

STALEMATES IN THERAPY AND THE NOTION OF GRATIFICATION

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In *The Inner World of Mental Illness* Mary MacLane (1902) wrote movingly of her experience as a disturbed human being.

I am not good. I am not virtuous. I am not sympathetic. I am not generous. I am merely and above all a creature of intense passionate *feeling*. I feel everything. It is my genius. It burns me like fire. . . . It is my little old life tragedy. It means everything to me. It will amuse you. It will arouse your interest. It will stir your curiosity. Some sorts of persons will find it ridiculous. But am I to suppose that it will also awaken compassion in cool, indifferent hearts? And shall my bitter little story fall easily and comfortably upon disturbed ears, and linger for an hour, and be forgotten? Will the wise wide world itself give me in my outstretched hand a stone? (p. 280)

Mary MacLane is a woman in search of compassion but expecting indifference. Many of our patients have similar expectations and suffer their disappointment with what is generally considered a negative therapeutic reaction. Indifference kills. Even hate can be handled more easily than indifference. This article will explore stalemates in therapy resulting from the unconscious interplay of transference-countertransference reactions of therapist and patient.

The patient-therapist relationship can be viewed as a practicing experience for the patient, a time when feelings of love and hate are made conscious before the ghosts of the past can be laid to rest. We know that a patient's earliest forms of object relationships reappear in the consulting room. When they do, therapist and patient often are caught in a web, and movement depends in part upon the therapist's ability to become conscious of and tolerate his or her intense loving and hateful feelings.

Stone (1954) writes about the therapist's ability to endure treat-

ment: "the decisive factor is the ability to stand the emotional strains of the powerful tormenting transference and potential countertransference situations which such cases are liable to present over long periods, without giving up hope . . ." (p. 587). Many patients with severe pathology are dismissed from treatment because of the therapist's conscious and unconscious terror of primitive fantasies and emotions related to sadism, sexual feelings, hopelessness, and helplessness. Harold Searles (1961), who was one of the great pioneers in the treatment of the severely disturbed, always wrote of his inner reactions to patients.

This article will discuss the treatment of a patient who, like Mary MacLane, expected indifference. The patient demanded love, developing a negative therapeutic reaction when love was not forthcoming. I will try to show how the analysis of conflict and countertransference reactions was essential for the patient's recovery.

I will raise the question of whether gratification of particular wishes may be necessary in the treatment of patients suffering from severe identity problems and disturbances in self-esteem. In his classic paper on transference-love Freud (1914) states: "The treatment must be carried out in abstinence." Freud goes on to say, "the experiment of letting oneself go a little way in tender feelings for a patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended." Freud also said about abstinence, "I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this" (pp. 164-165).

Modell (1975) who has written extensively on object relations and changes in object love makes some pertinent remarks on the issue of gratification:

in the usual, well-conducted analysis there is gratification implicit in the analyst's constancy and reliability. And further, there is gratification implicit in the analyst's capacity to perceive the patient's unique identity. . . . The analyst is able to maintain the patient's identity in focus over time. This is the mirroring function that Spitz (1965) observed in the mother's response to the child's smile. (p. 303)

In another paper, Modell (1968) goes on to say:

It is essential for the analytic treatment of both the neurotic and psychotic patient, but especially the psychotic patient, that the analyst

perceive the patient not as an 'it' but as a 'thou'. That is, the analyst must be able to perceive the patient's uniqueness and individuality and to respond with genuine feeling (although not necessarily expressed) to the patient's unique feeling. It is not only essential for the analytic process that the patient perceive the analyst's uniqueness