insights served what Ruth Cohn (1970) refers to as a "cementing function." However, the deep structural changes we experienced seemed to flow naturally in response to a group process. It was as if a mystic nurturing force existed in the setting.

A year later, I had similar experience in a workshop which functioned as a group in an effort to increase our understanding of various leadership approaches. This time it was much clearer to me that the nurturing force was, in actuality, an atmosphere. It was an atmosphere, in this case, clearly created by Ruth Cohn, the workshop leader, who skillfully and intuitively cut through a participant's defenses in a Gestalt exercise. These exercises focus on one volunteer who takes the "hot seat" and works intensively, under the leader's direction, on a dream or a conflict situation (see Perls, 1969 and also Cohn, 1970 for examples of this technique).

We met with Ruth only a few times and only two or three of us had the opportunity to work on the "hot seat," but the depth of openness reached was unusual to say the least. What is most important here is that the vulnerable moments we shared led to a great deal of growth in all of us.

The mystic power of such vulnerable moments can, of course, be understood. In fact, like all magic, it is absurdly simple once you understand the trick. The experience of being able to be totally open in an accepting (perhaps even loving) atmosphere allows those who share in it to integrate previously rejected parts of themselves. The sense of true vulnerability and humanness is contagious. Following such an experience, not only the individual who finds himself taking the original risk, but all those who are able to share such moments, are more fully able to evaluate their feelings and to begin to accept themselves. Another especially potent force for growth is the sense of creativity a patient can begin to feel when he realizes, as I did in these two groups, that his openness can generate a loving and accepting atmosphere that facilitates growth.

Cohn (1961) also reports discovering that the creation of an intimate atmosphere which allowed therapists to be vulnerable in a

countertransference workshop had a similar effect. Many participants became aware that in response to the atmosphere in this setting they increased their intuitive skills and became more empathic.

It is important, though, not to be carried away with the "simple and magical" in such moments. Vulnerable moments, if not handled skillfully, and, above all, worked through, cannot, in themselves, lead to full autonomy. The repeated experiencing of openness and defense must eventually result in giving up the rigidity of the defense, and a mourning and a relinquishing of the wishes for certainty and control.

In essence, the therapeutic process involves giving up the wish never to be vulnerable. True vulnerability occurs in brief moments. However, the courage to allow oneself to be vulnerable (nondefensive) when appropriate is also an ongoing personal quality. The enhancement of this ability is one of the goals of treatment.

Vulnerable moments always include a sense of separateness and, at the same time, a deep participating in the "human condition," and a sense of responsibility for one's own feelings. Such moments are achieved only through risk and struggle. One essential struggle involved is the anxiety-arousing awareness of the following "existential paradox." Each of us is essentially separately and unique and feels the pain of loneliness as well as the threat of meaninglessness; yet, in the very acceptance of this separateness and its risk, we touch the human condition we all share. It is in this vulnerable sharing that we are most truly *not* alone. It is at such vulnerable moments that we most fully experience ourselves.

The courage to share these moments facilitates growth. That is why the group is a particularly effective modality with which to implement the concepts we are discussing. Vulnerability is experienced as a narcissistic blow.

It carries with it a great deal of pain and grieving. If defenses are to be relinquished, even for a moment, the individual must get something of value in return. The group can provide this something of value in its intimacy and sense of belonging. It also capitalizes on the contagion of such experiences, thus providing a deeper sense of acceptance and “I’m-not-a-freak” than an individual analyst could.

The growth which follows these moments includes an increasing courage to face the risks of the future and an increasing ability to differentiate necessary barriers from rigid dehumanizing stereotypes. The growth we are talking about can, of course, also be viewed as the relinquishing of defenses, the resolution of transference and the letting go of omnipotent fantasies; the ability to mourn and move on to a new integration.

Masochism as a Barrier to Vulnerability

It is important to differentiate a masochistic pseudovulnerability from the concept on which we are focusing. The basic element in the masochistic syndrome is a denial of strength and separateness. The masochist demonstrates his fear, suffering and helplessness to the therapist, and to the world, in return for a bargain in which he will be fed without moving from his safe, passive position. It is a submissive, yet demanding, attempt at maintaining a symbiotic protection from anger and risk. It is a refusal to mourn, a refusal to relinquish fantasied ties to omnipotent protectors and providers. In essence, the masochist masquerades as helpless, but is really clinging in order to escape vulnerability (see Livingston, 1970 and 1971 for a more detailed discussion of masochism).

A vulnerable expression of pain or helplessness, on the other hand, is not an attempt to manipulate or bargain. It is simply an awareness and expression

of feelings. In contrast to the masochist, the vulnerable person has a sense of separateness and responsibility.

Contempt as the Major Barrier to Vulnerability

Contempt is the most significant barrier to vulnerable moments in a therapy group because it not only prevents the contempt defender from being vulnerable, but also poses a threat to the other group members, making it difficult for them to lower their own barriers. One real contempt master (see Livingston, 1973 for a more thorough discussion of this syndrome) can subtly set up a judgmental tone and an uneasiness in the entire group if his defensive patterns are not understood. Contempt is a defense against feeling inadequate and helpless in the face of overwhelming feelings. It is an attempt to set up a barrier which hides any vulnerability or need. Subtle tones and gestures are used to give the impression of being above such needs. Skillful condescension and justification are part of the pattern, often leaving anyone who tries to confront the contempt master feeling confused, helpless and inadequate. If these maneuvers are really carried out cleverly, the other person even feels that his anger is totally unreasonable and that he is somehow “the crazy one” for acting so irrationally.

Essentially, contempt is an attempt at escaping the human condition—an attempt at maintaining barriers which avoid vulnerability. This raises the question of what is so frightening about vulnerability. What fears lead to the erection and rigid use of these barriers? Fears of being overwhelmed by impulses, of being out of control, are part of the motivation. Fears of being rejected and abandoned, of being helpless and alone, are also part of the picture. However, in a group setting I think the greatest fears come under the heading of, “If I allow myself to be truly vulnerable, I could become the victim of ‘mind-fucking.’”

"Mind-fucking" is a difficult expression to define and an even more difficult one to replace. Perls (1969) uses it to refer to "ping pong games, 'who's right?' opinion exchanges, interpretations, all that crap." In another part of the same series of lectures, he resists defining it at all with the phrase, "Mind-fucking is mind-fucking. It is also a symptom which might cover something else. But what is there is there. Gestalt therapy is being in touch with the obvious." Essentially though, the term refers to obsessional or intellectual procedures which lead away from real awareness of the here and now and into a fruitless search for control and certainty.

In extending the term into the interpersonal sphere, it is often applied to the use of subtle intellectual maneuvers in order to maintain a superior, safe position at the expense of another individual who is treated as if he or she were inadequate, crazy or unreasonable. The victim in these games usually feels devastatingly confused. He feels humiliated and unable to deal with a flood of feelings. In extreme situations he may even be made to feel ashamed of his anger and resentment because the power struggle is camouflaged as helpfulness.

Perhaps an example can clarify better than further search for precise definition:

Len returned to group after a long absence and found himself keeping a distance from Gary, an older man whom he remembered as continually trying to establish his seniority. Throughout the session, Gary told the women in the group how surprised he was that Len could be a successful attorney and he recalled several rather embarrassing incidents from past groups. Then, towards the end of the session, he approached Len with a show of warmth and questioned his inability to respond. Len began to explain defensively why he was unable to shake

old feelings of uneasiness in regard to Gary and was rewarded with a condescending pat on the back for his efforts to "own up to his difficulty in accepting warmth from a man. " after a restless week, he returned to the following session with the realization that he felt constantly denigrated by Gary and was angry about it. Gary promptly asked how he could say that he had "put him down" when he had been so responsive to his recent success. Len once again began to feel confused. He tried desperately to prove that he wasn't "crazy ' by citing his previous remarks, thus, of course (as Gary pointed out), showing that "in some way this tapped a good deal of anxiety and ought to be explored. " It would be necessary for the leader and the group to support Len in such situations, to prevent Len from closing up and hiding his feelings.

A group can be a threatening setting in which to lower barriers because the fear of being ostracized by an entire group looms immense, but it can also become a potent force for openness if it is experienced as safe and trusted; supportive rather than rejecting and humiliating.

The contempt master thus learns his skills originally in order to wall off dangerous parental figures who, like Gary, could otherwise "drive him crazy" and set off feelings of being bad. The child also inevitably learns to set up contempt barriers for self-preservation, and also to use them for revenge—to "hit back first" to prove that "I'm not the crazy-bad one, you are!" Contempt can, in this way, lead to power struggles and sadomasochistic binds which go back and forth endlessly, preventing the whole group from experiencing vulnerable moments.

Contempt is closely linked to the sadistic component of sadomasochistic interaction. The individual employing it as a defense often feels that it is

simply a matter of self preservation. Also, as in the case of Gary in the above illustration, contempt is often subtle or at times masquerades nicely as condescending helpfulness or protectiveness. The sadistic, controlling attack often goes unnoticed, especially by the contempt master himself.

Masochism and contempt both can serve as barriers to vulnerability. Masochism is a refusal to mourn and an escape from vulnerability by clinging symbiotically to omnipotent protectors. Contempt is also an attempt to escape vulnerability and a refusal to mourn. The parental omnipotent introject is not relinquished. The contempt master struggles to see himself as omnipotent and above the human condition. This interrelationship between two styles of refusal to mourn suggests that perhaps a vulnerable moment always involves some subtle furtherance of a working through-mourning process, i.e., the relinquishing, bit by bit, of grandiosity.

The Group Leader as a Facilitator of Vulnerable Moments

A great deal of the group leader's role may be conceptualized as the facilitation and prolongation of vulnerable moments through dealing with such defenses as contempt and masochism. In this section of the paper I would like to outline some of the techniques I have found useful in implementing this concept.

It is essential to keep in mind while considering specific techniques that psychotherapy is a creative art. Guidelines can be sketched, but each of us must develop his own style rather than look for a "right way." Perhaps it is the group leader's sense of his own separateness and uniqueness and his willingness to risk that is one of the most potent forces for facilitating vulnerability and growth in his patients. What affects patients most is often more a function of who the leader is than what he says. His courage to

experiment, to enter into vulnerable space, and to let his work be an authentic expression of himself, underlie any effective technique. This risking may range from simply trying something new and exciting, through a willingness to enter an impasse without knowing where it will lead, to exploring his own countertransferences in the group occasionally, or allowing himself to be open in selectively sharing some of his own spontaneous reactions.

An appreciation of moments of extreme impasse requires almost an act of faith and infinite patience. These periods, which may last minutes or occasionally spread over many sessions, induce intense feelings of helplessness and inadequacy and a strong urge to give up in both patient and therapist. The patient on the "hot seat" often experiences the impasse as an uncomfortable and unyielding "I just can't." As a leader I often feel discouraged and come up with beautiful rationalization as to why we should let go and go on to something else. Other group members often become impatient with "wasting so much time." However, I have found that the more extreme the impasse, the more meaningful the vulnerable moment linked to it. It is frequently just when I'm ready to give up that some seemingly chance happening or remark (like realizing that the helpless "I can't" is really a defiant "I don't want to") catches the patient by surprise and swings the balance of emotional forces towards release, risk and vulnerability. Some of these situations reoccur frequently enough to be described as rules or games (Levitsky and Perls, 1970), but intuition and creative innovation are really the keynote.

The impasse which precedes deep vulnerability is related to a tremendous fear of what Perls (1969) has called "implosion." To allow extreme vulnerability means risking a sudden flood of impulse. Cohn (1970) describes this experience of impasse as "the ultimate expression of two strivings pulling

in opposite directions." She suggests that, "the therapist's guiding words are: 'be blank,' be confused,' be empty.' " She also points out that: "When the patient can endure and experience the extent of his feelings of confusion, blankness, impotence, etc., organismic change takes place." When patients face the vulnerable moment beyond the impasse an intrinsic growth process can unfold. Or, to use Perls' words (1969), "awareness per se by and of itself can be curative."

In order to get through the impasse the patient must have a sense of trust that he will not be abandoned and left along while feeling disintegrated. He must trust that an accepting atmosphere can be counted on. The more he senses this, the more he can risk confusion and helplessness. This will lead to a new integration and owning of previously rejected or even repressed parts of himself. The impasse is, in part, a testing of the water. The sense of timelessness provided by persistent sensitive attentiveness or by a flexible ending time can be a powerful factor in encouraging this risking and trusting. The leader's and the group's ability to stay with him even when he manages to induce a good deal of helplessness, and at times anxiety, is also important.

The leader's willingness to risk also raises the question of role rigidity as a barrier to vulnerability. Like other barriers, role stereotypes can be dehumanizing and interfere with vulnerability. The therapist's entering into the impasse with the patient, and sharing in his experience, is different from being carried away in a symbiotic fusing countertransferentially. Analytically-trained therapists are, by virtue of their training, thoroughly alerted to avoid overinvolvement. Often, however, in an overzealous effort to carry out such instruction, or perhaps as a reaction formation to repressed impulses to fuse symbiotically, they develop what Bernstein (1972) refers to as "a countertransference resistance to feeling compassion," or a difficulty in "being

human, though a psychoanalyst," Anxiety aroused by uncertainty and helplessness also makes it tempting to use an analytic position defensively.

The subtle condescension and contempt involved in rigidly maintaining a hierarchical role and not allowing oneself ever to be vulnerable could encourage patients to maintain a nonvulnerable, omnipotent picture of adulthood and hinder relinquishment of their own grandiosity and contempt. However, I am not in any way suggesting that the leader give up his unique role and responsibility in the group. If anything, I am advocating a more active leadership, and question the model of the blank screen and the mythical perfectly-analyzed analyst. In place of a role model which has become increasingly difficult to carry out in the group setting, I would suggest a stress on the therapist's humanness without giving up the analytic focus on transference. My experience has been that being seen as real and vulnerable by patients does not dilute transference reactions. On the contrary, both love and hate transferences can be even more intense.

The difficulty I have found is that it is at times extremely hard not to get too defensive or to retaliate when I have allowed myself to be vulnerable. Thus sharing and openness by the therapist should not be entered into lightly or without repeated reexamination of what is going on. A trusted cotherapist or a countertransference workshop with colleagues is probably the best way of doing this, once the leader is no longer in formal supervision. Mistakes will be made and countertransference is a fact of life in therapy. The important commitment is to growth and awareness, not to perfection.

Another broad attitude which facilitates vulnerability is openly valuing and enjoying such moments. The leader can convey this by sharing in them, perhaps by adding his own associations, and by indicating the warmth and openness created in other group members. The experience of vulnerability,

self-acceptance and growth is contagious in a group. Even the vicarious participation of silent members leads to a softening of barriers and a growing sense of worth. It is important for the group to realize this, so that patients who really open themselves up experience a sense of having shared something nurturing at the same time that they feel nurtured.

Another basic attitude which encourages a vulnerable atmosphere is a stress on accepting people and feelings as they are in the here-and-now. This is particularly true with regard to getting to know, even to cherish, resistances. This attitude is closely tied to Perls' (1969) repeated comparison of the now-and-then to the Gestalt concept of present-centeredness (Naranjo, 1970). Change in Gestalt theory is considered to occur paradoxically. "Change occurs when one becomes what he is, not when he tries to become what he is not" (Beisser, 1970).

Encouraging patients to "experience what they experience" or to "stay with the feeling" (Levitsky and Perls, 1970) often leads to surprising moments of openness. A related attitude is avoidance of "figuring out" (intellectual) games—especially quests for certainty which usually begin with "why?"

Developing the group's understanding that such questioning stems from fears which must be explored helps to establish the desired atmosphere. By interpreting these maneuvers as both defense and attack, group members can begin to avoid sadomasochistic repetitions. In the atmosphere we are talking about, contempt can be seen as the other side of the coin of feelings of adequacy and terror. Members who are not the target at the moment can begin to see through the wall and need not retaliate. By modeling and even by spelling out this technique, the leader can teach the group to grasp the trigger (the point at which the contempt wall is erected) and to relate it to the fears which motivated it. Patients gradually experience the alternation of aloof,

omnipotent contempt and the underlying hurt and anger and develop increasing strength to risk expressing their deeper feelings. As with any resistance, exploring fantasies of what would be experienced without the contempt pose and uncovering deeper derivatives of fears and wishes is part of the working-through process. This analysis of contempt is closely related to the analysis of resistance to dependency. It also goes without saying that the leader's understanding of contempt, including his own, enables him to stay out of (or at least extricate himself from) the power struggles which would otherwise be instigated. This sets a model and also allows patients to trust that they will not be devastated as a result of lowering their barriers.

One basic therapeutic skill is sensitivity to vulnerability. The sensitive therapist is alert to signs of vulnerability and is intently tuned in to it. It is at these times that a deep sense of empathic "witness" can be subtly communicated. The intuitive sense of timing, which an experienced leader develops gradually, is closely related to this alertness. The expert senses when his patient is opening up by cues from his eyes or his voice. A softness or slowness in his speech, a moistening or melting quality in his eyes, or a gentle pause, may be signs of a venturing out. This moment of testing the water often is accompanied by tremendous confusion and anxiety. "Can I lower my barrier?" "Do I dare let my hurt or confusion, my craziness, show?" "Is it safe?" "Will I be accepted?" "Is it worth the risk?" The patient is like a timid rabbit peering at a carrot from inside his safe bush. As he ventures out, inch by inch, his ears are exquisitely tuned to the least sound. The neophyte therapist, like a child with a carrot, moves excitedly. "Here bunny! Take the carrot." The moment is lost. The experienced leader waits patiently and alertly. Perhaps he leans forward slightly and gently encourages the patient to go on. Above all, he conveys a patient willingness to be with him and allows plenty of room without any insistence on where things will go.

As the patient's feelings unfold, the most helpful response to vulnerability is Asva L. Kadis' attitude of "claim, don't blame" (quoted by Lift, 1971). The patient is tentatively giving up his certainty of being blameless and is dreadfully afraid of being judged and rejected. The worst approach would be to blame, preach or point out distortions. Transference interpretations will be experienced as critical at such times. The leader and the group members must learn to be patient and to be sensitive to the timing involved. Any comment which is not clearly warm and accepting may be experienced as devastatingly rejecting and judgmental.

The leader can thus take an active role, not only in creating and encouraging vulnerable moments, but in prolonging them, and in helping the vulnerable person feel that he is not "crazy or bad." If a back and forth revenging of old hurts and self justification is allowed to continue, it can completely block vulnerable moments and growth and lead only to an entrenchment of defenses. It can be stopped, or at least minimized, if the urge to do it is accepted, pointed out and understood in terms of past hurts. (Incidentally, the urge to revenge at these moments is most pronounced in couples who have had a long history of sadomasochistic exchanges. Dissolving this need to gain revenge is obviously a necessity if the marriage is to survive.)

It is important that the therapist see to it that the group (or failing this, himself) acknowledges the pain which patients experience. The vulnerable moment is precisely the wrong time for interpretation, teaching, or, worse yet, preaching.

I want to introduce one more concept to clarify the approach I am suggesting, the concept of a "sub-contract." (Everything I am suggesting is within the context of a basically psychoanalytic contract.) Most of the time I let the group take the bulk of the responsibility for its own functioning; also,

individuals who take the risks of vulnerability take responsibility for the consequences. I do not want to be overly protective, and I believe that when resistances are gradually worked through to the point where risks are taken, any response provoked in the group is grist for the analytic mill. At such times I see my role largely as an analyzer of resistance, with probably a more active focus on contempt and vulnerability than most leaders.

When I sense the timing is right, however, I focus more actively on one person (perhaps inviting him to join me on the floor in the center of the group) and use a Gestalt-like "hot seat" approach. To the degree that I use my intuitive skills to temporarily and suddenly cut through barriers, I take on a different responsibility. my "sub-contract" for this period of time can be clearly differentiated from my overall analytic stance. Since I am encouraging the patient to risk a sudden dropping of defenses, I agree, nonverbally, to provide something in return. That something is a nonjudgmental atmosphere and an intense willingness to be with him in his anxiety-laden experience, along with a sense that I will not leave him in an overwhelmed, disintegrated state, even if it means extending the length of the group session. The group setting has tremendous power, by virtue of its acceptance and warmth, to help the individual not to feel "freakish and alone." The "sub-contract" attempts to provide an intense, temporary reorganization which can then be worked through overtime and with repeated experiencing. However, once deep vulnerability in a loving atmosphere has been experienced (and an awareness of the human needs underlying contempt and other barriers has been established), it is hard to deny them as skillfully. A working-through mourning process has been set in motion. If followed through analytically, this leads to the relinquishing of transferential wishes to escape vulnerability. Awareness of longing and pain is, after all, an important component of what really makes one a patient.

Conclusion

The growth, working-through process in group therapy can be greatly enhanced (perhaps accelerated) through an emphasis on vulnerable moments. Vulnerable moments are essentially those brief periods when a person is able to let go of his defenses fully and to allow himself to be open, soft, and very, very human. Intense awareness of self and others in the here-and-now enhances growth. In a nurturing nonjudgmental atmosphere which encourages such vulnerability, patients can tolerate the experience of helplessness and confusion which they have previously avoided. Wishes for omnipotence and certainty can be relinquished and patients can move on to a new integration.

Masochism and contempt are barriers to vulnerability. The masochist masquerades as helpless in order to attach himself symbiotically to a transference object, while the contempt master attempts to avoid uncertainty through intellectual games and maneuvers which reassure him that he himself is omnipotent and above the human condition.

Several attitudes and techniques which help to create an atmosphere conducive to vulnerable moments have been discussed. These are guidelines, but each of us must develop his or her own unique style. In fact, it may be the leader's sense of his own separateness and uniqueness, and his willingness to risk, which are the most potent forces for facilitating vulnerability and growth in his patients.

About a year after the above paper was written, I used it as the core of a Grand Rounds presentation at Brookdale Medical Center. I would like to present portions of it here because it included some reflections on the ideas in the paper in light of further experiences. These are

excerpts from a transcript leaving out sections which simply repeat what is already presented above.

Vulnerability, Seduction and the Role of the Leader in Group Therapy

Part of what I want to talk about is the effect on the therapist of being primarily a "group therapist." There is a strange phenomenon, if you get to know a lot of people in the field. There are some differences in the problems that arise for people who tend to do a lot of group work as opposed to the other extreme of those who mainly do individual work and stay behind the couch. To some extent, what I want to do is share with you some of my experiences and thoughts over the recent years that come largely from being primarily a "group" person. I run, between hospital and private practice, approximately 10 to 12 groups a week.

I spent a lot of my early adult years behind walls, as most adults tend to do. One convenient wall was the role of therapist. Anytime things hit the fan the therapist could roll the question back and not reveal himself. Then I had some experiences as a patient and as a student in some workshops, where I found that coming out from behind those walls and really being exposed as a vulnerable human being in a group setting was a very valuable, growth-producing experience. It was of value not only for those of us who really came out from behind the wall so fully, but also for the other participants in the group. I ended up developing a whole approach to group which centered around the leader's role as a facilitator of vulnerability. If you want to think of it more analytically, the analysis of resistance became a focal point (largely resistance to being open, non-omnipotent and vulnerable). I found myself stressing the statement, as in Frost's poem, that "before I built a wall I'd ask to know what I was walling in or walling out."

Recently, I have had some further experiences of allowing myself to be too vulnerable in the wrong places, and I found out what I was walling out, or should have been. Therefore, in addition to the other clear position of the importance of vulnerability represented in my written paper, I want to talk in a little more rambling and vulnerable way about some of the confusion that has come out of these experiences and some of the traps that a therapist needs to be aware of in risking vulnerability. Many of these experiences most often arise in group settings, but they also apply and work in individual therapy.

I want to present a dilemma, rather than a fixed position. It is a dilemma which all of us really have to deal with in group therapy. To not allow oneself to be open, involved and vulnerable would close off tremendous growth-facilitating experiences. Yet allowing oneself to be vulnerable, particularly as a therapist, leaves one open to a lot of hurt and seduction.

I want to talk about the three areas indicated in the title. First, what is "vulnerability" and its implications for therapy; the role of the leader as a facilitator of vulnerability and, finally, seduction and some of the problems involved. (Most of the first two areas were covered in the paper and will not be repeated here.)

Trying to say what constitutes a leader taking a risk can be puzzling. It has nothing to do with behavior. For example, it has been a risk for me to be relatively quiet and analytic in some groups lately. For awhile, I had moved from an analytic position out into the group and really mixed it up. It was very effective, but I've begun to see that it was also fulfilling my own countertransferential need to be the center of things. Recently, I have been struggling to be less central at times. This return to a more analytic position feels risky. For an analyst who has been quiet for years, that is a safe position. For him to say I'm angry with you or I'm feeling anxious right now, may be a

risk. For me (with patients who are used to my being, as we call it in group, "more real" and "being there"), to sit down and say "I want to experience what goes on in group if I don't respond to this," and then deal with the fury that comes, has felt risky. It is new for me in terms of changing the countertransference binds.

I guess that the essence of it. Risk is almost always changing the status quo. No matter how you start out working with a patient, there will be times that you are at an impasse, which often is related to a collusion to maintain the status quo. One way of working, at that point, is just to keep interpreting to the patient what you see as his resistance. Another is to look inside and try to work out your own countertransference. Focusing on the therapist's involvement does not lead to a clear sense of technique. Instead, something happens inside and you find yourself changing and being different.

When you become different in group, and you do it suddenly, it can become scary. Group has a lot more power to scare the hell out of a therapist than an individual patient does. When you sit with one person, especially behind the couch, they are not too aware of your reactions. You can bite your tongue, be quiet and figure things out. You are not as exposed. When you are leading a group and you respond to one person in a way that might be relatively safe, you have the rest of the group watching you and picking up five other things you weren't intending to get into. Some of the anxieties and transference reactions to "the group as a whole" which many leaders (as well as patients) experience, stem from this sense of the impossibility of controlling or being prepared for the multiple responses which you could set off.

Recently, I encountered a situation in which my willingness to be vulnerable seemed ill-advised in retrospect. Sometimes barriers are necessary. What I am referring to was being very vulnerable in a "fishbowl"⁵ situation. The observers were outside, looking in at us and discussing the group afterwards in a way that felt to us as if they were looking at bugs through a microscope. The pain of putting yourself out in an open and human way and then being responded to, even if accurately, with scientific criticism can really drive you crazy. This is an important lesson in having to protect yourself (and realizing that patients sometimes need their defenses, especially if the group climate isn't sensitive). It also underscores the key role of understanding the concept of vulnerability in leading a therapy group or even a workshop. An intuitive sensitivity to vulnerability is essential to the timing of interpretations. Even the most precise interpretation may, at a vulnerable moment, be extremely painful and disorganizing. The time for an interpretation is best a little while after that vulnerable moment has passed. The only thing that is meaningful in a vulnerable space, is a "witness" and understanding of where the person is. Then, once they are beginning to put themselves back together, an interpretation (such as: "This is a pattern I've seen before. It relates to something you did as a kid.") may be facilitative.

It is important to distinguish when you are choosing not to reveal yourself, because you have a sense that it would not be helpful to the patient, and when you are pulling back, because in some way you are uncomfortable. Incidentally, you do have the right not to reveal yourself if you are feeling uncomfortable. You have a right to your privacy, to not respond, simply because you feel uncomfortable and defensive. What I am looking for is an

⁵ Fishbowl is a one-way mirrored observation room.

awareness of this, an admission, at least to yourself, that your choice (for the moment) is that, "It's too scary. I don't want to take that chance."

However, the subtle condescension and contempt involved in rigidly maintaining a hierarchical role and not allowing oneself ever to be vulnerable could encourage patients to maintain a non-vulnerable omnipotent picture of adulthood and hinder relinquishment of their own grandiosity and contempt. This is particularly true of therapists as patients. Therapists who go through an analytic experience, and who don't come out with an awareness of their analyst as a real human being, often struggle for a long time afterwards to maintain some image of the analyzed analyst who isn't going to get involved countertransferentially. He doesn't have these weaknesses and problems. It is very important, the more so as they become healthy and begin to approach termination, that the patient begin to really see the therapist as a human being. There are many ways of allowing this to happen (many of which fit well within conventional bounds). The point is, that sometimes, defensively, an analyst will prevent this from happening because of his own insecurities.

I would like to talk now about some of my recent thinking which qualifies, or at times has even questioned, some of these ideas. The title of this lecture (in using the term seduction) is in itself very seductive. It sounds like a sexy lecture and it promises much more than I intend to deliver. Seduction in a narrow sense of somebody seducing somebody else into bed in some unauthentic way is an extreme example of what I want to talk about. Essentially, seduction involves promising more than one can or intends to deliver. It is most dangerous when that seduction encourages someone to be more vulnerable than they would be if they had good judgment about the situation. Being a therapist is a very seductive position no matter what you do. What you are saying is "come in and lie down and free associate." You are

immediately saying, between the lines, “get involved in your regressive transference reaction, but I do not intend to fulfill it. Instead, I will interpret it and play a role in your relinquishing it.” The difference between this kind of seduction with awareness, and a seduction that can be more harmful (especially when it’s done without awareness) is that the therapist is committed to work through the patient's reaction when he begins to be disappointed and disillusioned. It’s the commitment that is important.

This mutual seduction, and I want to emphasize “mutual” (especially when this goes on between therapist and patient), is always a two-way process. If you are really totally aware, you can see the patient's seductive behavior and choose to go along with it or not. (You are not seduced). To some extent, if you are seduced into a collusion to avoid experiencing certain feelings, it is because of some of your own unresolved problems are getting tapped. In some way, you too are also involved in seducing them (disarming or controlling them). This often takes the form of a non-aggressive pact (“I won't criticize you. I'll admire you, I'll flirt with you and you'll take care of me and won't confront me with anything painful”).

Vulnerability leaves one open (the word vulnerable partly refers to the vulnerability to being controlled). Many times when I speak of a therapist sharing his feelings, people say “Well don't you prevent transference?” I always say no, more out of experience than a particular understanding of why. You don't prevent transference, it somehow comes out more intensely and often in a crazier way. There is an old saying, “Nothing is inevitable except death, taxes and transference.” No matter what you do, the patient is going to be making transference demands and see you in distorted ways. The problem is, if you are vulnerable and you allow yourself to be really involved with the patient, then when the shit hits the fan and the patient starts seeing you as

letting him down (or crazy and no good) he can pull in things that he may know about you (especially problems that you have exposed). That hurts. It is very hard at such a point not to become defensive or to get in the way of his working out his negative feelings. Patients have to go through a process which includes attacking or discarding the therapist and once you are vulnerable (and can be hurt) it is very hard not to retaliate. Usually it is subtle, for example, through a condescending transference interpretation. It is hard to step back at such times and to be analytic in the sense of understanding that this is a transference process that goes on from the patient's side (because you are involved in some of your own countertransference). Incidentally, I use the word countertransference (at this point) as synonymous with the therapist's transference reaction to the patient. There are also countertransference reactions that I would call objective countertransference when feelings are evoked in the therapist which are unrelated to any of his own problems. Some patients are obnoxious and get you to feel angry with them. This may not have anything to do with your own problems except that if you were Superman you would understand them and not get angry. That kind of anger can remain within reasonable bounds and can be used as a clue in a helpful way.

What I am trying to say, is that if the therapist is seduced, he is vulnerable to being controlled. In other words, if the patient has the ability to hurt you deeply it becomes much more difficult to set limits and do other things that he doesn't want you to do. It's like giving him a club to hit you with. If you do this, you must have some way of protecting yourself when that club comes at you or at least some security that you can deal with the ensuing hurt in a growth-enhancing manner (for both therapist and patient).

Seduction is usually related to omnipotence. The more a therapist tries to seem omnipotent, offering more of a special deep involvement than he can fulfill, the more he can be charmed and controlled. Also, the patient's wish for an omnipotent protector or need to be omnipotent himself is what really leads to the seductive games in the first place. Ultimately the quest for omnipotence and certainty is an attempt to deny an awareness of death.

Another aspect of seduction that strikes me is that we immediately respond to being confronted with it in the way we would if someone said "You have a countertransference *problem*." I would like to approach seductiveness without so much of a pejorative and to explore it as something that comes up often and causes trouble, rather than as a sign of pathology or moral defect. I am not thinking here strictly of therapists, but also in terms of our functioning as professionals in a wider space as we move up the ladder. A lot of us can be very seductive. As we become more senior, for example as department heads, we may really want to promise a lot to our people. Gradually, as I took on more responsibility—becoming the head of a department, becoming a supervisor in three different training institutes, carrying a lot of patients, teaching classes—in each case I implied an availability and a promise to follow through, as if I were just the leader of that group. This stems from a desire to really fulfill a deep commitment, but I later realized that I have to evaluate my contract with each group. What am I really offering? We struggle with this issue a great deal in T-groups. What's our contract? What can we do most meaningfully to use the group to facilitate our growth as therapists? Is it getting to our own problems and our own reactions to each other? Is it talking more conceptually than actively? How much am I being seductive by trying to offer total training in a one group experience over the years? I have to clarify what my contract is and what kind of teaching I can do in each setting.

Another seduction which scares people is that they are afraid that the therapist will be seduced into totally becoming a part of his group. They are afraid of the group becoming a limitless, crazy, leaderless entity, where everybody is carried away in an omnipotent, transferenceal fantasy. If you've seen the play *Equus*, there is a beautiful development of this theme. The therapist starts out by questioning the teenage patient, and the patient immediately says that it's not fair. If he can ask the patient questions, then the patient can ask the therapist questions. So each time the therapist asks something, the patient throws something back. But the patient is more skillful. The therapist hears that the patient had a dream and asks, "Will you tell me your dream?" and the patient says, "No. Now it's my turn. Tell me your dreams." Gradually you get the feeling that the therapist is getting more and more involved. He is being seduced into giving up his role as therapist and becoming the patient. I felt tension building up in me, which I didn't understand until later. The tension was finally released in the last scene where the two let go and seem free and crazy, yet it's alright. You have a sense that they are coming out of it and the therapist is going to be able to go on—to step back out of it and retain his responsibility as therapist. The scene is dramatized as a wild horse ride and its excitement is a powerfully seductive force. There is value (in fact, life force) in going along, riding and having the experience of being a part of the group, as long as you also can step back and be a leader when you need to.

Sometimes, especially in large groups, if the leader is insecure there is an encouragement of openness which ends up disastrously. If you really get into these impasses and you don't take steps to set the limits, it can become a pretty wild experience. Working in a hospital ward with overt psychosis can help to make a therapist more comfortable with that. Part of my experience with marathons gives me a special kind of a comfort with such moments. The

important thing is to have some sense of what you are going to be able to tolerate, rather than pushing for an openness that you will later have to back out of. There is nothing wrong with a patient waiting to handle some problem until the therapist is healthy enough to deal with it. I would much rather that it went that way than forcing the therapist to get into an area where he will panic and abandon the patient. It's the abandonment that really causes the damage, not so much the seduction.

With all of these risks, I still want to suggest that the therapist's willingness to be less than an invulnerable, omnipotent human being is our most potent force for growth. To remain safe, uninvolved and sterile, or to get seduced into craziness are both hazards in our calling. And I use "calling" with an awareness of the implications. To give up, even momentarily, your ability to be analytic and objective at the cost of human involvement is at times painful and very scary. The real danger, though, is not so much the seduction into this, but the abandonment which may occur if the therapist panics and cops out. When seduction leads to really following through or staying with a group through the anger and disappointment which is involved, then growth can occur. Abandonment can lead to an overwhelming disruption and fragmenting or even to a psychotic reaction. If therapists are to have the strength and the courage to hang on, especially when they are scared and unsure in their early years, we must support each other. Supervisors and friends must be clear as to what commitment we have to each other and be willing to risk really talking about how we work. Only in sharing with each other what is really going on with patients (and I find that small groups are the best setting for this) can we give each other the support to take some of the risks in experimenting and finding ourselves as unique therapists rather than adopting some set of rules that make for mediocrity.

In order to work through our countertransference problems, we need help. We need someone with whom we can drop our defenses. When, as so often is true, we choose to avoid such vulnerability, then I would ask to know, “what I was walling in or walling out.” Reluctantly though, I will end with a sad but true acceptance that although “something there is that doesn’t love a wall” at times a flexible sense of limits and barriers is necessary.

In the process of editing these excerpts, I have been re-experiencing some of the painful struggle of that period in my emotional and professional development. The talk at Brookdale represented, for me, a somewhat shaky affirmation of my faith in the process I am describing in this book. I had been very hurt by some harsh and judgmental responses at a point when I was extremely vulnerable during the “fishbowl” workshop I mentioned in the talk. I felt rejected and abandoned by the institute in which I had matured over ten years. The transference impact upset my balance . . . my sense of who I was and of the process in which I believed.

In the talk I can see the painful self-questioning which I was going through—especially in comparison to the clear presentation of myself and my position in the written paper (written before the workshop). At the time of the talk, I had returned to personal analysis and had also found myself retreating to what I rationalized as a safe analytic position. Looking back on this period it feels like I was going through an identity crisis.

The talk reflects some of the doubt and pain. However, it also was a turning point for me. It was a decision as to how I was going to deal with what seemed like a failure in my sense of the value of vulnerability (though now I can see it simply as a mistake in the

judgment of where and when to take such risks). I would respond, not by closing off and hiding while building up a contempt-like defense, but by continuing to risk an authentic self presentation and by trying to come to terms with what might be of some value in the painful confrontations. I had been accused of being confused and seductive. Rather than blocking these criticisms off I was struggling to examine them openly (but without the judgmental rejection which had accompanied them, and at a time when I was not so raw). The answers to a questioning of the value of vulnerable sharing in the working-through process could only be found through the very process in which my faith was shaken.

What had been traumatic gradually has become “grist for the mill,” a part of my quest for identity. The directions in which it has solidified and become clearer are evident in the following chapters (particularly 15 and 16). Incidentally, it is important to note that what was traumatic was not that patients were harmed nor that their attacks on me were harmful. It was the unfortunately timed and judgmental statements of colleagues who were dealing with their discomfort by interpretation and labeling (rather than risking a vulnerable exploration themselves). I experienced this as an abandonment and a condemnation. In fact, it was really the transferenceal meaning which these remarks took on for me that shook my balance and it was the later working through of these transferences in an atmosphere of vulnerability and sharing which restored it.

References

- Beisser, A. (1970) The Paradoxical Theory of Change. In Fagan, J. and Shepherd, I. (Eds.), *Gestalt Therapy Now*. Palo Alto: Science and Behavior, pp. 70-80.

- Bernstein, A. (1972) The Fear of Compassion. In Wolman, B. (Ed.), *Success and Failure in Psychoanalysis and Psychotherapy*. New York: Macmillan, pp. 160-176.
- Cohn, B. (1961) A Group-Therapeutic Workshop on Countertransference. *International Journal of Group Psychotherapy*. 11:284-296.
- ____ (1970) Therapy in Groups: Psychoanalytic, Experiential and Gestalt. In Fagan, J. and Shepherd, I. (Eds.), *Gestalt Therapy Now*. Palo Alto: Science and Behavior, pp. 130-139.
- ____ (1970) A Child with a Stomach: Fusion of Psychoanalytic Concepts and Gestalt Techniques. In Fagan, J. and Shepherd, I. I. (Eds.), *Gestalt Therapy Now*. Palo Alto: Science and Behavior, pp. 197-203.
- Levitsky, A. and Perls, F. (1970) The Rules and Games of Gestalt Therapy., In Fagan, J. and Shepherd, I. (Eds.), *Gestalt Therapy Now*. Palo Alto: Science and Behavior, pp. 140-149.
- Liff, Z. (1971) Asya Kadis. *Group—Newsjournal of Eastern Group Psychotherapy Society*, July.
- Livingston, M. (1970) Speculations on Treatment of Masochism. *International Mental Health Research Newsletter*, Spring.
- ____(1971) Working Through in Analytic Group Psychotherapy in Relation to Masochism as a Refusal to Mourn. *International Journal of Group Psychotherapy*, 21:339-344.
- ____(1973) Contending with Contempt in Group Psychotherapy. *Voices*, 9:14—17.
- Naranjo, C. (1970) Present-Centeredness: Technique, Prescription and Ideal. In Fagan, F. and Shepherd, I. (Eds.), *Gestalt Therapy Now*. Palo Alto: Science and Behavior, pp. 47-70.
- Perls, F. (1969) *Gestalt Therapy Verbatim*. New York: Bantam.

JONATHAN AND THE PSYCHOANALYTIC TORCH (THOUGHTS ON THE SUPERVISORY PROCESS)

“Most gulls don't bother to learn more than the simplest facts of flight—how to get from shore to food and back again. For most gulls, it is not flying that matters, but eating. For this gull, though, it was not eating that mattered, but flight. More than anything else, Jonathan Livingston Seagull loved to fly.

“The more Jonathan practiced kindness lessons, and the more he worked to know the nature of love, the more he wanted to go back to Earth. For in spite of his lonely past, Jonathan Seagull was born to be an instructor, and his own way of demonstrating love was to give something of the truth he had seen to a gull who asked only a chance to see the truth for himself.

“And of his student, Fletcher Lynd Gull, it is said that, “This rough young Fletcher Gull was very nearly a perfect flight-student. He was strong and light and quick in the air, but far and away more important, he had a blazing drive to learn to fly.”

From Jonathan Livingston Seagull
by Richard Bach

Jonathan carried the psychoanalytic torch. He had a blazing desire to experience life fully and to touch other gulls through his flight. As he said to Fletcher, "You need to keep finding yourself, a little more each day, that real, unlimited Fletcher Seagull. He's your instructor. You need to understand him and practice him."

This blazing desire to light our inner depths in pursuit of increasing freedom and experience, despite anxiety and sense of risk, is the essence of the psychoanalytic spirit. The torch itself must be carried and passed. Techniques and laws are secondary. As Jonathan teaches us, "The early true law is that which leads to freedom. There is no other."

Once an analyst has begun to grasp the torch and to learn increasingly more about flying, he often wants very much to pass it on—to demonstrate some of the love and the truth that he has seen to others who will in their turn learn to fly and continue the relay.

However, psychotherapy, like flying, is primarily an art. Who an analyst is, is often far more significant than the technique he employs. The most effective force at his disposal is frequently his own humanity and willingness to risk or confront. A good technician can help many people to work out conflicts or to alleviate symptoms. The psychotherapist who wishes to free his patient to become the autonomous person he is capable of being, though, must truly become a creative artist. Therapeutic skills must be grounded on a logical, scientific understanding, but ultimately each treatment is a unique entity. If it is to be meaningful it must be a creative process.

How then can one aspire to become such a creative artist? How can experienced practitioners of this art pass the torch to young aspirants?

Training must include a foundation of theoretical-academic information. Readings and lectures are essential in helping the student to conceptualize the analytic process. The areas which are most important, as I view the process, include transference, resistance, the repetition compulsion and working through. These concepts need to be explained in relation to the therapeutic process, psychopathology and an understanding of personality development which must include early infantile symbiosis and grandiosity.

All the book learning in the world will not make an analyst, though. by far more important is the trainee's own growth which should include his own treatment. He must experience the process, including his own resistances and yearnings. The third foundation of becoming a therapist is supervision. Supervision is, in itself, a process which in many ways is similar to analysis. There is a greater stress on conceptualization, and technique must be learned but it is largely a growth process which must unfold slowly though the supervisee's repeated struggles with uncertainty. With the supervisor's support, he must go through many confusing periods. His own ambivalences and contradictory feelings will be tapped. Gradually, he will experience the use of what Freud called "free floating attention." He will realize that the only true clarity is that which is won through struggle and confusion.

Over time, the supervisee must be helped to see the process gradually unfold from the patient, to develop a faith in the process, through experience. In part, the supervisor's role is to lend his patience and faith to the beginner. Only from the perspective of time and experience will the student achieve his own.

Supervision often begins on a "what do I do now, Coach?" level of focusing on technique; however, in time, it must move toward an attempt at understanding the process. The therapist then begins to focus on the patient's transference demands and his resistances, his fears of proceeding deeper. At this point he begins to realize that technique must flow from a dynamic understanding. He can then experiment with varied techniques and begin to develop a conceptual model of psychotherapy as a process.

If supervision is to really pass the analytic torch though, there is another aspect which must in many ways become primary. A student can become a reasonably effective technician by looking at psychotherapy in terms of a

dynamic understanding of his patients. However, if he aspires to become a true creative artist, then he must view the process of psychotherapy, and of supervision, as one which demands an ever increasing knowledge of himself and his interactions with patients. He must learn to tap his own irrational intuitive resources. He must face the pain and fears of his depth responses to his patient's provocations. He must look at what we call countertransference (as if the patient's transferences were in some way totally responsible for setting it off). Supervision must help him to see his own transference demands on the treatment situation and even his deep resistances to the very process to which he feels so committed. In many ways he must come to accept that he is not unlike his patients; yet, at the same time, he must take responsibility for carrying the torch. He must be committed to investigation and risk in the face of resistance.

The process I am describing can, at first, be quite upsetting to supervisees who are more accustomed to conferences and supervision which focus largely on the patient's dynamics. After a few years of such learning, they have developed a good grasp of intrapsychic functioning and some comfort in understanding and working fairly well with their patients. This comfortable balance, as well as their basic defensive structure, is often disturbed when they find their own experience the focus of supervision.

For example, Mary is a young social worker who has worked with parents and children for several years. She is basically a flexible and sensitive woman, with an excellent grasp of dynamics, who tunes in well to what her patients are experiencing. She has had a few years of personal therapy.

I was supervising her work with a group of very difficult black parents. The atmosphere in the group and in our supervisory sessions was one of discouragement and heaviness. There was a lot of rational discussion of

whether the parents were willing to look at themselves or just to focus on their children. They seemed very unmotivated—often failing to show up. Mary very accurately picked up their feelings of helplessness and anger (with the institution for not giving them what they felt they needed, with the leaders for not giving “answers,” and with their children who couldn’t understand and didn’t obey). The patients either denied or agreed. Either way they remained passive, patient, unemotional and uninvolved. Their latent message was a clear, “We won’t actively seek anything here because you haven’t got what we need and it would be disturbing.”

Mary’s co-therapist responded by working very hard to sell the group. He repeatedly shut off any expression of anger by placating and reassuring. Over a few months, he has begun to see the subtle ways he reacts to budding anger and to become aware of his own discomfort around it. In another group, where he perceives the patients as tough manipulators (addicts), he is forceful and direct. That group is lively, often angry, and very involved with him and with each other. The parents in the group he co-leads with Mary, though, he sees as fragile and tends to be quieting and soft. Perhaps he responds to them with more of a transference protectiveness related to his own mother. We have been focusing on these issues and he has probably been working them through with his analyst.

Mary’s response to the situation is more subtle. She is in tune and makes the correct interpretations, but feels discouraged with the whole situation. Generally her feelings began to focus on a discouragement with me and with “my kind of supervision.” “All you do is ask what we feel; how do I get along with my co-therapist; what’s my heaviness and how do I experience it? You aren’t telling me how to keep the patients coming. We don’t really have a group.”

I tried to help her to become aware of her need to always understand and to "give" the right interpretation. I pointed out the parallel between her heaviness with me and the patients' with her. Eventually I realized—and this is the point I wanted to illustrate with this example—that there was a dynamic process going on and that a supervisee must be allowed time to get to know her resistances, to supervision and to the therapeutic process itself, just like a patient. She must, to a large degree, be permitted room to develop self awareness at a pace related to her own willingness to be confronted and to be revealing. Timing, just as it is in treatment, is an essential art. In fact, in some ways it is more complicated because much of the work is done in the therapist's personal therapy and the supervisor is only obliquely aware of it. Moreover, he is operating with a minimal knowledge of the therapist's underlying dynamics and family history.

I realized that I had pushed a bit too quickly early in our relationship. I had introduced a Gestalt technique in order to heighten Mary's awareness of her need to keep things rational and subdued. She began to experience the struggle which she was carrying on. She spoke of a lump in her throat and I asked her to speak for it. "Shush, be calm. Quiet. Don't get out of hand now." As she began to get into it her voice became heavier and softer, almost a whisper. She described it as weird and she backed off.

When we explored this in relation to the discouragement she felt, she really got in touch with her' anger. Over a few weeks, she became much more direct and emotional. Mary told me that I was "destructive, dangerous and don't know what the fuck you are doing." Her anger was set off by my confronting her resistance to looking at her own irrationality a bit too early in the relationship. She felt that she was not ready to be "put on the spot" in such a

revealing way and that she had not had sufficient choice in the matter. I learned a lesson the hard way about timing.

However, as I've so often also learned, through risking rather than being overcautious, such mistakes are far from irreparable. Within a basically warm and trusting relationship they become extremely potent grist for the mill—as long as the supervisor is open to facing his role in the situation. I think if I had responded defensively at this point, we would have ended up in breaking off the relationship (although even then there would probably still have been some period of time in which we would have tried to work things out and, if the defensiveness did not persist too long, this too could be further grist for the mill). In any event, Mary's capability to maintain her sense of integration is clear. With a fragile patient I would exercise more sense of timing. With a basically healthy supervisee I relied more on her ability to push back if too uncomfortable and to deal constructively with unsettling material (either with me or in personal therapy). A part of what Mary learned was that she was far from helpless in the situation and had some responsibility for where we went.

My respect for Mary's strength was confirmed when she confronted me directly and vehemently with her anger. In that session I simply listened, understood what I could and accepted the rest as her feeling of the moment. I did what I could not to respond defensively (that is, I didn't want to retaliate, and I also wanted to make sure not to do anything to get in the way of her really experiencing her anger). This was not easy because I was a bit bewildered and I liked her and felt too involved to be unaffected. When the smoke cleared the next day, Mary expressed some uneasiness about having been "irrational." I was able to help her realize how uneasy she always has been about being "inappropriate" or "childish." She eventually laughed with warmth and relief and shared the experience of it all "ringing a hell" in terms

of feeling that she had to be the stable one in her family. We didn't go into detail, but I'm sure she will explore it further. What we did go into was how her uneasiness might be related to her patients' remaining rational and unemotional and that leading a group was exaggerating her fears of irrationality. She was surprised at how different the experience of a patient being out of control with rage in a group felt, from the same occurrence in a one-to-one setting (where she was quite comfortable). In a group, she realized, she was much more uneasy about not knowing what to do or acting "childish," and being embarrassed in front of other people. (This was even more exaggerated because the group was observed by a class.)

The process of focusing on the feelings, including resistances, which she was experiencing was very unsettling to Mary and made for some uneasy moments. However, in the end, even her being disturbed and reacting angrily to my attempts to cut through her resistances could be a potent force for growth—a part of her gaining more touch with parts of herself which she can use creatively. Incidentally, the experience was also meaningful to her cotherapist, who was able to experience my willingness to explore rather than pacify her anger, and, of course, to me in furthering my awareness of myself and my tendency to move too fast when I like and respect a supervisee—to expect too much at times or even to overwhelm. I am much more aware on a gut level of these pitfalls now—thanks to Mary's confrontation and openness.

Another dramatic example of the effectiveness and importance of focus on the therapist's experience is my work with Lenore. Here, I was much more sensitive to timing and the supervisory process had unfolded much more smoothly. One reason for this, perhaps, is that Mary's group being observed by a class may have increased my expectations on myself and on the group leaders. Lenore, on the other hand, is a private supervisee whom I've seen

weekly for about a year now. Our relationship is just between us; there is no hospital or class involved. Also, Lenore has had extensive personal therapy, including currently being in analysis three times a week with a Sullivanian.

Over the year, Lenore has presented several patients with whom she felt uneasy. She sometimes became concerned with questions like, "How do you know when someone is psychotic?" or "How do I know she won't really kill someone?" We often spoke about her uneasiness with anger and also her need to carefully—at times forcefully—differentiate her ideas from mine. Like Mary, she had an excellent grasp of dynamics and tuned in well to patients. In fact, I'd describe Lenore as an unusually creative and intuitive therapist who often seemed to say the right thing and then to struggle in supervision to conceptualize what has gone on. Seeing therapy as a process and understanding working through had been a frequent focus for us.

Over a month or so she had felt bored with her own personal analysis and with many of her patients. We discussed the impasse as a working-through problem in which she understood the dynamics and was repeating them over and over, but did not feel involved. The patient she had been presenting was a symbiosis-seeking girl who made immense demands and became furious when she felt misunderstood. She had been very seductive with Lenore, who was beginning to feel uneasy. Then suddenly the patient left treatment. Lenore's reaction was, "Maybe it is just as well. I think she was psychotic."

Our relationship had developed slowly and included some struggles. We had often spoke quite candidly about our parental families and the ways in which they affected our work as therapists. I knew that although we had discussed her uneasiness with craziness, Lenore hadn't really experienced it in relation to her patients. I told her that I thought her patient left because she felt she had to in order to protect her therapist. I suggested that the reason she

felt this uneasy was perhaps that she was picking up Lenore's deep fear of her craziness.

Lenore was able to connect this to her letting go so easily and feeling relieved when her patient was gone. I asked her if she wanted to confront these fears with me. Then I asked her to describe the patient. "She's big, bigger than I am, and she gets a real mean look on her face." In response to my suggestion that she close her eyes and have an image, she saw her patient as "a monster, like a bear, wild." In speaking to the monster she felt very small and begged not to be gobbled up. "I can't give you all you want. You want too much." She realized that she was talking to her father and experienced a real fright. I asked if she wanted to continue (in order to be sure not to push too fast and also to enlist a conscious sense of choice as to how deeply she wished to pursue her fears at that moment). She hesitated momentarily and then plunged on: "You want too much. You want me to live your dreams. They are crazy dreams. You want me to give up my sanity!"

I asked her to take her father's chair and to respond. She continued in a painfully emotional dialogue with him. He urged her to "understand," to stay with him. He told her he needed her desperately and that he would die if she was so different. She became furious as she cried, "I have to be Lenore. But I feel like I'm stabbing you. I can't be you, I won't be crazy."

It was, as she described it later, "a heavy scene." I didn't try to do anything more than to be with her as she experienced it, to offer the support and understanding which she probably did not have in going through it as a child. Over the next few weeks, we spoke about how these fears led her to sometimes differentiate herself defiantly, and at others to feel she desperately had to fuse with a demanding patient. Her relief at her symbiotic patient's leaving was much more understandable. I'm sure that she had also been

working through these feelings in her analysis. I do not see that as one-shot magic any more than I would with a patient, but it did provide a powerful experience to crystallize and get in touch with how deep her fears of symbiotic fusion with her father were affecting, in a multitude of ways, the way she worked. Now, with a heightened awareness, her intuitive tuning into deep symbiotic longings can be used more creatively and probably with less fear. This experience is an unusual example of how within *some* supervisory relationships (with a deep sense of timing, a respect for the supervisee's right to decide how much intimate detail to share, and an awareness that she will need to work through the experience in analysis) a focus on the therapist's emotional involvement can be a tremendously potent lever which can be applied in the service of freeing the supervisee to fly.

Lenore's lifelong struggle to differentiate herself and her dreams from her father and his craziness is integrally related to her developing sense of identity as a psychotherapist as well as a woman. Supervision must contribute to the young therapist's view of himself or herself as a creative artist who is an essential tool in the therapeutic process. It must lead him toward being in ever-increasing touch with himself. He must develop a sense of his own unique style—his own identity—and how he can use it creatively—his strengths, and his limitations and fears.

Another way in which the supervisory process parallels an analytic one is in the supervisor's role in the student's development of the sense of separateness and identity. At first the supervisee tries to learn through a kind of identification. He tries various styles as he is confronted by many teachers. (He may at first be resistant to this, just as a patient resists experiencing his dependency needs, but if the process is effective he probably identifies partially with his teachers for a time). Eventually though, he begins to

differentiate himself from his analyst and his supervisors. If supervisors are open about not only how they work but also who they are and what has gone into developing their own particular style as therapists, then students can begin to compare themselves. If the atmosphere is one of acceptance and mutuality, rather than one of correct answers or one right way, then the student can see likenesses and differences. He can differentiate his own unique style creatively against the backdrop of a person he can see as worth taking from, but far from infallible and also quite a different person from himself. This also helps the young therapist to work through his needs to be omnipotent. He sees not only the supervisor's conceptual model and techniques, but the struggles and confusions which must be accepted. In seeing the supervisor as generally comfortable and effective, yet still in a process of further struggle and growth, he can accept and get to know himself better.

Supervision thus becomes a process which in many ways parallels analysis. The student learns that he, too, can not only fly, in his own unique way, but also teach the art of flying to others. In fact, if the student really goes through this process he will even realize that he has had some meaningful impact upon his flight instructor.

The essence of what makes any psychotherapy or supervisory process work, lies in its very spirit—not in a rigid adherence to orthodox techniques. The psychoanalytic spirit is built on a never-ending (but flexible rather than compulsive) commitment to investigation and a search for understanding. It leans on a sense of rational responsibility for one's own choices and seeks an ever-increasing freedom to choose. Supervision must help the trainee to understand the working through of transference and resistance and introduce him to a variety of approaches; however, which of many diverse techniques

the student chooses must be a reflection of his own sense of identity and be tailored to specific patients. He must learn that the true analyst is not one who woodenly follows rules of technique. If we are to pass the psychoanalytic torch, we must, like Jonathan, demonstrate a blazing desire to fly. We must strive to “keep finding (ourselves), a little more each day.” We must pass (to our patients and our students) not a set of techniques, but the courage to be—to develop and take responsibility for one's own unique style of being, as a therapist and as a person.

• 12 •
MANNIE⁶

Mannie often spoke at symposiums as the representative of Freudian position. All through my own analysis with him, and for a few years afterwards, I thought of him as espousing a rational insight-oriented position. “The analyst must stand for reality—for reason.” I’ve often struggled with my image of him as critical of an experiential or humanistic approach (see, for example, his long polemic on “Irrational Psychotherapy: An Appeal to Unreason,” Wolf and Schwartz, 1958, 1959) and pictured him as an “orthodox” analyst who even as a group therapist maintained an objective analytic stance. Yet when I reminisce about my own analysis with him, the most potent moments I remember are moments in which I was aware of Mannie the human being. Above all, I was affected by a sense of who he was as a man.

My memory of him is so much a wordless sense impression that it is hard to convey it. I felt his presence, his compassion and his zest most, paradoxically, when he said nothing. I recall the experience of Mannie sitting in group and laughing with his whole body as he enjoyed a patient’s excitement about new-found strength. I can feel the way he would turn attentively to me when I was struggling to express what I felt toward him. It made little difference whether I felt rage or deep affection. His expression, his posture and his mannerisms all said, “Come on, I’m ready to engage with you.” One mannerism I particularly visualize, and often find myself expressing, is a simple, quiet, beckoning gesture he often made. It left the responsibility with me, but he clearly welcomed direct emotional contact.

⁶ Emanuel K. Schwartz, Dean of Training at Postgraduate Center for Mental Health until his death in 1973

Occasionally, one of us would come in early and take Mannie's chair. He responded differently with the meaning he felt from each of us who sat in his place, but it was always an exciting and meaningful experience. In fact, it usually electrified the group. One day, a class of group therapists was talking about their discomfort when a patient “displaced” them. Many leaders voiced an uneasiness about whether to respond to the “challenge” or whether to allow the patient to “get away with it.” Eventually, they wondered how Mannie handled such occurrences. His reply was, “If the only seat left was on the chandelier, I’d still be the leader.” I laughed heartily because I knew so well what he meant. What I remember most about Mannie is a sense of his vigorous, compassionate presence.

There are two other experiences in treatment which stand out in my memory. One I feel as a beginning—the point at which I became a patient. The other was an essential part of my struggle towards termination. Beginnings first. I was very successful through the years of my prolonged adolescence. In my mid-twenties, I was a psychologist in analytic training with a comfortable family life. I had all the trappings of success and experienced very little anxiety. After a year or so of sitting quietly behind the couch offering well-timed interpretations and empathic understanding, Mannie blew his top at my grandiose defense. He was furious and threatened to throw me out of treatment if he “continued to feel this way about my unwillingness to see any weakness or conflict in myself.” For the first time in my life since my grandfather died without warning when I was three years old, I was shaken to the core. I do not think any interpretation on earth could have broken through my need for certainty and control the way Mannie’s fury did. He saw it as a “parameter.” I see it as the turning point in my analysis—perhaps in my life. I felt him as a man involved in struggle with me and I felt my terror of losing him. I became a patient.

The third image that forms in my mind, as I reflect upon those years, is the look in Mannie's eyes when (in one group session toward the end of my treatment) I was very in touch with my love for him. From the distance I can describe it as a part of my struggle to establish a healthy, loving introject during the later stages of a mourning-working through process (see Livingston, 1974 for a conceptual description of this process). My memory of it though, even now, is far from theoretical. I wondered about his never having had children, since he so obviously was so able to be a loving father. He spoke longingly of having thought of adopting a particular Oriental girl whom he felt a love for when he visited her country and with sadness of his decision not to do so. I felt the softness in his eyes and in his voice. I told him that I loved him. He was analytically quiet. I started to push for a response, but I could see in his eyes that my love had meaning for him. I cried softly and soon after I was able to stop trying to get him to work more experimentally. I really experienced a sense of separateness and began to develop my own style as a therapist and as a man. Only then could I move towards termination.

The true spirit of an analysis must be a love of freedom and individuality. My orthodox analyst's presence as a human being intimately involved in my struggle to actualize my own uniqueness enabled me to be me. Like Mannie, I now attempt to engage my patients in a growth struggle, like him, I use my own style, my separateness, and myself as a unique human being. My technique stresses interaction, feeling and the experience of struggling, growing human beings. Conceptualization, psychoanalytic foundations and the working through of transference are an ever-present backdrop in my work. It is very different from my analyst's style on the surface, yet my zest for individuation and the expression of creativity stem largely from my experience with him. My orthodox analysis—like any good analysis—freed me to express my own uniqueness creatively. Such freedom is the spirit of

psychoanalysis and of an existential humanism. Any preoccupation with rules of technique and any dichotomy superimposed upon these approaches, misses the essence of both.

References

Livingston, M. (1974) On Struggling Towards Termination. *Group* (The News-Journal of the Eastern Group Psychotherapy Society), November.

Wolf, A. and Schwartz, M. (1958,1959) Irrational Psychotherapy: An Appeal to Unreason. *American Journal of Psychotherapy*, 12:300-315, 508-521, 744-759, 1958; 13:383-400, 1959.

• 13 •

OFF TO CONNEMARA⁷

(A REPETITIVE TALE OF RESISTANCE, RESENTMENT AND REFUSAL TO MOURN)

Once there was a little man who led a little life. One day he packed a little bag and set off down the road when he came upon an old friend. "Where are you off to?" asked the friend. "I'm off to Connemara" he replied with glee. 'You mean, you're off to Connemara, God willing,'" the friend added instinctively. "I mean, I'm off to Connemara," the little man repeated simply. At this point he was transformed into a frog and placed in a frog pond for seven years.

At the end of those seven years he was changed back into a little man again. No sooner did he find himself a man again, than he began to pack his little bag and set off once more down the road. As before, he came upon the friend. "Where are you off to?" asked the friend skeptically. "I'm off to Connemara," he replied solemnly. "You mean, you're off to Connemara, God willing, don't you?" the friend queried with a note of plea. "I mean I'm off to Connemara," he replied resolutely. . . and then, almost as an afterthought, added, "or back to the frog pond."

Adapted from F. Caballero 's
Old Spanish Fairy Tales

Basic truths about life and psychotherapy are often dramatized in tales which are once naively simple and eternally enigmatic. In this delightful folk

⁷ This article first appeared in *Comprehensive Psychotherapy*, 1:13-20, 1980

tale it is possible to grasp a sense of the essence of repetitive neurotic suffering and an inkling of how therapy might lead to a way out.

I heard The Frog Pond from a patient, who was charmed by the delightfully defiant little man, and was equally taken by it. The next thing I knew, I was using it to highlight a point or to engage patients in looking at some similar qualities in themselves. It worked; that is it enabled us to light-heartedly increase their awareness of some rather painfully self-destructive patterns. It also began to work on me. I became fascinated by the enigmatic truth I was playing with. As is my style, I became inquisitive about what it all really meant; which boils down to: I couldn't resist the temptation to translate it into language I'm more familiar with. The story suggests parallels to some psychoanalytic and some Gestalt concepts, as well as, in a way, posing a *koan* (a riddle, posed by Zen masters, which cannot be solved through logic, but attempts to force the student to find a totally new viewpoint). What follows are my reflections upon relating the tale to these diverse conceptual systems, in the hope that they will throw some light upon each other and on the mysterious truth embedded in the fable.

As a psychoanalyst, I would like to consider the plight of our little man in terms of the repetition compulsion, resistance and a refusal to mourn. Then, perhaps, we can speculate about engaging him in a therapeutic process focusing on the concept of transference and working through.

The most striking quality of our main character is that he appears trapped in a repeating pattern. He seems to be doomed forever to returning to the frog pond. It is his noble struggle in the face of this which engages us. We laugh because we recognize a sense of human plight and foibles. The little man sees one road and only one choice. He feels he must choose between a wholly acceptable submission to a primitive judge and a defiant but ineffectual

position which again lands him in the frog pond. As he experiences life, the situation leaves him no way out.

Psychoanalytically, what we see here is a caricature of what Freud referred to as a repetition compulsion. Our little man seems doomed to compulsively repeat what is, in all likelihood, a replication of childhood experiences. He transferentially approaches authority figures as he once responded to his parents. He repeats, rather than remembering, and is resistant both to change and to an awareness of the pattern and his complicity in it. He even defiantly resists the dawning awareness that there is no way out so long as he clings to his view of authority and of the world.

The fable thus poses the double challenge of accounting for the phenomenon of what we call repetition compulsion, as well as solving the riddle of finding a way out.

In accounting for the tenacity of these transferential patterns, we must look at resistance on two fronts. First of all, it is important to understand the character's reluctance to allow any awareness of these patterns. Then we need to look at his resistance to changing or relinquishing them.

As the little man becomes aware of his impending return once again to the frog pond, he will no longer be so placid about his plight. Blind repetition binds a tremendous amount of anxiety and confusion. I am reminded of a patient who, throughout her 26 years, had worked arduously to be what her mother wanted. She hid her terror of the dark, her craving to be taken care of, and, above all, her growing awareness that she didn't always agree with her mother's values. She felt ashamed of who she was and was unable to win parental approval. She saw her mother as strong, good and righteously correct. After years of treatment (and less frequent contacts with her family), she began to feel the stirrings of self respect. She began to succeed at a career she

chose and valued (one which, not by accident, mother knew nothing about). She occasionally spoke back to the mother despite her terror of rebuke. No direct abandonment or rebuke followed. Both the patient and I had expected to breathe a sigh of relief.

It was at this point though, that in one particular session I sensed a growing desperation, despite her calm manner. The content dealt simply with her concern that her mother might be getting sick. I didn't catch on until, as we walked toward the door at the end of the session, I felt her icy calm and caught the words "no way out." I am not one to panic and I've ended many a session with patients still voicing veiled or even overt suicide threats. This one was different. I insisted we go back and sit down to talk about those words and the desperation they conveyed.

Yes, she had clearly formed a plan to end her life. That was her solution and the surface calm was her resoluteness in that plan. Finally, she broke down and shared her terror and confusion with me. She had always known at some level, but now it was becoming painfully clear, that what mother really needed was for her to be the family failure—to go through life ashamed and literally feeling that she was a rat with a tail. Not only was she to maintain the family equilibrium in this horrible way, but, furthermore, any awareness (no less verbalization) of the pattern would mean the arousal of her punitive hallucinatory voices and even worse, the destruction of her mother's precarious pose as the strong one—maybe her return to a hospital; perhaps even her death. There was no way out. With the awareness she now had, a submissive return to the old ways was no longer possible. She had become a person—no longer a rat—and she could not comply anymore. She had to grow and her growth might mean the end of the mother upon whom her survival depended. Or did it?

With that question came a great deal of confusion. The resistance to awareness of this facet of transference repetition gradually had been eroded. The flood of anxiety had been survived. Now we were ready to begin the next phase, the working through of this awareness in order to relinquish the perceptions and wishes involved. It is this phase that is accountable for the length and difficulty of moving gradually from awareness to deep and lasting change. Transference involves a repeated attempt to seek an omnipotent protector and provider or to have such control and invulnerability oneself. The dawning awareness in our patient's question is that her survival no longer depends upon mother's goodwill. In fact, it never did to the extent she experienced it. The working through process is essentially the mourning of these transference wishes and views. She will realize gradually that here again she wished that someone would be the strong mother she wanted. She will have to experience again and again this disappointment in not having anyone to totally protect her. And again and again she will experience her lack of omnipotent control, her vulnerability. Resistance during this part of the process is essentially a refusal, a refusal to let go of the wish to escape the human condition.

Our little man is also refusing to mourn. He clings to his wish for a God who can protect or punish. It would release a flood of anxiety; however, he already is beginning to become aware at the end of the tale (a good prognostic sign). In treatment, he probably would experience the therapist as another authority with whom to play out his script of submission or defiance. The working through of this transference relationship would constitute the kernel of the treatment process. The aim of this process would be the resolution of the transference distortions involved in his view of the world. Without such a resolution there is, truly, no way out. Although the language of the Gestalt approach is not my native tongue, I have found it valuable to translate some of

my thoughts into it. Gestalt concepts, such as a stress on the here and now, dealing with expressed resentments and unfinished business, and the reowning of projections complement and enrich a psychoanalytic understanding. Using these concepts, we can speculate about treatment in terms of helping our little man to experience the stuck point or impasse which he is approaching, and to integrate previously unavailable parts of himself, to emerge from the confusion with the sense of a newly discovered configuration.

Perls, the originator of this approach, often said that Gestalt therapy is simply becoming aware of the obvious. Awareness of the here and now is curative in itself. We might ask our little man at the end of the story to "stay with his feeling." People tend to avoid awareness when it becomes confusing, painful, or otherwise uncomfortable. If, in therapy, we thwart a patient's tendency to avoid contact with parts of himself or his environment, then the basic assumption is that the most important unfinished business will always emerge and can be dealt with.

If our character could stay with his feeling, his dawning awareness of "or back to the frog pond," he would begin to experience the pattern he has been repeating. He might well become aware of his unexpressed resentment toward a God who demanded submission and threatened the inevitable return to the frog pond. Resentment is closely related to getting stuck. It is an attitude which holds tenaciously to a grudge. In his resentment, the little man neither lets the authority fade into the background nor can he tackle him directly. He is stuck as long as he clings to seeing the world as he does.

If he were able to continue to be in contact with his feelings, he would approach the sense of impasse, or no way out, we've already discussed. At this point, he would get desperate and confused. Suddenly, his previous sense of configuration, his view of himself and the environment, would no longer hold

up. At such a point it often feels like one doesn't know anything more. Attributes that were disowned and projected onto the authority suddenly can't be so easily disowned.

We all feel a panic as we approach such an impasse. It feels as if there is no way out, no way to survive. Our little man might fantasize that if he expressed his anger at God he would surely die. We all have these catastrophic fantasies by which we prevent ourselves from being fully alive, fully in contact with the now.

If we experience the confusion, if we feel blank and still risk staving with our feelings, then a new configuration emerges. It's like Alice in Wonderland as she finally confronts the queen and her court who have been mercilessly driving her crazy. "You're nothing but a pack of cards." She awakens. She understands on a gut level that the impasse was nothing but an outlived, or maybe never accurate, view of things. Or, in Perls' (1969) words, "It's the awareness, the full experience, the awareness of how you are stuck, that makes you recover, and realize the whole thing is just a nightmare, not a real thing, not a reality."

It is important to realize, though, that a single breakthrough will have only minor impact on the repetitive patterns. Gestalt therapy involves a working through, a moving process, much the same as psychoanalysis. It is usually expressed as a repeated taking of responsibility for projections. Over and over again a dialogue between oneself and a projection onto another person (or for the sake of experiential exercise onto an empty chair) leads through confusion and impasse to a reowning and an ever-increasing integration and fuller self acceptance of one's many facets. The aim of this process is a whole person, one who can be in ever increasing contact with himself and his environment in the here and now and, thus, take responsibility for his own experience. Blaming

God or some other authority, or trying to be such an authority, gives way to autonomy and awareness.

The spirit of Zen has enriched my life and my work in recent years. Its language is difficult for one to translate because it is so much a nonverbal experience. It has been said that: "Those who know do not speak; those who speak do not know." Despite this difficulty, I'd like to look at our fable as a *koan* as well as in terms of the concepts of direct experience and satori. A Zen master presents his student with a *koan*. Our little man's plight is in itself just such a puzzle, it seems that there is no way out. The riddle defies logic as well as any of the student's usual ways of approaching life. Essentially, the unenlightened view of all things is in terms of dichotomies like life and death, right and wrong, or, as in the case of our story, defiance and submission. Through staying still and meditating upon the *koan* despite the discomfort involved, the student reaches a point where he does not actively strive toward a goal or a solution. Through an effortless effort, he suddenly and directly experiences the absurdity of his attempts to solve the problem (and, ultimately, the problem of life and death). This direct experience allows, or, in fact, actually is, a satori. Suzuki (1934) defines satori as an "intuitive looking-into, in contradistinction to intellectual and logical understanding. The unfolding of a new world hitherto unexperienced in the confusion of a dualistic mind." The enlightened mind no longer is trapped striving to control or to choose between false dichotomies. Life is not a problem requiring a solution.

Our little man could find his way out once he experienced the absurdity of his view of God and of the world. The road to Connemara would once again be simply the road to Connemara and not a path fraught with authority problems and repeated trips to the frog pond.

In conclusion, I would like to underline the similarity in these three seemingly diverse approaches. Most importantly, the goal in each case is identical. It is described in different words, but, in essence, there is really only one true goal. Awareness is the here and now, leading to integration and a new configuration; deep insight (beyond the intellectual), leading to enlightenment and release from striving. These goals may sound as different as the French word for chair may differ from the English; however, a chair is a chair, is a chair. In all three approaches, the essential aim is more fully experiencing the human condition—simply because that is what is.

The paths to this identical goal seem quite diverse, especially if we look superficially at technique. Psychoanalysis puts the patient on a couch and asks him to free associate. The analyst responds with a third ear for latent meanings relating to transference and resistance. Gestalt therapy asks the patient to talk to an empty chair or to role play figures in his life in order to experience the here and now and to reown projections. Zen philosophy suggests sitting still in meditation and poses *koans*. On the surface, the paths certainly sound miles apart.

It is not by coincidence, though, that I am drawn to all three. When I look deeper and understand the essence of each rather than their surface tools and techniques, I am struck by how closely each is the same. In all three, there is a sense of balance between, on the one hand, an immediate experience, which is at times sudden and always defies logic and verbal explanation, and, on the other hand, a patient repeatedly experiencing within a sense of an unfolding process. This process always seems to involve the experiencing of confusion and impasse in the presence of a fellow human being who has already had similar experiences. What was naively concrete, dualistic and simple becomes infinitely complex. The other side of this direct experiencing, in all three

approaches, consists of a new view of things. Then, again in all three systems, it is interwoven with a gradual letting go and mourning of strivings to avoid the human condition. As we have seen, the end result of this process is once again a simple view of life, this time with a deeper acceptance of the human condition.

In thus outlining this process, I am reminded of an old Zen saying: "Before a man studies Zen, to him mountains are mountains and waters are waters; after he gets an insight into the truth of Zen through the instruction of a good master, mountains are to him not mountains and waters are not waters but, after this, when he really attains the abode of rest, mountains are once more mountains and waters are waters" (Ch'ing Yuan, quoted in Ross, 1960).

Our little man began by simply setting out upon the road to Connemara. The road was simply a road and Connemara simply Connemara. As he began to develop awareness, the road was no longer simply a road and Connemara was no longer simply a town. He began to be aware of the deep unconscious and complex meaning they held and of his conception of God and the world in relation to this road and this town. At the end of our fantasied treatments, the road would once again be simply a road and Connemara simply Connemara.

So, too, have we come full circle in our awareness of the fable. At first, it was simply a delightful tale; then, upon serene reflection, it began to unfold its mystery and to shed a great deal of light on some basic truths about life and psychotherapy. Now, in the end, to fully and directly experience the tale, it must once again be read simply as a delightful tale; for, after all, that is what it is.

References

Perls, F. (1969) *Gestalt Therapy Verbatim*. New York: Bantam Books.

Ross, N. (1960) *The World of Zen*. New York: Vintage Books.

Suzuki, DT. (1934) Satori, Or Acquiring a New Viewpoint. In Ross, *The World of Zen*. New York: Vintage Books, 1960, pp. 41-47.

• 14 •

RECALCITRANT WORKING THROUGH, NARCISSISM AND THE QUEST FOR IDENTITY

ABC

ABC? ABC . . . DEF . . . G!?

That's for Glenn, and Glenn is me.??

That's what he said alright.

He seems to want I to listen to it, as if he somehow expected I to repeat it.

ABC, DEF, G!

That's for Glenn, and that's me.

But what is "me"? Is it like "I"? But then, what is I?

Each day for as long as I can remember has been filled with such problems. Since I noticed that what I refer to as "I" existed—that was about six months ago—I've wondered about what "I" is for. I know "I" is! I know "I" is because sometimes I hurt and sometimes I enjoy. But what for? And what in the world is "Glenn?" She is for feeding and making warm . . . but what is he?

He and she seem to be able to make each other understand. Will I be able to do that some day? They must know all the answers; about meaning, and "Glenn," and "me," and those sounds they make. Will I ever be able to really know and to communicate like they do?

I'm tired. I'm hungry. I wish I had food. I wish I could communicate like they do. I wish I knew, like they must, about what I'm for and about what he calls "me."

Oh good, the bottle is here! A bottle is to drink. I'm so tired. I worked hard today. I learned to squish string-beans and I worked on those sounds that make them happy. They must be important because he gets so excited.

He knows!

I'm so tired. I could just sleep now. I think I will. Maybe tomorrow I'll know.

ABC and that is "me?" Maybe when I can communicate and be big like he, then I'll know.

He's taking I to the crib now. I'm tired. Maybe tomorrow.

I wish I could get to sleep. I wish the radio was 't so loud. Someone shot in Selma? War in Viet Nam? Well, he must know. I'm sleepy. Maybe tomorrow. A B C. . . .

Working Through, Symbiosis and Identity Formation: Three Interwoven Concepts

The sense of identity we all seek in order to provide some stability and meaning in our lives cannot be simply found. It must be created through repeated experiences which inherently bring with them the very anxiety and confusion of which we once dreamed we would be free. I wrote the introductory poem when my first child was an infant. His quest for identity had already begun. Looking at these lines, I can see the anxiety and confusion of a young man still shaping his own identity—becoming “Daddy.”

This quest is a lifelong process. Each old identity must be allowed to crumble, or, at least, to fade into the background, in order to flexibly reform with the passing of time and circumstance. Any sense of identity that remains rigid for too long becomes a brittle shell. Such brittle shells form a pseudoidentity of rigidly played out roles, which are then sometimes clung to defensively (in order to magically ward off the anxiety and confusion inherent in human growth). The more tightly these roles (and the distortions they create to protect them) are clung to, the more terrifying the prospect of shedding them.

The development of a healthy sense of identity is thus closely connected to the mourning of unrealistic, often magical, wishes and fears. Originally, as we see in the ABC poem, an infant attributes omnipotent powers to the adults around him (or at other moments perhaps to himself). These magical fantasies reduce the buzzing, booming confusion of infantile experience. Too sudden a loss of this sense of the world would throw him into a terror with which he could not cope. Too rigid a maintenance of these fantasies would lead to a delusional view of the world.

In order to gradually tolerate doses of confusion, the child needs what has been referred to as "a holding environment"—a safe enough place. In a warm, accepting (nonjudgmental) atmosphere, these roles and distortions can be relinquished, and the child can increasingly develop a sense of himself in relation to the world, one that is grounded in realistic perceptions and feedback. It is this extremely close relationship with his family which provides the basis for a stable and continuous, yet not rigid and unchanging sense of self.

This period of being closely merged with mother provides the foundation for the separation-individuation process to unfold (Searles, 1966). It is, in

essence, a healthy symbiotic phase in the process of identity formation. This period is re-experienced in the transference. Earlier and earlier roles are played out (along with their accompanying archaic feelings) in the attachment to the analyst. Orthodox theory sees the analyst as a blank screen upon which the transference distortions (wishes and fears) may be projected. If the analyst is totally accepting and tuned in, the patient may experience the relationship as an intense holding environment, thus providing a 'healthy symbiotic phase.'

It is during such regressive experiences that earlier and earlier derivatives of the basic infantile wish to fuse with (or to become) a magically omnipotent protector and provider emerge. In these extremely vulnerable moments, the wishes can be mourned. Mourning is a two-part process, including first the incorporation of a loved object and then the gradual relinquishing of ties to the object (along with the infantile wishes).

Psychoanalytic treatment may be conceptualized as the establishment of an intense transference within which these regressive experiences can occur, in order that the infantile distortions can be corrected, and the losses of childhood mourned and accepted. This process is one of forming a transference attachment, accepting the wishes inherent in it as unfulfillable, and gradually relinquishing them. The repeated confrontation with the many facets and hidden forms of these wishes, so that they may be mourned, defines the working-through process that Freud (1914) considered the cornerstone of psychoanalysis. It is the working through of transference wishes within a warm, accepting (perhaps, at times symbiotic) relationship, which enables a patient to tolerate the confusion of shedding his pseudoidentities in order to create a healthy sense of self. Identity is never really found at the end of the quest or a rainbow. It is found through repeated struggle and confusion. The

quest simply leads the individual to face the necessary experiences rather than to flee into comforting pseudoidentities or roles.

Recalcitrant Working Through: Narcissism in the Transference

It is essential to distinguish between a healthy symbiotic phase and a self-perpetuating symbiosis. In the infantile symbiotic bind, often associated with schizophrenogenic mother-child interrelationships, the parent does not have a clear sense of a true self. She has little sense of her own identity beyond a precarious role-related one. Her narcissistic defenses depend upon mutual merging with the child. Any sign of separateness threatens her defenses and she must act to prevent the crumbling of her symbiotic pseudoidentities. Such a parent or therapist would then become punitive, contemptuous or otherwise prevent the emergence of the child's (patient's) separate identity. She cannot tolerate being seen differently from certain of her own perceptions—particularly those of being a good and not dangerous parent.

In contrast, during the developmental periods that we are calling a healthy symbiotic phase, the mother or therapist has, to a large degree, developed a clear sense of her own identity. She has a sense of herself as worthwhile, human and nurturing, a sense that is not dependent on rigid or grandiose models. She does not expect to be omnipotent, and can tolerate the child's (patient's) distortions (as well as some painful realistic perceptions). In other words, she allows the symbiotic merging and confusion, while at the same time maintaining a sense of separateness. Thus, she can allow room for the patient's transference distortions within an essentially close human relationship.

The distinction between a symbiotic bind and a healthy symbiotic phase is dependent upon both the therapist's own growth in personal therapy and

upon an increasing understanding of the working-through process. It is never absolute, which scares both patient and therapist, creating resistance on both sides. Transferentially, the patient resists regression and vulnerability for fear of being swallowed symbiotically by the therapist, or, by the process itself. He, often with the intensity of psychotic distortion, fears that he is disintegrating or going crazy on the one hand, or, on the other hand, he sees the therapist as swallowing, dangerous and crazy making. The childhood experience associated with these fantasies (along with the underlying infantile wishes) must be patiently explored if this resistance is to be worked through. This is often difficult to accomplish because of the terror involved in the here and now experience of trusting the therapist. The patient, after all, cannot safely discern the difference between allowing himself to be temporarily confused and vulnerable (perhaps, at moments, even to feel symbiotic merging) on the one hand and falling into a psychotic trap with a schizophrenogenic mother on the other hand. The difference lies, as mentioned before, in the therapist's sense of her or his own separateness and identity. A healthy therapist will be able to allow a human intimacy along with serving as a transference object who can tolerate a fair amount of not being seen for herself. She will also be able to accept (even enjoy! the patient's individuation.

Patients need repeated experiences that approach brief symbiotic phases in order to develop the capacity for trust and intimacy. Without such experiences, it is very difficult for them to relinquish the distortions with which they have ordered their world. It is often important for patients to go through a very confusing period of regression within the process of treatment (regression in the service of growth through awareness) on the one hand, and a symbiotic pursuit of illusion on the other. Without this awareness, therapists often fall into one of two traps. In one, they are sometimes seduced by the patient and by their own unconscious needs into an over involvement which

does not leave the room for two separate identities. In this case, they unknowingly attempt to fulfill the patient's transferential longings and get lost in a symbiosis. The more common trap, though, is not to recognize the need for a healthy symbiotic phase for human contact and even merging. Therapy becomes an intellectual correction of distortions, but lacks the emotional intensity possible when regression and intimacy during such phases are understood.

After a dozen or more years of clinical experience, most therapists are struck by the patients who are still in treatment after many years of working through analytically. What leads to psychotherapy taking so long for some people? A large number of patients, who are clearly treatable and are not schizophrenic, have a very difficult time in working through their blocks to spontaneity and mutual intimacy. These patients may work in treatment for ten or fifteen years before approaching core transferential issues. During these years, they are often successful in most peripheral areas, such as a career, and, to a certain degree, in social relationships. Yet, a basic area of deeper human contact remains threatening and unreachable.

I'm thinking, of course, of the hard-core narcissism we so often run into (especially in otherwise very gifted and creative people, often therapists themselves).

Diagnostically, these patients are usually referred to as having some borderline traits and a severe narcissistic character structure; however, labels don't really help to understand the difficulties involved.

As with most psychotherapeutic issues, it is not a matter of description and technique, but one of understanding the underlying process. Working through is the fundamental psychoanalytic concept for the understanding of the nature of change and its slow, repetitive quality. In a previous chapter (Livingston,

1971), I stressed the relationship between working through and a mourning process as an explanation of the necessity for repeated confrontations over time. A loss cannot be experienced all at once, especially by a young child or a patient who has not developed a sufficient sense of identity. It would be overwhelming. Thus, small derivatives enter awareness and are experienced and mourned a little bit at a time. The working-through process is, in essence, a mourning and thus, eventually, a relinquishing of infantile wishes and distortions as they are experienced in the transference. It takes time for such a process to unfold in the same way that it takes time to mourn a loved one.

The patients to whom I refer seem to take even longer; however, they stubbornly cling to their resistances. Working through proceeds, but ever so slowly. Despite a great deal of insight, the core working-through issues remain recalcitrant. Recalcitrant working through arises, essentially, when the patient is unable (or in a way unwilling) to relinquish his or her transference wishes. In order to work through this core, it is important to have a dynamic understanding of the wishes and fears involved (of the transference and of the defenses).

The core transference demand in these patients is not so different from the demand in those who respond to a more conventional analytic approach and reach a reasonable degree of resolution in about five years. The infantile wish is for a parent who is perfectly tuned in to the child's feelings and needs, an omnipotent protector and provider (or at times the wish may be to possess this omnipotence oneself). Such a parent would protect the patient not only from harm, but from the experiences of confusion, fear and vulnerability. Essentially, the wish is to be protected against the human condition itself. Then there would be no separateness and no need for a separate identity. Thus, the transference demand is that the therapist (parent) merge

symbiotically and, at the same time, respect the patient (child) as a separate individual who must be allowed to individuate and must not be swallowed.

The differences that create recalcitrant working-through problems are very subtle. One important one is the degree to which the patient, unknowingly, demands that the therapist give up her own sense of separate self and allow herself to be treated as a non-human transference object; while, at the same time, demanding that she be humanly connected and even vulnerable. The demand is not merely impossible to fulfill because of its perfectionistic immensity, it is impossible because it masks an inherent contradiction which can, if not understood (or even at times when understood), become crazy-making and painful. It is a demand that the therapist provide the nurturing needed for a healthy symbiotic phase while, at the same time, insisting (more totally than most patients) that she give up her own sense of separate identity (her own feelings, needs and protecting against damage). Yet, without a firm awareness of her own separateness, it would be impossible for her to provide the patient with even the degree of nurturance which is possible during this phase. Without her own sense of separateness, the therapist cannot hope to allow the patient to merge symbiotically, and then to individuate.

It is important here to note the difference between hurt and damage. Recalcitrant working through will go on forever if the therapist is not willing to risk some pain in the growth process. Both therapist and patient must confront previously disowned parts of themselves (and pain and confusion are inherently part of any changes in identity). If the therapist mistakes this to mean that she must masochistically allow herself to be abused in a damaging way, the recalcitrance will also persist forever. One reason why these wishes are so hard for such patients to relinquish is that, although they are in part illusory transference demands (which must be experienced and mourned),

they are also related to real developmental needs. In order to form an identity stable enough to really work through transference wishes and to face the human condition, patients must have enough experiences with a parental figure who can allow them to merge and still respect their separateness. The same demands are transference at some moments and at other moments (when they are less imperious, perfectionistic, and total) are connected to real developmental needs. These needs can never really be fully fulfilled. The losses of childhood must, eventually, be accepted and mourned; however, some degree of nurturance is often necessary before the transference aspects can be experienced and worked through. This is especially true with narcissistic, borderline patients whose parents were either unable to allow the symbiotic closeness because of their own fears and shame, or were unable to allow the child to individuate because of their own lack of separateness. As children, these patients were inconsistently condemned or threatened with annihilations for any moves toward closeness or distance which did not meet the parent's needs. Any beginnings of identity formation were thus thwarted.

In short, these patients are unwilling, or perhaps unable, to work through the transference past more fully until they develop a strong enough sense of identity to have a capacity to mourn. At first, both identity formation and mourning require an intimate (even symbiotic) sharing. Thus all patients to some degree—with the exception perhaps, of the theoretical healthy neurotic—need to be nurtured by a “good-enough” mother before they can resolve transference distortions more fully.

Recalcitrant Working Through: Narcissism in the Resistance

Children who are fortunate enough to be allowed a healthy symbiotic phase, develop a healthy degree of self interest. They have the chance to experience repeated closeness and separateness with a loving parent who is

able to tune into their need in an empathic merging, yet secure enough in her own identity to respect their separateness. These children are thus enabled to develop a healthy sense of their own identity, which is based on both the capacity for separateness and on a sense of human connectedness to others. They can be aware of their own needs and interests while, at the same time, accepting and valuing others as individuals (each with his or her own needs and values and each the center of his or her own perception of the world).

To the extent, though, that the parental attachment is a narcissistic one (stemming from the parent's own lack of a healthy sense of identity or self), the child is then used as an object to bolster the parent's pseudoidentity. He is swallowed and not allowed to develop enough individuation, or, when he no longer fulfills the parent's narcissistic needs, he is then disowned. This leads to the child growing up with an excessive degree of narcissistic needs of his own. In other words, such an individual would develop an unstable sense of self. This would be manifested either by too much preoccupation with himself or with a fear of showing any self interest at all. The anxiety and confusion inherent in the process of identity formation and separateness thus becomes overwhelming and must be bound in a defensive manner. In contrast to the healthy symbiotic phase, which allows an individual to tolerate increasing doses of confusion and anxiety and to develop an identity, individuals who are treated as narcissistic objects and do not have the opportunity of a healthy symbiotic phase tend to develop pseudoidentities, i.e., they adopt roles whose purpose is to bind confusion and anxiety and provide a false temporary sense of certainty and safety. These roles are either attempts to satisfy the narcissistic demands of the parent who is then seen as an omnipotent protector and provider, or are adopted in an attempt to experience the self as omnipotent.

In contrast to a healthy, stable sense of identity, pseudoidentities tend to be inherently rigid and unstable. In order to prevent the crumbling of these pseudoidentities (which would then lead to a flooding of anxiety and confusion), several defensive patterns emerge and crystallize. As a group they are often referred to as narcissistic defenses. These narcissistic defenses are essentially barriers against vulnerability. They are attempts to maintain a certainty and risk-free experience of life. Essentially, they are a refusal to mourn the infantile transference wishes for an omnipotent protector or for a magical omnipotency of one's own. They are, in other words, defenses against an acceptance of the human condition.

Psychotherapy and the working-through process are inherently connected to the mourning of transference wishes and the acceptance of the human condition. Thus, it is not surprising that when working through problems seem to become recalcitrant, the resistances involved are closely related to a narcissistic core. These narcissistic defenses fall into two categories: masochism and contempt.

In several previous papers, I have written about masochism as a refusal to mourn and its relationship to the working-through process, on the one hand, (Livingston, 1971) and to symbiosis on the other (Livingston, 1970). I have also written about "contending with contempt" (Livingston, 1973) and about the relationship between contempt and masochism as barriers to vulnerability (Livingston, 1975). Surprisingly, until recently, I was not aware that I was writing directly about narcissism. Masochism and contempt are both narcissistic defenses. They are essentially attempts at maintaining a role, a pseudoidentity, in order to bolster an unstable sense of self and to prevent overwhelming confusion and anxiety. Masochism is the adoption of a role of submission and helplessness. The masochist seeks a symbiotic tie to an

omnipotent parental figure who will provide certainty and safety. He attempts to avoid the risk and responsibility of a separate existence. To play this role, he surrenders any opportunity to develop his own sense of identity. Any self interest that might separate him from his protector must be concealed. Imperious demands for passive gratification are stubbornly made. The basic masochistic role is "Since I am so helpless, you must take care of me (serve me)." The underlying grandiosity is, of course, masked along with the secret self interest. Masochism is a refusal to relinquish transference wishes. It often contributes greatly to the recalcitrance of working through problems.

Contempt is also related to an imbalance in narcissistic tensions. Unlike the masochist, a person whose major defense system is contempt does not surrender his sense of self importance. He exaggerates it. In order to hide his inner feelings of shame and inadequacy (centering around his lack of a clear sense of identity and self worth), he adopts a pseudoidentity or grandiose separateness. He maintains a role of never needing anyone and tries to behave as if only his values and feelings existed. He is smug, certain, and superior; clearly above the human condition. This position is, of course, very unstable. The deep needs of which he is ashamed, and so vehemently denies, forever threaten to break through and to cause his pseudoidentity to crumble. Perhaps, though, even more sadly, it works for long periods of time, serving to protect the individual from experiencing the vulnerable moments so necessary for growth (leaving him very very lonely). Contempt, like masochism, is also a refusal to mourn infantile wishes for magic and power, and is also often involved when working through becomes recalcitrant.

One level of defensive process, which takes years to change in some patients, is the projection of the source of suffering onto a partner. Often, years are spent with the feeling that, "If only my husband were different." This same

dynamic can be played out in the treatment itself. The therapist is seen as the source of difficulty. Essentially, the patient's own impulses are, at times, denied and projected onto the therapist. She is the one whose ego must be fed or she will be rejecting and punitive.

In fact, as Giovacchini (1975, p. 38) has pointed out, the patient puts something objectionable from within himself into the analyst. Furthermore, one often discovers that, in addition to projecting, the patient has created an ambiance that is an approximate reproduction of the infantile traumatic environment. Instead of being aware of his own distortions and projections, the patient unconsciously provokes reactions and induces feelings in his environment which justify his own behavior through the conformation of his perceptions of the world. The patient has then succeeded in creating an environment, which, although traumatic and leading only to despair, is familiar to him. In this manner, he can maintain some degree of psychic organization. This is an environment with which he has learned to cope.

Giovacchini later suggests: "If the analyst consistently functions as an analyst, that is, nonjudgmental observing and not anxiously responding, the patient will continue projecting, but will not be able to fixedly reproduce his world. He can maintain such a world only when the analyst is willing to participate in it" (1975, p. 43).

It is important to note here that this in a way, becomes tied to a transference demand. Giovacchini expresses this as a demand that "I conduct myself in an unattainable psychoanalytic fashion. . . . They were, in a sense, demanding I adopt an analytic role which would obliterate my existence as a person." (1975, pp.-7).

This demand becomes paradoxical and ultimately unfulfillable. On the one hand, the analyst's inability to always consistently respond unanxiously and

nondefensively leads to the reproduction of the patient's infantile ambiance and justifies his refusal to relinquish his projections. On the other hand, if the analyst were able to obliterate her own existence as a person to provide the space the patient needs in order to regress in complete safety, she would essentially be creating a symbiotic environment. Only one self would be present (the patient's). The therapist would no longer be available as a separate identity and the transference wish to avoid a separate existence, would, for the moment, seem fulfilled.

This countertransference dilemma of "how to be human though an analyst" (Bernstein, 1958) will be discussed further in the following section. For the moment, though,

I want to focus on the forces behind the patient's resistance to tolerating and exploring his own impulses and demands. In order to experience these as his own, he will need to reown his distortions and projections, and to stop what Giovacchini refers to as "externalizing." This involves a major change in viewpoint, and is inherently tied to beginning to deal with the therapist as a whole, real and separate person, as opposed to simply a transference object. This confrontation is often stormy and protracted because it covers a desperate separation anxiety. In order to negotiate this hurdle, the patient must have developed the beginnings of a more stable sense of his own identity as separate from mother and therapist.

One force which makes this phase difficult to move beyond is that these patients are extremely ashamed of their need to hold on. There is a large, powerful symbiotic core that must be denied at all costs because of the amount of shame surrounding it.

The shame must be explored in great detail, preferably in the open atmosphere of a group. This shame, along with the needs for closeness and

symbiotic experience (merging), must be felt rather than projected and denied.

These needs must be deeply experienced in the therapeutic setting in order to then relinquish the dependent wishes and go through the analytic working through and mourning process which leads to true individuation and a capacity for real intimacy.

Essentially, the defensive denial and projection are massive because of the danger of humiliation which threatens to set off a flood of overwhelming shame which could annihilate the security of self system that is currently functioning. This is the powerful danger and risk which must be faced in order to be truly nurtured and then to mourn, separate, and move on. It is a formidable task.

Some patients exhibit an especially stubborn refusal to mourn and seem to feel: "I'm smarter, or I can be more lovable than all these other people." These patients demonstrate an extremely skillful use of narcissistic defenses in a way that succeeds on many levels—all but the most intimate ones. The most difficult working-through problems seem to arise when such patients are able to disguise their clinging symbiotic demands as realistically sounding expectations. This is often difficult to discern. The difficulty arises both because of the confusion as to what is transference demand and what is realistic expectation, and because the intricate interweaving of defensive behaviors does not fall clearly into either of the two categories which we previously discussed. These patients combine both masochism and contempt in a creative manner. Since there is a great deal of shame and a fear of humiliation at revealing any wishes to merge and be taken care of, these patients disguise their masochistic wishes. Passive dependent demands are projected and then treated with contempt. These patients wish to merge, but,

rather than the masochistic presentation of a submissive, helpless front, they demand, imperiously, that the therapist give up her sense of self and be controlled. This, then, is a combination of both masochism and contempt, and masquerades as an exaggeratedly independent and rational position. This pseudo rationality and independence often induces a great deal of countertransference problems in the therapist, who may fall into the trap of trying to either satisfy these demands as if they were rational, or, equally fruitlessly, to use rational means such as interpretations or lengthy intellectualized discussions (in the hope of correcting the patient's distortions and persuading him to relinquish his transference demands).

In essence, these patients are imperiously demanding that the therapist give up her own real self (her feelings and emotional reactions) and provide a totally nonfrightening symbiotic world. This is what his mother demanded of him (and/or tried to provide), and it seems (to the patient) a reasonable expectation. He must go through repeated experiences of merging and then separating (with all the accompanying confusions and terror of letting go of parts of his narcissistic self and its grandiose demands) before he can tolerate seeing his demands as not being ultimately gratifiable.

Until these transference demands are worked through sufficiently, such patients will continue to skillfully pick up the therapist's imperfections whenever they are terrified. In this manner, they continue to hide their terror and humiliation, their feeling of shame at being less than perfect, and their unsureness of their identity. They thus continue to cling to a pseudoidentity at the expense of blaming, accusing and pushing away (symbolically destroying the nurturing person). They manage to cling while still refusing the vulnerability essential for a healthy symbiotic phase.

Narcissism in the Countertransference: The Therapist's Recalcitrant Working

Through

When psychotherapeutic work seems endless and even a psychodynamic understanding of transference and resistance leads only to paradox and sense of impasse, it is time, once again, to return (as did analysts through time all the way back to Freud) to our own analytic work. We must shift our focus from patient to therapist, to our own involvement in the treatment process. We must consider the same dynamic material we have been discussing again. Only now, we will focus on recalcitrant working through in the analyst and, ultimately on the interwoven process of working through in the transference-countertransference (the patient-therapist dyad).

One major countertransference difficulty that prolongs narcissistic resistance (in fact exacerbates it) is the therapist's unconscious sense that what the patient is demanding is just what her own mother in essence demanded.

This demand is that the therapist surrender her own identity in order not to threaten (symbolically destroy) the only mother she had and without whom she feared she should not survive. The important difference this time, of course, is that the patient is not mother and that the therapist is no longer a dependent child. Thus, as reasonable as the patient's imperious demands may sound, there is no real danger of the therapist being forced to kill parts of herself. The hurt experienced in being seen as a dangerous witch after trying to be nurturing is real. It must be attended to, perhaps in supervision, but the terror is only symbolic. In fact, there is an opportunity for further growth, not only for the patient, but for the therapist as well (once she becomes aware of these countertransference fears and works them through).

In the process of working through her own narcissistic transferences, the psychotherapist meets several countertransference traps. The most important

of these, as we have discussed, is a confusion between the patient's transference demands and his or her real developmental needs. Patients, again, especially the narcissistic ones, are able to present their transference wishes in a disguised form—to seem to make sense—and not to be regressing. What needs to be treated as a regressive wish and to be analyzed (mourned) sometimes gets confused with reasonable (or even simply unrealistic, i.e. unfulfillable in the perfectionistic degree) developmental needs. One aspect previously mentioned is the conflicting demand for the therapist to be perfectly tuned in, never hurt or defensive, while, at the same time, also to be human and emotionally and intensively connected (symbiotic) to the patient. Patients need to feel meaningful, that is, humanly important, and, at the same time, need to throw away, retrieve, and throw away again. This need demands, as we have seen, that the therapist be objective in order to be able to be killed off and to survive, while, at the same time, also being a human being who allows the symbiotic feelings to develop in herself and who also experiences some degree of transference. The patient, thus, becomes on some level a transference (parental) figure to the therapist (as well as the other way around). To the extent that this countertransference-transference situation develops, the patient is then capable of deeply hurting the therapist by not seeing her (through his transference distortions and projections).

Many therapists have, to a degree, worked out (resolved) their transference wishes in their own analysis. Often, however, although they have given up their wishes for a masochistic dependency, that is to be protected and provided for by a parental figure, they have secretly (and often righteously) held on to a piece of their own grandiosity. The common fantasy is that the therapist now will be, herself, the one who can provide and protect omnipotently and perfectly. In this manner, although the therapist has given

up, ostensibly, the wish to be the child who can be taken care of, she has not totally relinquished her wishes to participate in such an experience.

There are several steps, each with its own trap, through which many therapists must pass in their further working through. During each step, another piece and another piece again of their own grandiosity must be worked through and relinquished.

Many analysts pass through several steps in the process of developing their identity as a psychoanalyst. Perhaps the first common position taken by the analytic trainee is the wish to not be vulnerable. Such a therapist sees herself as a blank screen and does not accept her involvement as a participant in the psychoanalytic process. All the patient's responses, then, are transference. Any negative responses to the therapist are seen as distortions. Thus the therapist is free to listen "objectively" and does not feel any risk or need to reexamine her own perceptions of herself (her own pseudoidentities). In effect, the therapist has turned the analytic position into a contemptuous exaggeration and caricature.

In contrast to the contempt-like position of the strong-man analyst is another trap which new therapists often fall into, that of merging masochistically with their patient. Such therapists wish to leave room totally for the patient's projections, experiences and feelings. In effect, then, they totally submerge their own identities and allow themselves to be distorted despite a great deal of discomfort and suffering. During this phase, therapists often over-identify with patients and leave little room for separateness.

Another countertransference trap often arises at this point: an attempt to avoid being "obliterated as a person." No longer willing to fall into the contempt trap of perfectionistic exaggeration of the analytic model, nor wanting to masochistically become the all-giving mother, the analyst may take

an experiential-humanistic stance. Such a therapist tries to be authentic and humanly involved as much as possible. She has the courage to risk being seen as a struggling human being who, at times, can be extremely vulnerable. This allows a great deal of sharing and facilitates a great deal of working through since the unreality of the patient's infantile demands and projections is repeatedly confronted. It also helps to induce a great deal of the regression and intensity needed to experience the unfolding of the transference.

There are two drawbacks, though. The first one, which can be surmounted as the analyst becomes increasingly skillful, is that the satisfying of transference demands is often confused with the real meeting of developmental needs and by the here-and-now interaction between patient and therapist. This confusion can be parceled out and clarified, though, once the therapist develops enough experience on this process and also enough self awareness to sense when her own involvement has a larger transference component than usual.

The second problem that arises during this phase is more serious. Since the therapist is more vulnerable, she tends to also experience more regressive impulses, and a sense of attachment. This, of course, can be worked through in time, but, at moments, it makes it very painful to be symbolically thrown away or destroyed. Remember, as we discussed earlier, narcissistic patients are very skillful at sensing the therapist's imperfections and vulnerable points. In fact, part of their repetition of an infantile ambiance is the wish to destroy mother's pseudoidentity, to force her to see that she has failed them. These patients, in short, protect their own precarious sense of pseudoidentity through attacking the therapist's identity. This skillful, often well-disguised attack, places a great deal of strain on the therapist's sense of herself. This is even more true to the extent that she is still developing her own identity as a person and as

psychoanalyst. Unfortunately, the human response to this strain is to become, subtly if not overtly, rejecting and punitive. A retreat to the nonvulnerable position of contempt described earlier is not at all uncommon.

For me, the awareness of these traps led to years of struggling with the question of whether to be analytic or to be human and vulnerable, and then to try to shift back and forth between these positions depending upon what a patient's needs seemed to call for. Struggling with the dichotomy has, in itself, been a working-through process. Of course, the obvious answer is that the question is really a false dichotomy. Working through leads to an integration rather than to a choice of one or the other. It must be possible to be both psychoanalyst and human being at the same time. It is just not possible to do it perfectly or without pain.

As mentioned earlier, in order to work through narcissistic resistances, the therapist needs to be able to be connected, yet survive symbolic destruction. The key is the therapist's own working through, which must lead to a stable sense of identity and a real knowing that the destruction is only symbolic. She can be hurt by patients and experience new losses. In fact, she may be confronted with parts of herself which are still disowned, parts which threaten remaining aspects of her own pseudoidentity. But her real sense of self, her identity and its ongoing process cannot be destroyed by the patient's attacks. The next step, then, involves the relinquishing of enough grandiosity to accept the impossibility of not only the masochistic wish for one's own analyst to be perfect, but also relinquishing the omnipotent side. The secret wish to become the all-powerful one and provide a perfect nurturing experience, or at least an ideal analytic one for our own patients, must also be treated as a transference wish. The dream of giving others everything we needed and thus participating in a magical omnipotence must also be mourned. Acceptance and continued

working through of her own unresolved narcissism allows the therapist to use the pain inherent in the analytic situation in the service of growth, rather than to suffer masochistically, or to retaliate with contempt.

Transference-countertransference involvement may then lead to growth for both participants. The therapist first, then the patient, must relinquish their narcissistic defenses and not blame and try to symbolically destroy or label as “dangerous” the other. Once this “externalization” is avoided, the real underlying threat to one’s own narcissistic defenses must be explored (repeatedly). Such exploration will lead to the experiencing of deep confusion and, at times, to an identity crisis. It is tied to feelings of shame and to the loss of a clear sense of self; however, if the confusion and anxiety can be tolerated, it will lead to further acceptance of reality, further self knowledge, and a more stable sense of identity.

Ideally, the therapist works out much of this in her own treatment, during which her analyst can provide the safety on a non-omnipotent yet tenderly tuned-in and protective figure with which to merge and from whom she can individuate. She then can tolerate experiencing the attachment with patients who will need to ambivalently merge, yet attack and symbolically destroy, again and again, until they develop a strong enough sense of their own identity to begin to relinquish and work through some of their distortions. Only at that time can they begin to see the therapist as a real human being rather than as a transference object. In fact, this is often part of growing up.

A further countertransference position, in which I find myself at the moment, is the one I am taking in being able to write this paper. After twenty years in the field, I have (to a considerable degree) come to accept myself as a “good enough” parent and analyst. I have my own identity. I am never perfect, yet I am committed to growth choices and human relatedness, and I am aware

of the value of my own particular way of clarifying and participating in the therapeutic process. I have seen some striking changes in my most difficult patients in recent years, as well as in my ability to survive my own symbolic destruction without getting too contemptuous or masochistic. But in describing some of these ideas to other analysts, I have become aware that I have been feeling secretly righteous about being able to provide these experiences for my patients and in my understanding of the analytic process. This secret righteousness especially comes up, of course, when I am feeling attacked. It is subtle, as I have learned to keep my mouth shut at such times. Therapists, just as skillfully as the narcissistic patients about whom we are talking, can disguise their own defenses. This hidden, hopefully-slight, piece of contempt and grandiosity must be felt, if not consciously perceived, and, of course, increases the patient's resistance to a degree.

In a sense, writing these paragraphs is itself a part of my own working-through process. In writing and talking about my “secret” countertransference attitude, it will now be out in the open and no longer a source of possible shame or fear of humiliating discovery. On the contrary, I feel some delight in its discovery. I’m sure that I will now be more aware of it when it arises, and also will undoubtedly be confronted repeatedly as my patients and supervisees understand it. This working through will hopefully lead to a greater freedom of choice and a deeper self knowledge. Undoubtedly, it will also lead to an awareness of further phases of countertransference traps in my development as an analyst and teacher.

Summary and Conclusion

Identity formation requires a period of time during which the child or patient can repeatedly merge and separate from a parental figure who has a

strong enough sense of his or her own identity to engage in this process. This period has been referred to as a healthy symbiotic phase.

It is not possible to fulfill the infantile wishes which are experienced during the regression of this phase. Transferential wishes to merge forever masochistically with an omnipotent figure or to contemptuously play such an all-powerful role oneself, must be intensely experienced, and then be relinquished as illusory. Working through is the process during which these distortions and demands are repeatedly confronted and mourned.

The relinquishing of these infantile perceptions and wishes also involves letting go of the unstable role-related pseudoidentities which up to now have provided a sense of psychic equilibrium. Narcissistic defenses, like contempt and masochism, are the deeply-entrenched preservers of the infantile ambiance. They are tied to a stubborn refusal to mourn the transferential wishes and maybe refractory to the analytic process.

Recalcitrant working-through problems place a great deal of strain on the analyst and her own sense of identity. In order to work through the patient's narcissistic transference and resistances, she must be aware of her own countertransference responses and attitudes. No matter how much she has worked through in her own therapy, some narcissistic dynamics will persist in the countertransference. Often, therapists who have given up their masochistic wishes to be taken care of passively, still secretly harbor the wish to participate in the magic of omnipotence by being the all-powerful parent themselves.

Paradoxical demands of being human, though a psychoanalyst, of being both a transferential object and a real person, leave the analyst forever vulnerable to intense narcissistic pressures. Working through is a never-ending process. Over and over again, grandiosity and magical wishes must be

discovered and relinquished. Again and again, barriers to vulnerability and the human condition must be discarded. Only the very acceptance of the depth of this inevitability allows the analyst to find a measure of peace and happiness in her work, and a comfortable sense of her own identity which is so essential to it.

What is recalcitrant in recalcitrant working through is simply a stubborn refusal to mourn, to relinquish the primitive wishes for magic and omnipotence and to shed pseudoidentities. It is recalcitrant refusal to face vulnerability and the human condition.

Postscript

In finishing the last chapter and thinking about the development of my thoughts from paper to paper through the years, I am reminded of a story that I wrote when I was about ten years old, and also of two savings which I have heard many times.

The story I wrote about thirty-five years ago is called "Boa Constrictor on the Loose." I sold it to a magazine called *Open Road for Boys* for eight dollar's. The magazine went out of business before it was printed, so I never saw it published and can no longer locate the copy. Otherwise, I would have included it in this book since, even then, in a child's way, I was relating to the same themes which flow throughout my current writings (vulnerability, risk taking and the need to be both separate and connected).

In the story, a little boy has been warned repeatedly by his mother of the dangers in the outside world. Despite these warnings (or, thinking analytically, perhaps even because of them), the boy wandered off one day to explore on his own (in search of his own separateness and identity). He got lost (sheds his role as mommy's little boy) and became confused.

The mother had allowed him to wander off because she didn't want to be overprotective (she let him go too easily and too soon in order to deny her own symbiotic needs). Once she became aware that he was gone, though, she became very frightened (both because of her view of the outside world and her own anxiety about separateness). She read the newspaper and learned that there was a boa constrictor on the loose and was terrified that her son would be swallowed (by someone else, a projection of her denied wishes).

She found him with the snake lovingly curled around him. She later found out that the article she only partly read explained further that the snake was a tame one which had escaped from a traveling circus. It loved (and, of course, magically protected) little boys.

So there I was, already as an eight year old, trying to explain myself to my mother through my writing. Wanting her (of course without awareness of what I was expressing) to know my feelings and accept them without being afraid. I get a warm feeling of myself as a little boy trying to say, "Trust me. My feelings aren't dangerous. Closeness (curling up together) isn't dangerous. My need to wander and to be separate is all right. The world of animals and snakes (men) can be loving. Getting lost for a time (the confusion and craziness of letting *go* of roles and taking risks) can work out in the long run." Perhaps the bottom line was, "You don't always see everything (didn't finish the article). I need to be held more closely and also trusted to be separate. We are connected and we are also two separate individuals who must find our own ways." The story sounds like an eight year old trying to teach his mother that a healthy symbiotic phase is a developmental need along the way to creating a separate identity.

My reaction to examining the story after several years contains a note of irony. As I have discovered that I can see a repeating theme in my writing, all

the way back to childhood, I have two contradictory reactions: I feel a deep sadness, and a compassion for the little boy trying to connect to and to separate from his mother over all these years. I understand my own recalcitrant working through a little better and I feel a sadness that I am still involved with it. Also, I sense the little boy's pain in not being trusted, in being seen as doing dangerous things, when he knew that the risks he took had to be taken in order to find himself. I mourned the childlike sense of a magical solution. I can't end my papers with magical protective encircling snakes anymore. Although, I have to admit, I still hold on to a secret fantasy that my mother will hear all I wish (just like the little boy's mother saw all that he wanted). Also, on some level, my style of ending with paradoxical senses of truth feels a bit like involving a magic circle.

I feel sad when I see how much I have worked out and yet how much I am the same (in some ways stubbornly unchanged). Still, I think you have already discovered the delight of my tone as I describe my awareness of my own recalcitrant nature. My favorite poem has always been Henley's "Invictus" which ends with the line, "My head is bloody but unbowed. I am the master of my ship, the captain of my soul."

Granted that, as had been said in response to Henley, I am in many ways first mate at best, the very recalcitrance which saddens me, also is an inherent part of my sense of identity. I am thrilled to experience myself as having a continuous core over all these years. It has given me continuity and stability. It gives me a theme. My recalcitrant working through is, itself, a process which creates a meaningfulness in my life as it unfolds. It is an inherent part of my identity.

I'm also aware of another reaction as I write this postscript. I have been very free when writing this section. Somehow a postscript seems to free me

further of some of the restraints of writing for a professional journal as I was doing in the earlier chapters. Suddenly, though, I feel unmasked. All of my adult psychoanalytic writing can be seen as a disguised expression of my infantile self. Colleagues could say it is all a sublimation of my neurosis. I feel vulnerable to their contempt. One reflex is to edit, rewrite, protect myself by trying to control their responses. That would be a masochistic giving up of a sharing which I feel is valuable. Another reflex is to become contemptuous in return and include a long psychoanalytic interpretation of the underlying dynamics of my critics' need to disown parts of themselves which I arouse. I couldn't resist saving that much, but I really know that such "explanations" do not change anyone except to anger them and to exacerbate their defenses.

To be true to the working-through process that I am describing means accepting the risk of being open without being certain of how I will be received. I write to express myself, to be understood, but if I try to control the reader's responses, then I lose touch with what is really mine. The value of what I write, and even with how I work, depends upon accepting that I am child, and I am adult. It depends upon an integration which is more than any one part. To deny the child in me would deprive my writing of its creativity and uniqueness. Writing, like doing psychotherapy, must be a growth experience for both reader and author. Moving toward ending this book, accepting it as it is, and sharing it, is a vulnerable moment.

Before I close, I want to mention the two sayings to which I referred. The first of the sayings is from the "Ethics of our Fathers." It is a succinct statement of states of the human condition and its vulnerable moments. I am often reminded of it by patients in a group who are excited by discovering their own self interest and enjoying it, yet are aware of it when therapists struggle with two paradoxes. First of all, a therapist must be aware that his own sense of

vulnerability and humanness (his own sense of identity) is his most valuable asset, yet also leaves him open to being hurt, and to becoming defensive in ways which interfere with the working through of transference and resistance (which is the cornerstone of his work).

Then, also ironically, therapists must become aware that, at times, their conceptual understanding of transference and resistance (which has been gained only through years of training and struggle and which sets apart their work from more superficial attempts at psychotherapy can, itself, be utilized as a narcissistic defense. It can be a subtle form of contempt which masks feelings of helplessness and inadequacy. An emphasis upon theory and intellectual understanding, can, in other words, be motivated by a "Quest for Certainty" (Wolf and Schwartz, 1959) or simply a fear of vulnerability and a need to separate themselves from their patients as well as from the human condition.

The first of the two sayings reads simply:

*"If I am not for myself who will be
If I am only for myself what am I?
If not now, when?"*

Lastly, when I begin to comprehend the unendingness of the working-through process and the inevitability that one's own analytic process is a lifelong one, I am reminded of a Robert Frost poem which also says simply, "... and miles to go before I sleep. And miles to go before I sleep."

With the expression of that awareness, I can rest . . . for now.

References

- Bernstein, Arnold. 1958. "The Problem of Transference in Psychoanalysts," *Psychoanalysis and the Psychoanalytic Review*, 45:86-91.
- Freud, Sigmund. 1914. "Recollection, Repeating and Working Through," *Standard Edition*, 12:145-156, London: Hogarth Press, 1958.
- Giovacchini, Peter. 1975. *Tactics and Techniques in Psychoanalysis. Volume II: Countertransference*. New York: Jason Aaronson.
- Livingston, Martin S. 1970. "Speculations on the Treatment of Masochism," *International Mental Health Research Newsletter*, Spring.
- _____. 1971. "Working Through in Analytic Group Psychotherapy in Relation to Masochism as a Refusal to Mourn," *International Journal of Group Psychotherapy*, Vol. 21, No. 3, p. 339-344.
- _____. 1973. "Contending with Contempt," *Voices*, Vol. 9, No. 2, p. 14-17.
- _____. 1975. "On Barriers, Contempt, and the Vulnerable Moment," *Group Psychotherapy*, eds. L. Wolberg and M. Aronson. New York: Stratton, 1975.
- Searles, Harold. 1966. "Concerning the Development of an Identity." *Psychoanalytic Review*, 53:507-530.
- Schwartz, E. and Wolf, A. (1959) The Quest for Certainty. *Archives of Neurological Psychiatry*, 81:69-84.

SPLITTING, PROJECTIVE IDENTIFICATION, AND CONTAINMENT AS COUNTERTRANSFERENCE ISSUES IN THE TREATMENT OF BORDERLINE PATIENTS⁸

Introduction

The label "borderline" has a significant focus as the developmental object relations viewpoint has extended psychoanalytic thinking. Blanck and Blanck (1979) refer to this period as the "era of ego psychology." This era has precipitated a breakthrough in the attempt to understand borderline phenomena. The term borderline is, essentially, a geographical metaphor used to define a broad area bounded on one side by neurosis and on the other side by psychosis.

In 1971, Mahler suggested that the etiology of these borderline phenomena lies in failures to complete the tasks of separation/individuation. She then went on to describe four crucial subphases in this growth process (Mahler, M., Pine, F., and Bergman, A., 1975). This research has been pivotal in a developmental understanding of borderline conditions and their relationship to what she referred to as "subphase inadequacies". Essentially, her position is that a failure to have attained the point in object relationships, which she refers to as object constancy (her fourth subphase), is the core problem in the borderline states.

Several investigators, including Kohut (1971, 1977, 1984) and Kernberg (1975, 1984), have made significant contributions in exploring what the

⁸ This paper was stimulated by (and contains some ideas from) "Treatment of Borderline Patients," a lecture given at the September, 1990 meeting of the Suffolk County Psychological Association by Daryll Feldman

Blacks (1974) refer to as "the vast, heretofore relatively unknown territory that lies between the transference neurosis and the psychosis." Kernberg defines his designation of borderline personality organization as the attainment, developmentally, of the differentiation of self images from object images to a degree sufficient to permit the establishment of integrated ego boundaries and the differentiation between self and others. However, primitive aggression prevents development to the stage in which the "all good" and "all bad" self and object images can be integrated into a concept of self and objects which are no longer split. Borderline patients thus preserve a good degree of reality testing (in comparison to psychosis on the other side of the border), but retain serious difficulties in interpersonal relationships and in their subjective experience of reality.

Kohut approaches from a somewhat different perspective. He focuses on an area he describes as disorders of the self or narcissistic personality disturbances. He sees these as related to an arrest in development at a point where a cohesive grandiose self and cohesive (albeit archaic) idealized objects have come into existence. Because of the cohesion, Kohut sees these patients as capable of developing a stable narcissistic transference that can be worked through in a manner not totally unlike the so-called "analyzable" transferences of neurotic patients. With these narcissistic personality disorders, however, there is a danger of regressive fragmentation (which is usually defended against by avoidance, dissociation and isolation), which requires a different understanding from the classical analysis of resistance. These patients require a good deal of "mirroring responses" that focus upon the empathetic bond between patient and therapist and the patient's responses to breaks in this empathetic connection.

Several investigators, then, seem to be describing similar phenomena and understanding the etiology somewhat differently, as well as suggesting a fair range of variation in technique for treatment. Major differences lie in the questions of whether defenses should be confronted and, if so, at what point in treatment. There is also some confusion as to when “mirroring” facilitates an unfolding process and when it is a subtle form of gratifying the transference (thus slowing progress).

In this paper, I would like to approach our use of the label borderline from a countertransferential perspective. I would like to suggest that analysts develop new labels to make sense of new experiences. Back in the sixties and early seventies, an increasingly large number of patients appearing in our offices presented a very different experience in treatment from the neurotic patients whom our training had prepared us to expect. They stimulated an intensity of feelings and fantasies which made us uncomfortable. They “got under our skin.” Hence, the need for a new label in an attempt to gain some perspective and to restore a semblance of rationality and order to an experience which at times proceeds to the sound of a different drummer than the comparatively rational unfolding of transference neurosis.

If we stay true to a psychoanalytic quest for knowledge and a wish for more effective treatment, then new labels must lead to new conceptualization—to a new understanding of the psychodynamics of this group of people; as well as to new contributions to the treatment process.

I would like, in this paper, to look at the ways in which treatment of borderline patients is a different experience than working on the north side of the border with their neurotic counterparts. I will focus primarily on the differences in the manner in which transference-like behavior unfolds and the major defenses replicated in this process (the splitting of self and object

representation into "all good" and "all bad," and the concept of projective identification which is the basis of the borderline's ability to recreate his infantile ambiance in a primitive manner). I believe that it is the primitiveness of these mechanisms (including their preverbal nature) that accounts for the borderline's ability to "get under our skin." Furthermore, I believe that this propensity constitutes the most difficult aspect of the successful treatment of borderline conditions.

Therefore, the thesis I would like to open for further investigation is that attention to the underlying transference/countertransference interaction is more basic than questions of technique. How the therapist develops the capacity to contain the patient's projections and to return them to him at the right time in an integrated form is, I sense, the mystery that underlies the variations in the valuable contributions to technique in recent years.

Transference-like Phenomena in the Borderline

Classical analytic technique was developed in the treatment of neurotic patients whose repressed Oedipal conflicts required uncovering through the analysis of resistance and the working through of a transference neurosis. Neurotic patients have, to a significant degree, completed the tasks involved in Mahler's early subphases of separation-individuation and have, in her terms, moved towards object constancy and identity formation. They have developed to the point of organization which enables them to maintain a degree of whole self and object relationships which are integrated (not split into all-good and all-bad! and cohesive over time. In more classical psychoanalytic language, they have developed an observing ego and are capable of entering into a working alliance with the analyst who is experienced as a whole, separate, person. Transference is the re-experiencing of a past relationship to a primary (familial) person in the present. It includes demands of libidinal (incestuous)

gratification and the fear of punishment for these forbidden wishes. Even if, at times, pre-Oedipal strivings for passive gratification are present in these patients, working through within the transference neurosis essentially entails the uncovering of deeper and deeper derivatives of wishes and threats of punishment. Their gradual unfolding unlocks a previously-arrested mourning process, which leads to the relinquishment of these demands, a reduction in the threat of punishment and the resolution of associated transference distortions and underlying conflicts. Throughout this process, the patient is able to maintain some degree of working alliance and the transference distortions are experienced as part of an unfolding process while the therapist is still accepted as a helping professional.

That, in an oversimplified nutshell, is the basic classical analytic process. In it, the therapist attempts to maintain a basic neutrality and objectivity. He is outside the process and through free-floating attention and logically thought out and timed interpretations of transference and resistance phenomena, he facilitates the unfolding process. His experience is empathetically involved, yet largely separate. In addition, which may be most significant for our purposes, the analyst's experience is largely subject to his own secondary processes. For the most part, despite the intensity of the patient's reactions and, at times, his own countertransference responses, the analyst's own experience remains intelligible. He can understand his own reactions. But, once the analyst enters the realm of the borderline, most of the experiences described above cannot be counted on. Most disturbingly, at times he cannot even fully understand his own internal reactions.

Balint (1968) was one of the first to point out that many patients did not fit the classical model and try to understand the challenge that they posed. He observed that many patients 'are described . . . as 'deeply disturbed,'

profoundly split,' seriously schizoid,' 'having a much too weak or immature ego,' highly narcissistic wound,' and so on, thereby implying that the root of their illness gives further and deeper than the Oedipus conflict." These patients seemed to suffer from a "basic fault" related to much earlier trauma or deprivation.

These observations led Balint to the recognition of two levels of analytic work. The more commonly described first level was that of the Oedipus Complex, which could be understood and treated in accordance with the classical model. At the second level (that of basic fault), interpretations of transference and resistance, which were the analyst's most powerful interventions, were not at all effective.

Balint writes about the experience described by general medical doctors at a research seminar (1968, page 13). Doctors often reported that they had explained to a patient, *very clearly* what the implications of their illnesses were. Surprisingly, it often emerged that the explanation was clear only to the doctor; to the momentarily regressed patient, it often was no explanation at all. A running joke developed among the doctors, whenever a doctor reported he had explained something very clearly, the habitual question was: "'clearly to whom?" Balint points out that "the reason for this discrepancy between intention and result is that the same words have a totally different meaning for the sympathetic but uninvolved doctor and his deeply-involved patient."

Analysts often face a similar experience, he continues. "We give our patient an interpretation, clear, concise, well-founded, well-timed and to the point, which often to our surprise, dismay, irritation and disappointment, either has no effect on the patient or has an effect quite different from that intended." In other words, our interpretation was not clear at all, or was not even experienced as an interpretation.

Essentially, Balint explains, working through (in the sense of the classical model) is only possible if the patient is capable of taking in interpretations and allowing them to influence his mind. Classical analytic process, which depends upon interpretation and verbal intervention, can only be effective “if our words have approximately the same meaning for our patients as for ourselves.”

Neurotics with their Oedipal conflicts pose no such problem. Patient and analyst “confidently speak the same language; the same words mean about the same for both.” At the level of the basic fault, however, true communication is on a much more primitive preverbal level. Another important quality of relationships at this level is the “immense difference of intensity, between the phenomena of satisfaction and frustration.” When subject and object “fit,” then there is a feeling of quiet, tranquil well-being. On the other hand, a lack of “fitting” of the object evokes “highly vehement and loud symptoms.”

Balint describes the therapy experience with these patients (who of course we now recognize as borderline) as often proceeding smoothly for a time. “Then at some point, suddenly or insidiously, the atmosphere of the analytic situation changes profoundly.” Interpretations are no longer experienced by the patient as interpretations. There is no cooperative observing ego, no working alliance. Instead, the patient experiences the analyst’s words as an attack, a demand, an insult or at least an unfair lack of consideration (essentially in more modern terms a narcissistic injury or a break in empathetic connectedness). On the other hand, “it is equally possible that the analyst’s interpretations may be experienced as something highly pleasing and gratifying . . . as an irrefutable sign of consideration, affection and love . . . At such times, the analyst’s every casual remark, every gesture or movement,

may matter enormously and may assume an importance far beyond anything intended.”

The patient *somehow seems able to “get under the analyst’s skin.”* He has an “uncanny talent” to understand the analyst’s motives and to interpret his behavior. As early as 1955, Balint described this uncanny talent as giving the impression of clairvoyance or telepathy. This uncanny experience also progresses in the other direction. The analyst also knows and experiences parts of the patient in a pre-verbal manner. His own countertransferential experiences are no longer clearly logical and discernible through secondary process. At times he cannot understand his own reactions. He has entered the realm of the borderline.

Many therapists have considered these patients as “unanalyzable” or tried, unsuccessfully, in a procrustean manner, to force the patient to fit the same old treatment format regardless of differences. One major argument in questioning the treatability of borderline conditions has been the view that they do not develop a transference which can be worked through. More recently, several investigators have explored the concept that, although these patients do not develop a classical transference neurosis, they do engage in transference-like behavior.

Kohut (1971 and 1977) described significant differences in these patterns of behavior, which he labeled narcissistic or selfobject transference. These narcissistic aspects of transference, like their neurotic counterparts, contain “the repetition and confusion between old and new object,” but, instead of the “repressed drive element . . . seeking satisfaction . . . an injured narcissistic ego is seeking reassurance.”

In the transference neurosis, the repetition compulsion acts in the service of a refusal to mourn (Livingston, 1971). Transferential demands are

repetitions of infantile libidinal desires (either Oedipal or pre-Oedipal). In attempting to “repeat rather than to remember,” the patient is avoiding the eventual resolution and relinquishing of these unrealistic wishes. Analytic interpretation and working through of earlier and earlier derivatives corrects the associated transference distortions and dissolves the resistances that block the mourning process (which, in object relations terminology, allows the separation-individuation to proceed).

In contrast, the selfobject aspect of the transference is seen as an attempt to go back to a point where development was arrested because of a failure in the parenting process. Essentially, according to Kohut, these failures are due to insufficient empathetic responses from the nurturing objects. The thrust of the repetition is not a refusal to mourn, it is not a resistance to separation-individuation. The selfobject transference is a search for missing structure, a part of the patient’s self which has not developed. If sufficient empathetic connection can be established in the analytic setting, then the at-first archaic forms of narcissism can be expected to be transformed into more mature forms of self-object relationships. Growth unfolds in the safety of empathic bonding as the developmental narcissistic need is, to a degree, fulfilled. Structuralization proceeds both through the healing force of the connection and through the “optimal frustration” of the inevitable breaks or failures in empathy even in the analytic situation. Empathic attention to these failures within the transference situation is central to the analytic process. The pain of early childhood failures or breaks in connectedness must be experienced in the present moment. The acknowledgement and understanding of these breaks is critical. The analyst thus functions, not as a blank screen maintaining neutrality, nor as a separate whole person, but as an empathy-providing selfobject (a function, or part, which is lacking in the borderline patient). Analysis leads to what Kohut calls “transmuting internalization,” which

enables the patient to eventually develop this structure (or function) within himself.

It is important to stress the difference this conceptualization makes in the analyst's attitude and technique. Narcissistic transference could now be appreciated and facilitated as a developmental process and not seen as a inability to develop an analyzable transference or a resistance. Kohut (1971, page 213) states: "Since these positions constitute healthy and necessary maturational steps, even fixations on them or regressions to them must, in therapy, be first understood as in essence neither ill nor evil. The patient learns first to recognize these forms of narcissism in their therapeutic activation and he must first be able to accept them as maturationally healthy and *necessary!*—before he can undertake the task of gradually transforming them and of building them into the higher organization of the adult personality and of harnessing them to his mature goals and purposes."

Blanck and Blanck (1979, 1986) have also made significant contributions to the understanding of transference-like phenomena in borderline conditions. Similarly to Kohut, they state that "an object is wished for to provide, not instinctual gratification, as in the more structured patient, but narcissistic (ego building) supplies." They suggest the phrase "search for replication of early self-object experience" to describe the "longing for replication of the selfobject in fulfillment of experiential needs in the immediacy of the dyad." Following logically from their understanding or structuralization, and using Mahler's (1975) discovery that pre-structural life is interpersonal, they view the under-structured patient as "attempting to use the therapist as a real more than as a transference object." Borderline patients are seen as still in active negotiations with primary object representation. Thus their behavior is not a transference "displacement from past to present; it is the persistence of

primary object need." They report that "such transferences are uninterpretable (but not immutable) because they are lived in the here and now." Out of this conceptualization, they elaborate "ego-building techniques" within a therapeutic climate. The therapist is often more of a real object rather than a transference object, and thus functions similarly to good-enough early object representations. The Blancks discuss the following list (1986, pages 62-70) of the functions of an object representation: (1) provision of a safety feeling (2) establishment of internal regulatory functions (3) promotion of ego autonomy (4) serving as a model for character formation (5) promotion of super-ego development (6) provision of an "ego ideal," and (7) enforcing resolution of Oedipal wishes, thereby enabling the child to enter latency.

Essentially, object relations theorists, like the Blancks and self psychologists (as the Kohutians refer to themselves), stress different aspects of the transference-like behavior presented by borderline patients. They also differ somewhat in their emphasis on aspects of treatment recommendations. They differ primarily in the degree to which narcissistic and borderline behavior is to be treated as acting out, or resistance, and frustrated as opposed to viewing it as a reflection of real developmental needs. The timing of interpretation, or even confrontation of these behaviors, is a sensitive area of different opinions. There is, however, agreement that borderline transference and countertransference is an intense and trying experience. In order to further understand these experiences, and attempt to provide a focus for working them through, it will be helpful at this point to approach them from another angle. At this point, I would like to consider these same phenomena from the vantage point of the differences in basic defensive processes utilized by borderlines and their neurotic counterparts. Then, I hope to return, with a sharper focus, to countertransference issues and their working through.

Primitive Mechanisms of Defense in the Borderline

Neurotic patients have achieved a certain amount of structural organization which includes the capacity to employ more developed defense mechanisms than borderlines. As Blanck and Blanck (1979) point out: "We tend to think of the defense mechanisms on a hierarchy of efficiency, with denial, projection, and introjection on the lower order; isolation, reaction-forming, undoing, and the like is a middle range; and repression as the most effective and most sophisticated of mechanisms." Repression, in this sense, is the keeping out of consciousness of conflicting or prohibited wishes and fears (especially those concerning the Oedipal complex).

Anxiety is utilized as a signal by the more structured personality. It signals the need for defense against the intrusion of repressed impulses which threaten to overwhelm the ego. Ego defenses are then employed to bolster the repression and postpone the facing of conflicts and the relinquishing of infantile wishes. Classic technique, as we have seen, employs the process of working through these defenses in order to uncover the repressed material. Interpretation, free association, and verbal communication uncover deeper and deeper derivatives of the latent material. The old classical dictum was to make the unconscious conscious and "where id was, to let ego be."

With borderline patients, signal anxiety, as just described, has not been achieved. In contrast, anxiety is experienced as total organismic distress. A precariously-formed, not yet cohesive, self is threatened with fragmentation. Anxiety is not just a signal of intrusive repressed material, it is a question of "to be or not to be." The very existence of a developmentally understructured sense of being is threatened with annihilation.

In treating borderline patients, recovering repressed material is not the problem. Repression in the sense of the sophisticated neurotic defense

mechanism has not been achieved. In order to protect his early fragile sense of self against fragmentation and nonexistence, the borderline has at his disposal only the most primitive mechanisms of defense. The two most important of these are splitting and projective identification. To the infant, these phenomena are a universal developmental necessity. In the adult borderline, they function as an archaic, often no longer adaptive, form of defense.

Kernberg (1976) defines splitting as the dissociation of polar opposite ego states. He sees normal splitting as an attempt to keep the good relationship with the mother intact in the face of frustration while pathological splitting divides others into "all good" and "all bad" and becomes the central defensive mechanism of the borderline personality organization.

Grotstein (1981) defines splitting as "the activity by which the ego discerns differences within the self and its objects, or between itself and objects . . . In the defensive sense splitting implies an unconscious phantasy by which the ego can split itself from the perception of an unwanted aspect of itself, or can split an object into two or more objects in order to locate polarized, immiscible qualities separately." In this phantasy, the individual may thus experience himself as split into, for example, a good self and a bad self. He can also imagine his objects (for example, his mother) as split similarly into good and bad. The original motive for such splitting is connected to establishing an early sense of organization and development of structure. It stems from early responses to tension and pleasure. Splitting the object also buys developmental time. The infant needs the sense of safety of a "good-object representation" in order to reduce the organismic panic inherent in early primitive experience. He needs the sense of an omnipotent all-good mother to contain some of his primitive overwhelming impulses, as well as to cushion him from the bombardment of stimuli from the environment. Grotstein refers

to this sense as the "Background Object of Primary Identification." It is also similar to Winnicott's (1965) concept of a holding environment or the "environmental mother." Splitting allows the infant to linger a little longer with this sense of protectedness (until he is developmentally ready to relinquish it).

In the borderline personality, this gradual relinquishing of splitting and of omnipotent objects has not proceeded. Confrontation with reality was probably too harsh, too early, too sudden, or simply without sufficient environmental nurturance and support. Occasionally, on the other-hand, the environment colludes sufficiently to postpone reality confrontation beyond the developmentally expected period of rapprochement (Mahler's term for this crucial subphase). In either case, reality testing is somewhat impaired (as the fantasies of all good and all bad selves and objects are maintained) and damage is done to the development of a cohesive sense of self.

The main problem in treatment of the borderline is, thus, not the undoing of repression, but the nurturing of an arrested and damaged self. Prior to exploring the transference/countertransference process as such a nurturing process, I would like to look at a second and related borderline defense mechanism, projective identification.

Projective identification is defined by Grotstein (1981) as, "a mental mechanism whereby the self experiences the unconscious phantasy of translocating itself, or aspects of itself, into an object for exploratory or defensive purposes. If projective identification is defensive, the self may believe that through translocation, it can rid itself of unwanted, split-off aspects; but it may also have the phantasy that it can enter the object so as to (actively) control it, or disappear into it (passively) in order to evade feelings of helplessness." Projective identification, in a more positive sense, is the

essence of vicarious introspection and empathy which Kohut has stressed as the prime tools of psychoanalysis. It exists very early in infancy as a primitive and obviously preverbal mechanism of communication. Mahler's (1975) description of symbiosis and coenesthetic sensing are related to early forms of this mechanism. The nature of early bonding allows the mother to sense the infant's emotional responses, especially its distress. A subtle sense of mutual cueing is communicated back and forth, enabling the mother to identify, that is to vicariously sense in her own body, feeling states in the infant. The boundary confusion, of course, proceeds in both directions, the infant experiences its mother's feelings (especially her anxieties) and, at first, cannot differentiate them from his own. Sullivan (1953) was one of the earliest psychoanalysts to focus on this interpersonal process to which he applied the term empathy. He pointed out that although, at the time, his concept seemed "mysterious," those who have had pediatric or mothering experience actually have data which can be interpreted on no other equally simple hypothetical basis."

Projective identification is largely an imaginative process. In fantasy, it rids the unwanted contents of one's mind or even the mind itself. For example, children who are sexually abused often imagine that it is not they who are being used this way—they are someplace else (energetic psychotherapists descended from Reich refer to this as the energy and consciousness leaving the body). On the other hand, objects or feelings from outside may be fantasized as introjected and identified as parts of the self.

Transference is essentially a form of projective identification. In neurotic patients, the analyst is seen as possessing characteristics of previously-experienced people who played a significant role in development. In the borderline patient, who has not developed the capacity for whole object relations, this cannot be the case. Instead, the transference consists of the

patient projecting parts of his self or his internalized objects onto the analyst. This more primitive and preverbal process unfolds through the mechanism of projective identification. Not only does the patient distort and imagine the analyst to have various characteristics and feeling states, he uncannily produces them (or at least triggers them) in the analyst. Projective identification is the mechanism by which these patients "get under our skin."

Grotstein (1981) describes 'the quintessence of projective identification as its capacity to protectively transfer mental pain from the self to the therapist in a special kind of siamese bonding which allows for an exchange transfusion . . . Ultimately, projective identification in its most basic communicative form, is the cry of agony of the infant who must put its experience into the caretaking object so that that object can know how the infant feels." He then concludes that, "it is as if all human beings, parents and children alike, are really children who wish someone to know their agony so that the tale can be told. The transmission of this message is projective identification. The capacity to know that message is the ability to tolerate suffering through this exchange transfusion' between the sacred and the profane . . . Projective identification has a significance beyond the simple communication and can be likened to a spiritual experience."

Thus our exploration of borderline defense mechanisms has shed a good deal of light on how vastly different the therapy experience must be for both patient and analyst. In describing that experience, I have already moved to the area of countertransference.

Countertransference and Containment with the Borderline

The term countertransference has often been used quite imprecisely. Many writers use the term to include rather different phenomena. Many writers use

the term to include rather different phenomena. On the narrow end of the spectrum, it has been used to refer to the analyst's residual neurosis interfering with (operating counter to) the unfolding and eventual resolution of the patient's transference. On the broad end of the spectrum, it has been used to refer to the whole range of attitudes and emotional experiences stimulated in the therapist by the analytic situation and the patient or even those he simply brings with him to the setting—in other words, any emotion or subjective experience the therapist has.

In this paper, what I mean by countertransference is the analyst's subjective responses to the patient in the treatment situation. These include what have been referred to as "induced" responses, which clearly are appropriate to the patient's behavior and would probably be experienced by most analysts. They also include responses which are more "idiosyncratic" and stem from the analyst's own psychodynamics. In actual experience these categories overlap. Any intense reaction by the therapist, even if it is clearly "induced," is probably intense because it triggers residual conflict, or activates archaic self and object representations, in the analyst.

As the Blancks (1979) point out, countertransference is "often regarded negatively as reflecting flaws in the analyst's personality and, as such, an obstruction to the analytic purpose." They also mention that "it has also been thought to be useful, when, as is true of transference as well, it can be given the right turn." Their discussion of newer attitudes toward countertransference dictated by the discoveries of psychoanalytic developmental psychology also strikes a largely cautionary note: "With changing techniques arising out of the relatively recent recognition that certain patients need some sort of therapeutic interaction for structure building, it becomes difficult to sort out

what is detrimental activity because of destructive countertransference and what is truly essential to the patient's development.”

Despite their caution, which is quite valid in itself, the Blancks do raise “certain knotty issues about countertransference such as whether, when, why, and how the analyst accepts the role of a real’ object; whether there is corrective or reparative value in a here and now’ interaction, and if so, how to go about it.” They also point out that, long ago, Hartman (1937, translated in 1958) asserted that “the human being cannot and, further, must not be fully rational. While unconscious processes with their distortions do indeed contribute to conflict and pathology, they also are adaptive as sources of some of our most cherished ideals.”

The position I want to develop here is that, although unbridled countertransference-acting out can be dangerous and destructive, it can also be the most powerful source of change in analytic work. This is infinitely more true, and important, in work with the borderline patient, who gets under our skin through projective identification, than it was in classical analysis of the neurotic.

The analyst ’s personal analysis will never be so complete that he is invulnerable to the preverbal affective input of primitive defense and communication. Perhaps some analysts have worked out their own Oedipal conflicts and sufficiently mourned and relinquished their own transference wishes and distortions to be relatively free of countertransference problems in working with neurotics from the safety of their behind-the-couch neutrality. Perhaps. But none of us, ever, so fully heals our own early narcissistic injuries that they cannot be touched by the agonies communicated by our borderline patients. If we were so healed, it would thwart the patient’s necessity to projectively implant his message. As Grotstein points out, “we wish the other

to know the experience . . . We cannot communicate or unburden ourselves of it until we have been convinced that they understand, until we are convinced that they now *contain* the experience. Projection into a vacuum is not projection. It always has to have meaning, and meaning is the suffering of the flesh and the spirit of the other, whether the other is an internal object, an object representation, or a person.” Thus, even if it were possible for the analyst to be free of all countertransference, it would not work. The myth of the totally analyzed analyst is just that, a myth. Vulnerability is the essence of the human condition. In fact, as I see it, the analyst’s wish to be, or to appear, less than vulnerable is as equally dangerous a countertransference trap as the more obvious one of “drowning in the countertransference.”

The situation is similar to the tale of a young rabbinical scholar who was to move to a far-away land. “How will I choose a new rabbi to trust as I’ve trusted you,” he asked the old rabbi. The elder said simply: “Ask each man you are considering one simple question. Ask him to tell you how he succeeded in wrestling the devil from his being.” “But how will I judge the answers,” the youth demanded. “If he tells you how he has completed this challenge, simply look further for your teacher,” the old man said softly.

The truth is that the interminable working through of the analyst’s own narcissistic wounds, the continual maturing of his own self-object relationships is what enables him to be a good-enough real object and container for his patients. Mahler’s subphase four—“*towards* object constancy and identity”—centers on the period between rapprochement and three years, but it is really a lifelong period.

When analysts describe the working-through process as the “warp and woof” of psychoanalytic work (Glatzer, 1969), they are, of course, referring to the working through of transference and resistance. I would like to include the

working through of countertransferences, as they arise, within this description. It is the analyst's vulnerability to projective identification and, thus, to countertransference that allows him to receive the patient's primitive communication. It is his ongoing growth process which allows him to contain these projections, to process them, and then (in some altered form at the proper time) to return them to the patient for organization and integration.

At this point, I would like to reiterate Bion's (1957) concept of containment and to be sure the reader understands its relevance for the transference/countertransference experience. At the end of the introduction to this paper, I suggested the thesis that how the therapist develops the capacity to contain the patient's projections (the capacity to hold the agonizing message of the projective identification experience) and then, at the right time, in an integrated altered form, to return them, is the mystery which underlies the variations in the valuable contributions to technique in recent years. In fact, an understanding of containment in the transference/countertransference experience probably holds the major key to the question to which Kohut (1984) devoted his final book: *How Does Analysis Cure?*

Bion's conception of the container and the contained is a model relating to the infant's experience with a good-enough mother. The mother, or her object representation, helps the infant to sort out the chaotic bombardment of stimuli from the early environment. Through projective identification, she receives his message of distress and suffering. She contains the communication in such a way that it is subject to her internal process. She is capable of integration, rather than the total splitting of the infant. She has a more cohesive sense of self, as well as developmentally-structured soothing functions which the child does not. In other words, she is able to help the infant to transform experience

of organismic panic (Mahler, 1968) into signal anxiety. She also serves as a reservoir, or container, to enable the infant to postpone certain feelings and to linger a while with a sense of what Grotstein (1981) refers to as the Background Object of Primary Identification, or the idealized parents as described by Freud (1908). The projection of painful feelings, such as badness and helplessness into a containing object, buys developmental time to remain with omnipotent grandiose fantasies until a developing ego can bear to gradually confront reality and begin to relinquish such projection. Without sufficient containment, provided by early self-objects and their mirroring, intensely empathetic responses, the infant's budding sense of self would be overwhelmed and a cohesive identity would not develop. The sufficiency of this early process, especially on through Mahler's rapprochement period, makes the difference between a psychosis, borderline features, and the development of neurotic structure. It's sufficiency in the transference/countertransference bonding experience is "how analysis cures."

Countertransferential Hazards

Countertransferential involvement cannot be eliminated. In fact, if valued and understood, it is one of the key factors

in promoting structural change. Having established its value, it becomes imperative at this point to clarify some of the hazards involved. These fall into two categories. The first group comprise the traps which have frightened many analysts and led to the cautious position described earlier where countertransference is viewed as something to be avoided or at least minimized through personal analysis and professional distance. I would like to describe these pitfalls and to clarify what I feel needs to be avoided. Throwing out the baby with the bath water is clearly not the required remedy, but just as clearly we must recognize some dangers. The second category of hazards I

would like to discuss are countertransference experiences that are potentially troublesome, but, if understood, can be transformed into a working-through process and therapeutic advances. In this category I also will try to clarify the relationship between the therapist's underlying attitudes and questions of technique.

Category One—Traps to be Avoided:

When analysts consider the kinds of ideas presented here, they are often inordinately frightened by the risk they visualize in considering psychotherapy as an interpersonal-interactive process. They are particularly uneasy with the concept of a bonding between therapist and patient that intensifies the efficacy of empathy, mirroring, and containment as described in earlier sections. The danger sensed is the possibility of the therapist “drowning in the countertransference”—the possibility that he will totally lose his sense of separateness and professionalism. Events such as sexual exploitation and *folie a deux* do occur. I want to be very clear here that, in understanding the concept of containment, what I am advocating is an openness to intense, at times irrational, emotional experience within the countertransference.

I am not suggesting countertransference acting out, which I see as actions taken in desperation not to experience the primitive communications (and their agony) that the earlier sections of this paper have referred to. Containment is, in effect, the opposite of acting out. It is the holding and tolerating of primitive projections in order to transform them. The danger here is a repeat of some form of earlier experience where the parent was unable to contain the projections and, instead, acted out in a way which was oblivious to the child's emerging self. The child was forced to deal with an overload of impulses (from the parent and the environment as well as from

internal sources) without the aid of a containing object. In effect, the therapist is then failing to contain and transform the projections. Instead, he, like the original objects, is transformed by them.

Fenichel (1941), a clear representative of early classical analysis, saw this countertransference issue. He cautioned that the analyst might strive for direct satisfaction in a manner that could make use of the patient for some piece of acting out determined by the analyst's past. He also, incidentally, noted that "the libidinal strivings of the analyst are much less dangerous than his narcissistic needs and defenses against anxieties." In other words, the analyst's own need for mirroring may at times lead him to projective identifications of his own that would force the patient to become a container duplicating the original parental errors. Alice Miller in *Prisoners of Childhood* (1981) points to the inevitability of some of this pattern being passed to the next generation as a result of the parent's having been deprived by their own parents of containment and mirroring and, instead, having been taught to sense the parent's narcissistic needs. Interestingly, though Fenichel also presents the danger in striving to avoid these errors, he states, "fear of the countertransference may lead an analyst to the suppression of all human freedom in his own reactions to his patients." He concludes, "the patient should always be able to rely upon the humanness' of the analyst."

Clearly, the answer to avoiding either extreme position lies in personal analysis and in a supervisory process that values the therapist's vulnerability and countertransference experiences while supporting his increasing capacity to tolerate his feelings without acting out, thus becoming a good-enough containing object. I will return to the supervisory proceeds in a later section.

Category Two—Hazards to be Experienced and Worked Through:

In order to achieve a clearer sense of some common countertransferential feelings in response to patients in what he refers to as “the borderline state of mind,” Josephs (1990) describes his experience over six years with one particular patient. He sees this state of mind as characterized by a chronic sense of urgency and desperateness with feelings of being flooded and overwhelmed, as well as by a rapid fluctuation between disjointed self states. It is essentially a state of mind in which the patient experiences her situation as a life or death crisis. His patient, whom he calls Mary, entered treatment in a desperation to rescue her drug-addicted son. In the early stages of treatment, she presented herself as overwhelmed and helpless, insistently demanding answers to her advice-seeking questions. She focused on her son and responded to attempts on the therapist’s part to be empathetic from a neutral position as an abandonment. “Yes, but what should I *do*?” was essentially her repeated position. Josephs, a Self Psychologist, tried for several months to focus on being more accurately mirroring. Empathic reflections would feel on target only momentarily. When he empathized with her helplessness, she shifted to the angry-aggressive stance of an outraged indignant victim. If he empathized with her feeling cheated, or unjustly accused, she suddenly shifted to a self-blaming position. All his efforts at empathy seemed to end in further experiences of failure and drew subtle reproaches.

After several months, Josephs decided to allow more of what Self Psychologists refer to as a merger transference to develop. He began to give her some real advice so that she could experience him as a positive self-object functioning as a coaching part of herself. She welcomed the advice, but, just like the empathy, only momentarily. Then she used it to berate herself for not having seen or done things years earlier. Sometimes she was just too frightened to implement advice with which she agreed. Or she would shift to a

bewailing “Why do I always have to be the one to carry out plans? Why do I have to always be the responsible one? Why doesn't my husband do it?”

In a nutshell, she presents herself to the therapist as overwhelmed and desperate—screaming “save me!” Anything less than miraculous rescue attempts leave the therapist feeling accused of abandonment, of malpractice through negligence, and a lack of caring. On the other hand, he gets a clear, if unstated, message that if he advises her it will end in disaster and it will be his fault—again malpractice, this time through active blunder.

So what is the therapist's experience here? He feels left behind by her shifts from one self state to another, by her lack of cohesive self. He feels reproached, rejected and confused. If she is really good at what she does, and perhaps adds some unconscious-to-unconscious projective identification, the therapist begins to feel as if he, too, is in a life or death situation. He begins to feel desperate and overwhelmed. He has entered the “borderline state of mind”. Now he is in trouble, yet, at the same moment, he is finally able to begin to really empathize. He has gotten the message.

The therapist's task is to swim in this ocean of experience—to swim and not drown. To do this requires the ability to experience from an intense “near” position. It requires engagement, which at times approaches a symbiotic oneness. It also requires the ability to experience from a “far” position, which gives the therapist a perspective not available to the patient. To alternate from near to far, from an almost fused sense of oneness to a clearly separate sense of individuation, requires a good deal of structure and cohesive sense of self in the therapist. As he continues to develop that ability, he can be aided by the supervisory process and by concepts. As an illustration of the value of conceptualization in enabling the therapist to survive in rough waters, let's take a step back and regain our perspective.

Borderline patients like Mary are lacking certain structural capacities because of early (in Mahler's terms) subphase inadequacies. Mary lacks a sense of a self agency, of a cohesive sense of self. Thus, she does not have the capacity to contain affect and is easily flooded by either internal or external stimulation. She is terrified that her precarious self will be swept away, leaving her in a state of fragmentation like Humpty Dumpty after his fall. In actuality, she lives in some degree of chaos with her several self states alternating and lacks the ability to contain them. She cannot remember them in an integrating manner. She does not see the organization hidden within her chaotic experience.

The therapist, though he is at times also confused and overwhelmed, can repeatedly step back and sense the organization. He can contain the patient's multiple feelings and self states and resonate with them while transforming them through his own more developed psychic structure. For example, he can be aware that empathy means attunement with several varied self states with diverse and often conflicting points of view. He can begin to sense when each self state is triggered, thus subjecting the seemingly chaotic material to his own organizing processes. He can provide this self-object functioning and containment until (through what Kohut called "transmuting internalizations") the patient can begin to develop similar structure and functions in herself.

Josephs suggests what he calls "bridging interpretations" to aid the patient in gaining some of the far-experiencing ability she lacks. For example, the therapist might reflect: "Sometimes you feel small and helpless and at other times you expect to be all powerful." Statements like that attempt to empathize with more than one point of view, more than one self state, at the same time. Hopefully, this could lead to a deeper empathic tie and begins to integrate the different self states. Often, such interpretations fall flat with the patient. I

believe the important effect of such a formulation is on the therapist. What we see here is the therapist's use of his conceptual ability in the service of making sense *for himself* of his recent swim in rough waters. It is probably not necessary, or even helpful, to the patient at this time. It simply aids the therapist in becoming a better container.

Another understanding of the transference/countertransference experience with patients like Mary is that she needs to test the container. Previous containing objects have failed her. If she trusts this one and is failed again; it will be devastating, in fact, the underlying fear is that this time Humpty Dumpty will never be put back together again. So she tests. She tries to flood the therapist, to explode him, to see if he will crack. The difficult task of relinquishing omnipotence is to accept that you will crack! Inevitably, and humanly, we all crack—unless we maintain sufficient distance and rigid professionalism to allow us to escape our vulnerability. In that case, of course, the therapist does not swim in the ocean and can provide a quantity of support and interpretation, but cannot be available as a container. A container requires depth and vulnerability. A good-enough therapist will not be omnipotent. He *will* crack. The key to his usefulness is his tenacious return to the work. Cracks can be repaired, in fact, it is the repair of breaks in the empathetic tie that strengthen it. Eventually, the search for omnipotence and omnipotent, perfect, selfobjects can be relinquished and a trust in good-enough ones can develop slowly.

Essentially, the working-through process in the countertransference consists of cracks in empathy and their repair. Racker (1968), in a major contribution to the analysis of the therapist's internal processes, throws some light on many of these failures to empathize. He starts from the observation that the analyst's 'intention to understand creates a certain predisposition, a

predisposition to identify oneself with the analysand which is the basis of comprehension. The analyst may achieve this aim by identifying his ego with the patient's ego, or, to put it more clearly, although with a certain terminological inexactitude, by identifying each part of his personality with the corresponding psychological past in the patient—his id with the patient's id, his ego with the ego, his superego with the superego, accepting these identifications in his consciousness. But this does not always happen, nor is it all that happens. Apart from these identifications, which might be called *concordant* (or homologous) identifications, there exist also highly important identifications of the analyst's ego with the patient's internal objects, for example, with the superego." Racker suggests the term *complementary* identifications for these potentially empathy-breaking experiences. In other words, if the patient were dealing with a punishing object representation of his mother, he might feel frightened and helpless. The concordant identification then would be to experience his fright and helplessness and to feel compassionate. If a complementary identification took place, however, the therapist might begin to experience punitive wishes and annoyance at the patient's masochistic position. Instead of empathy and an identification with the patient's experiencing-self, the patient would have succeeded in projecting his internal object onto *and into* the therapist who now feels treated like, and sees the patient as, his mother probably did. Obviously, this does not make empathy easy. In fact, what we have here is what is often referred to as a negative countertransference.

Complimentary identifications, as well as concordant ones, are based on projective introjection. Complementary associations are produced by the fact that the patient treats the analyst as an internal object which is then projected outward (splitting it off and disowning it), in consequence, the analyst feels treated as the object was, he identifies himself with it. Racker goes on to point

out that when the analyst fails to make the concordant identification, perhaps because it would stir archaic disowned feelings and objects of his own, then the complementary identifications become intensified. In effect, then, the analyst has rejected a part of himself and is projecting it onto the patient—the patient thus becomes a split-off and rejected object for the analyst.

In simpler terms, what has happened (from the patient's experience) is that his attempt to use the analyst as a container has failed. Instead of containing and transforming the patient's toxic projections, the analyst has been transformed by them. If the scenario goes further, the analyst may be provoked into rejecting or punitive behavior. If, on the other hand, he can contain the feelings he is experiencing (and not act them out), then a working through of the countertransference is possible. Through his understanding of these concepts, and/or some help from his own analyst or supervisor, the therapist needs, once again, to gain some perspective—to do some "far experiencing" to balance the archaic "near experiencing" he has been going through. He can then re-own or at least recognize (re-cognize) his own split-off objects. This working through of the countertransference is once again a back and forth between near and far experience, it allows the therapist to accept the transfusion and confusion of primitive process and then regain his more structured, organized and cohesive state of mind. It is this capacity to contain his own experience without acting it out destructively, that enables the therapist to repair failures in empathy and become a good-enough container. The degree of containment versus subtle or not-so-subtle countertransference acting out is itself a relative one. If the therapist is so cautious and distant as to never crack in his intent to contain, then his refusal to be vulnerable will limit the intensity of the healing process. Yet, at the same time, unbridled acting out of the countertransference in the sendee of so-called "authenticity" can be self-indulgent on the therapist's part and re-traumatizing for the patient.

Repeatedly, we are struck by the Scylla and Charybdis of the countertransference dilemma. If we stay too far away, we are sterile; if we get too near, we may drown. The resolution of paradox is never a simple choice. Resolution is always via a working-through process. It always involves the sustaining of tension and uncertainty between seeing polar opposites such as near and far experiencing. In the end, it always means relinquishing omnipotent rules of technique and living with complexity and vulnerability.

Racker suggests another conceptual tool to aid the therapist in navigating these complex waters. He says that complementary countertransference arises in every transference situation. These responses, "may be emotionally blocked but can probably not be avoided if full understanding is to be achieved." In order to help the therapist deal with the complexity and even chaos of these situations, he points out that they are governed by laws. So, once again, we have an interplay between near-experiencing providing intensity and a deepening of experience, while far-experiencing allows perspective and organization. Closeness and the wish to merge provide a wealth of material which threatens to become overwhelming. Separateness and far experience produce the structure and organization that makes meaning out of chaos and enables us to go back into the ocean for more of what fuels that meaning. The repetition of this sequence is inherent in the therapeutic process, as well as in the working through of countertransference. It is inherent also in building conceptual understanding as I am endeavoring to facilitate in guiding you through the material. In fact, it is inherent in life itself.

Now let us return to Hacker's statement that transference/countertransference situations have an underlying organization. In the same way that an individual's borderline experiences seem chaotic yet have underlying patterns, the analyst's subjective reactions also have a subtle

organization. He goes on to describe these situations as governed by "the laws of the general and individual unconscious. Among these the law of Talion (the biblical law of "an eye for an eye") is especially important. Thus, for example, every positive transference situation is answered by a positive countertransference; to every negative transference there responds, in one part of the analyst, a negative countertransference." He stresses the importance of being aware of this law because awareness of it is "fundamental to avoid drowning in the countertransference." If the therapist is not aware of it, he will not be alert to avoiding the potential vicious cycle of transference/countertransference acting out thus repeating the patient's childhood experience.

In order to approach countertransference attitudes from a somewhat different perspective, we can look at them as related to two major positions of narcissistic defense. The onslaught of the patient's projections are, at some level, experienced by the analyst narcissistically. If they support his positive-self representations, they are experienced as supplies. The obvious pitfall here is an exaggerated and defensively-based positive countertransference.

This is essentially, as I pointed out from a slightly different viewpoint earlier, the situation Alice Miller (1981) describes in *Prisoners of Childhood*. The child is forced to adapt to the parent's narcissistic needs by developing what Winnicott (1960) referred to as a false self. It is important to differentiate these countertransference demands (which force the patient into such a position) from the warmth and bonding which the therapist feels from repeatedly working through the negative transference/countertransference and restoring empathic identifications. The counterproductive repetition is essentially a subtle form of countertransference acting out. The analyst is encouraging the patient's

masochistic position in order to avoid facing his own narcissistic vulnerability. In effect, the analyst's false self is bolstering itself through a collusion with the patient's false self. It is quite different from what Racker (1968) refers to as the "sublimated positive transference." What Racker is referring to is the warmth and identification with the patient that allows the analyst to empathize with the patient's emerging true self.

Pitfalls when the patient's projections are experienced as narcissistic supplies are easy to understand, at least from a supervisory distance. Working through can be a lengthy process, however, because the collusion is mutually soothing and pleasurable and relinquishing its protection will tap underlying rage and grief in both partners.

Pitfalls in another category (from the point of view of the therapist's narcissism) occur when the patient's projections are experienced as narcissistic threats or injuries. In these situations, the countertransference attitudes that are triggered are essentially the analyst's underlying character defenses against such threats. I have written extensively elsewhere about masochism and contempt as two basic defensive positions which attempt to avoid vulnerability (Livingston, 1970, 1971, 1973, 1975). Therefore, I will be brief here. Essentially, I see masochism as a refusal to relinquish early transferential wishes for an omnipotent protector and provider. This omnipotent object is thus searched for and projected onto other people. Masochistic attitudes and behaviors are an attempt through compliance to eventually compel the omnipotent object to become a source of narcissistic supplies as well as a desperate attempt to avoid abandonment by it. Alice Miller's "gifted children" developed their false-self skills early in life in order to provide good narcissistic mirroring to their mothers. This highly perfected ability is, unfortunately, trapped within a masochistic fear of losing the object.

Analysts are frequently such "gifted children." We learn the essence of our empathic skills very early in life. If we are fortunate enough to find, in our own analyst, a good-enough container and a source of good-enough mirroring, then our projections of all-good and all-bad objects can be worked through. We relinquish, to a good-enough degree, our wishes for an omnipotent protector and provider. To the degree that the therapist's working through is accomplished, his empathic abilities become autonomous (in Hartman's 1958 sense of the word) and operate in a "conflict free sphere." They are separate from their original masochistic intent and available as a truly (and mutually) nurturing response.

However, to the degree that the therapist's archaic self-objects and narcissistic wounds can be triggered, he will manifest some masochistic attitudes toward his patients. Fearing their rage and disappointment (perhaps only unconsciously) and his own terrors of abandonment (again perhaps subtly or unconsciously), he will try too hard to satisfy transference demands. He may be hesitant to be limit setting or to be confronting. The most difficult problem surrounding the therapist's masochism, though, can be a confusion of mirroring empathetic responding with submission and compliance. Mirroring is the reflection of a struggling, emerging true-self and not the compliant aggrandizing of an inflated grandiose defense. There is a fine line between the nurturing of a child's (or a patient's) early emerging phase-appropriate grandiosity and an unrealistic and phase-inappropriate bolstering of a maladaptive defense. The excitement a parent feels when a child begins to walk (reflecting how wonderful he is) is quite different from telling a five year old that he or her is too good to play with the neighborhood kids. Responding to a patient's grandiose and endless listing of achievements with compliant affirmations of his wonderfulness is probably not what he needs. On the other hand, bursting his balloon by an interpretation of his unrealistic boasting will

be disastrous. Perhaps empathy with his need to keep demonstrating achievements in order to be acknowledged would be more in the direction of healthy mirroring.

In addition to the danger of the therapist taking a masochistic stance, another common countertransference attitude is the other side of the same coin. Many “gifted children,” once they become aware of the roots of their gifts, resent anything which triggers their recollections of sacrificing their true-self development in order to perform for mother. If the patient triggers these feelings, as many narcissistic patients will, the therapist may experience complementary identification and thus become unempathetic and withholding.

The therapist just described is essentially moving from masochism towards contempt. While masochism is a defense against abandonment and, in the extreme, is an attempt to merge symbiotically with an omnipotent provider, contempt is an attempt to distance and deny such wishes. In effect, an attitude of contempt is an attempt to be the omnipotent provider and protector and thus no longer need one. Like masochism, it is a refusal to mourn and an attempt to avoid vulnerability.

Grandiosity and contempt are often the most difficult defenses to relinquish—especially for the analyst. The very talents and position that bring the patient to his office can function as a set-up to bolster these attitudes. Even a sense of having worked through his own problems can be a grandiose position. In addition, many analysts have had personal analyses that enabled them to work through a good deal of their masochistic transferences. They were confronted with a reality that their analyst would not fulfill their fantasies and become their omnipotent provider and protector. However, especially if the analyst was never seen as vulnerable, as a whole person with

unresolved issues like everyone else, the trainee frequently leaves his training analysis with a hidden fantasy. He gave up the search for the perfect parent/therapist, but now that he is safely away from evaluation, training, and analysis, he returns to what he learned long ago as a child. If the search for an omnipotent object is fruitless, then the gifted child will just have to become one himself. The narcissistic core has not yielded so easily. It is merely waiting impatiently, yet with a tenacity, for the right time.

Obviously, the therapist's needs to distance himself from parts of himself, from his vulnerability, will interfere with his capacity to receive and contain the patient's projective identifications. Vulnerability, helplessness, chaos, irrationality, and agony are important communications that must be shared on a rather primitive level. So, while masochism tempts the therapist to lose his distance, to merge, and ultimately to drown in the countertransference, contempt beckons him to give up his humanness and ability to identify, to lose his capacity for near experiencing. As analysts, we have chosen a life path which forces us to continually confront these demons. The complexity of our work requires sustaining ourselves between the near and the far (as bi-polar opposites). Neither is the solution an attempt to rigidly maintain a middle position. Working through is a dialectical process. Growth proceeds through the freedom to move back and forth without getting so enmeshed as to drown, or so far as to die of aloneness.

Let us now turn to the question of how we can guide the therapist on his journey. Of what help can we be in the supervisory process?

On Growing the Therapist: The Supervisory Process

Like his patients, the inexperienced therapist often approaches supervision in a "borderline state of mind." He feels overwhelmed by the complexity of

verbal and nonverbal material presented by his patients. He sometimes feels flooded by projective identifications. His self experience fluctuates from omnipotent to worthlessness in a chaotic manner. He has not yet, as a therapist at least, developed a cohesive organizing sense of identity. He is afraid all his patients will leave him or that they will stay and be impossible to satisfy. He masochistically fears their reproaches and then, alternately, feels reproaching of them. He knows it is not a life or death situation, but he feels as if his professional life is precarious. He desperately wants advice: "There must be a technique which will work."

If supervision focuses on transference and resistance it meets some of the therapists needs. It enables him to get some distance and to begin to organize what is going on. It enables him to understand the patient from afar and protects him from drowning in the countertransference. Also, it teaches him to maintain neutrality and to facilitate the unfolding working-through and mirroring process. Proper timing of interpretations can be taught (although that may not be so easy to learn without more near experiencing) leading to understanding of how the patient's transference distortions can be resolved.

In working with the therapists of borderline patients, however, most supervisors find that after a while (perhaps as the therapist begins to trust the supervisor more or perhaps simply as a result of his experiences with patients) the focus shifts. No longer is the therapist looking from afar at the patient's process and asking technique-oriented "what to do" questions. He now becomes interested in the interactive process between himself and his patients and in his own experiences. I think if the supervisor is comfortable with this shift and is empathetic, rather than becoming too involved in "teaching" or evaluating, a natural flow will develop back and forth between a countertransference (near) focus and a more conventional focus upon learning

about dynamics and upon understanding the patient (far). The supervisory process, parallel to the therapy process, also fluctuates between closeness and distance. Perhaps it is easier to do this in a private practice setting where the therapist is not concerned in any reality way with evaluation; however, even then, the same fears often arise.

Returning to our description of the novice's experience of being in a borderline state of mind himself, let's think about what he really needs from the supervisor. I see supervision as a therapeutic process that fluctuates between personal analysis and conceptual instruction. In his personal analysis, the trainee's repeated focus on his experience as a therapist and his requests to step back and conceptualize are often a resistance to focusing on his primary relationships and on himself as patient. On the other hand, in a classroom too much focus on himself and too much revelation of his own narcissism may well be inappropriate and unwise (if for no other reason than because the class has an agenda to follow). Supervision, lying between these poles, is the best place to open up and work through his countertransference.

The supervisee, like his borderline patient, needs an empathetic, good-enough, container. He needs a safe place to open up the intense experiences he is having with his patients to a more observing ego. The supervisor serves this self-object function, in a parallel manner to the function of a therapist, until the trainee, through what Kohut (1971) calls transmuting internalizations, can develop this functioning within himself. Only in such an atmosphere can the student feel secure enough to reveal (to himself, along with his supervisor) the unfolding countertransferential process.

Once the supervisee feels invited to explore in this way and learns to trust the supervisor's capacity to return to concordant identifications and to repair breaks in empathy, countertransference is often the most important focus.

This is especially true when therapist and patient are at an impasse. Often impasses are presented in supervision in search of technical solutions. The supervisor's suggestions and conceptual understanding of the "case" are interesting, even enlightening, but the impasse continues until the supervisory process at least uncovers (at best, begins to work through) an underlying countertransference. The therapist realizes his unconscious collusion with the patient's transference demands, or, perhaps, his fear of allowing the unfolding of another facet of the patient's reactions to him. In still other cases, the therapist becomes aware of some transference demand of his own. In most cases, this unearthing of the countertransference enables the therapist to shift from a complementary identification to a concordant one and to repair the break in empathy. With this working through in the therapist, the impasse is dissolved and therapy progresses, often with no conscious change in technique.

Helping the therapist to make these shifts and reestablish empathetic connectedness is much more than a conceptual process (although supporting the therapist's conscious endeavors, as well as providing a conceptual framework is of inestimable value, too). The key is the bond between supervisor and supervisee and their commitment to uncovering, digesting, and integrating.

The therapist must discover and work through (that is re-own) the different archaic self and object representations stimulated in himself so that he can overcome his own sense of archaic splitting (his feelings of someone being to blame, someone being bad). Only then can he respond to the patient in a way that can be both empathetic and confronting, which will provide support and, at the same time, the optimal frustration necessary for growth. The supervisor, in allowing the therapist to be both a professional (a respected

colleague) and at the same time a regressed projectively-identifying student, provides a parallel function which meets parallel needs.

This process is impossible to describe without making it sound like an intellectual, detached, puzzle solving, it cannot be. It is a confusing and often-intense experience that often cannot be resolved (especially by the relatively inexperienced therapist) in any single session. It requires an openness to confusion and new experience without premature closure. For many years it requires supervisory support. Even the fully-experienced analyst perhaps needs occasional help from a colleague (self-object) in allowing his emotional experiences to unfold and integrate. It is a working-through process. That means that the therapist is working through continually deeper aspects of his own development, along with the patient (in fact, also along with the supervisor and the senior analyst teaching the supervisor).

Role playing (in a Gestalt therapy-like manner) is one means of inviting regression and the expression of intense feelings aroused by the transference/countertransference situation. The supervisee is asked to dialogue with his patient. First, he plays the patient talking in a session. Then he is asked to role play himself responding as the therapist. This recreates the mood and frustrations of the treatment setting. It brings the impasse alive into the here and now. After going back and forth playing each role a few times, I ask the supervisee to now respond to the imagined patient with his feelings as a person (dropping his therapist role). A few role reversals (in turn playing himself and then playing the patient) with this new instruction, often becomes fairly intense. Without his therapist role to maintain distance, the exercise becomes an intimate one. The supervisee experiences his own objects (and those of the patient) from up close. The two roles often clearly (or in disguise) become mother and child or other significant representations of objects from

the past. Sometimes it is hard to tell whether it is the patient's self and object representations we are working with or those of the therapist. Occasionally, confusion develops as the splitting breaks down and neither role is clearly good or clearly bad anymore. Often the supervisee reaches an increased integration and owning of split-off parts of himself. by the end of the session, he may have a clearer, certainly closer, understanding of and identification with the patient as a fellow struggling, vulnerable, human being. The impasse is usually much clearer and less threatening; however, I have also found that, even without clear insight, the therapist's capacity to experience the patient increases and the impasse begins to lift.

Obviously, I am not presenting this supervisory technique as the magic answer to treating the borderline. I am offering it as one way I have found to further a process in the therapist. It is based on the experiencing of polar opposites like near and far, self and other. Through sustaining the tension between these poles, a process unfolds that leads to working through, to healing splits, to relinquishing distortions. It is a process that furthers the therapist's growth and enables him to contain his patient's projections; to process them, and then to feed them back in an altered form when the time is right. It is not the specific technique that is important. It is the attitude toward supervision as a therapeutic process that I want to underline here.

Conclusion

In the treatment of borderline patients, the importance of a focus on the underlying interactive process between therapist and patient far outweighs questions of technique. Treatment succeeds, or fails, depending upon the working through of transference and countertransference. As Racker states: "Psychoanalytic cure consists in establishing a unity within the psychic structure of the patient . . . For this unity to be achieved the analyst must, in

the countertransference, achieve a kind of unity especially with what the patient rejects or splits off from himself. . . . To be cured is to have the integrity of mastery of one's personality restored; and to cure is to integrate the patient's psyche by integrating one's own."

The patient's parents failed to provide a good-enough container for the patient's projections. They failed because of their own developmental deficits. A parent can only further the growth of his or her children and guide them toward (in Mahler's terms) "identity formation and object constancy" to a degree that they themselves are in a process of individuating. To the degree that the parent relates to the child in terms of his own archaic self and object representations, he will fail to be empathetic enough or separate and reality-related enough to contain the child's projective identifications and to facilitate realistic self- and whole-object representations.

So too the therapist. The therapeutic process, regardless of theory or technique, rests upon the therapist's continued ability to further his own individuation process.

Mahler describes the final subphase of separation—individuation (which she labels "towards identity formation and object constancy")—as taking place largely between ages of two and three, but continuing throughout one's life span.

The parents failed because of their own developmental deficits. We, as therapists, also, inevitably, will fail. Countertransference and associated failures in empathy are inherent in the analytic process. Attention to their working through and repair are what makes the process work.

Countertransference cannot be eliminated by personal analysis. Nor would eliminating it fully be the ideal procedure (if that were possible). A fear of

countertransference has delayed the recent and inevitable focus upon it as our most valuable tool. This fear is akin to the borderline's terror of the complexity of life. Without an adequate containing object, he was overwhelmed and now, through splitting and projective identification, he seeks to locate the source of his terror (which is really his inner turmoil) outside himself. He does this to desperately buy time at the cost of his psychic unity. In a parallel manner, psychoanalysis has focused on the patient, on his resistances and on his transference. A great deal has been accomplished in understanding the complexity of psychodynamics and the human condition. Perhaps, though, we are now gradually relinquishing our distancing defenses as well as our exaggeratedly clear boundaries between therapist and patient. Perhaps it is time to accept the lifelong complexity of the psychoanalytic process and to more fully re-own it as located within ourselves.

Questions of technique and the understanding of borderline processes and transference are very important. However, at this point in the development of psychoanalytic object relations (as it applies to the treatment of the borderline patient), I think they are becoming secondary and that future breakthroughs will come from the study of the therapist's internal processes and their interaction with those of his patients. The working through of transference/countertransference experiences is the key, not only to the growth of patient and therapist alike, but also to future expansion of our knowledge.

References

- Balint, M. (1955) Notes on Parapsychology and Parapsychological Healing. *Int. J. Psycho-Anal.* Vol. 36.
- ____ (1968) *The Basic Fault*. Tavistock Publications, London. Bruner/Mazel, New York
- Bion, W. (1957) Differentiation of the Psychotic from the Non-psychotic Personalities. In *Second Thoughts*(1967) Jason Aronson, New York.

- Blanck, Gertrude & Blanck, R. (1974) *Ego Psychology: Theory and Practice*. Columbia Univ. Press, New York
- ____ (1979) *Ego Psychology II: Psychoanalytic Developmental Psychology*. Columbia Univ. Press, New York.
- ____ (1986) *Beyond Ego Psychology: Developmental Object Relations*. Columbia Univ. Press, New York.
- Feldman, D. (1990) "Treatment of Borderline Patients," an unpublished talk delivered to Suffolk County Psychological Association, New York
- Fenichel, O. (1941) Problems of Psychoanalytical Technique. *Psychoanalytic Quarterly*, New York.
- Freud, S. (1908) Family Romances. *Standard Edition*. 9:235-241
- Glatzer, Henriette (1969) Working Through in Analytic Group Psychotherapy. *Int. J. of Group Psychoth.* 9:158-166.
- Grotstein, J. (1981) *Splitting and Projective Identification*. Jason Aronson, Northvale, New Jersey
- Hartman, H. (1958) *Ego Psychology and the Problem of Adaptation*. Int. Univ. Press, New York.
- Josephs, L. (1990) "Borderline Self Experience," an unpublished paper delivered at the Society for the Advancement of Self Psychology, New York.
- Kernberg, O. (1975) *Borderline Conditions and Pathological Narcissism*. Jason Aronson, Northvale, New Jersey.
- ____ (1984) *Object Relations Theory and Clinical Psychoanalysis*. Jason Aronson, Northvale, New Jersey.
- Kohut, H. (1971) *The Analysis of the Self*. Int. Univ. Press, New York.
- ____ (1977) *The Restoration of the Self* Int. Univ. Press, Madison, Connecticut
- ____ (1984) *How Does Analysis Cure?* Univ. of Chicago Press, Chicago and London.
- Livingston, M. (1970) Speculations on Treatment of Masochism. *Int. Mental Health Research Newsletter*. Spring
- ____ (1971) Working Through in Analytic Group Psychotherapy in Relation to Masochism as a Refusal to Mourn. *Int. J. of Group Psychoth.* 21:339-334.
- ____ (1973) Contending with Contempt. *Voices*. 9 (2): 14-17.

- ____ (1975) On Barriers, Contempt, and the Concept of the Vulnerable Moment. In Wolberg, L. & Aronson, M. (Ed) *Group Psychotherapy*: 1975. Stratton, New York.
- Mahler, Margaret (1968) *On Human Symbiosis and the Vicissitudes of Individuation*. Int. Univ. Press, New York.
- ____ (1971) A Study of the Separation-Individuation Process and its Possible Application to Borderline Phenomena in the Psychoanalytic Situation. *Psychoanalytic Study of the Child*. 26:403-424.
- Mahler, Margaret, Pine, F., & Bergman, Annie (1975) *The Psychological Birth of the Human Infant*. Basic Books, New York.
- Miller, Alice (1981) *The Drama of the Gifted Child*, originally titled *Prisoners of Childhood*. Basic Books, New York.
- Racker, H. (1968) *Transference and Countertransference*. Hogarth Press, London.
- Sullivan, H.S. (1953) *The Interpersonal Theory of Psychiatry*. W.W. Norton, New York.
- Winnicott, D.W. (1960) Ego Distortion in Terms of True and False Self in *The Maturation Process and the Facilitating Environment*. Int. Univ. Press, New York (1965).
- ____ (1965) *The Maturation Process and the Facilitating Environment*. Int. Univ. Press, New York.

MIKAIEL AND MESHA (An Addendum)

In a dark corner of the van, Mikaiel (Me-kay-el) lay with his Mesha (Meee-shhaa). She had always felt more like wolf than hound. Together they felt connected to the darkness and the moon more than to the light and the sun. There was strength in the moon and there was aloneness. Wrapped in Mesha's fur, Mikaiel felt known and cherished. He could feel his agony and his peace. Alone with the wolf, he felt supported and whole, yet troubled. He often sensed that they were both of the dark. Only the wolf could know the depth of his pain, of his anger. Mesha protected him. Mesha's strength blocked out the strangeness. Mesha could be ferocious in anger and protectiveness at the outside, yet so soft and knowing. Only Mesha could contain the strange seething within and keep the strangeness out.

Mikaiel believed in his wolf. He counted on her foreverness. Then, at some point, he sensed Mesha's responsiveness shift. Lying next to him she no longer seemed to melt with him. Her breath was slower. She was quiet all the time. She no longer stirred with the moon. Mikaiel knew his wolf was dying.

As foreverness was lost, Mikaiel felt bewildered, terrified and, worst of all, alone. Mesha no longer seemed to know. She could no longer hold his terror or his lover. She had her own.

Mikaiel tried. He tried desperately to be the wolf for Mesha. He wanted to hold her the way he had been held; to make the aloneness okay for her; but he felt too little. He wanted to soften her hurt. He wanted to stay forever, but the once-comforting van now felt confining and terrifying.

Mikael felt his wolf die. He huddled close as if he could take it inside him. He lay next to it on the floor and wanted so badly to be dead too, so that they could again be creatures of the moon together. He couldn't get close enough, and yet, at the same time, he sensed he needed to leave.

Mikael didn't know how to say goodbye. Maybe somehow, he thought, he could return later and do it. He was scared and confused. He wished his wolf could be close forever and he began to admit quietly to himself that he needed, even wanted, to leave the van.

The door was heavy and hard to open. He was afraid it might lock behind him. He opened it a crack and felt the sunlight. It was good, and it was very bright. It was hard to take all at once. He darted back several times, but eventually he let the door close behind him.

One thing bothered him more than all the other confusions. Without Mesha he wasn't sure. In this world of sunlight he felt alone and unsure. Was he no longer a wolf of the dark, of the moon? Was he really a two-legged little boy? Did he want to be? How alone did he need to be to stay connected to his wolf? How close did he need to be to these creatures of the sunlight?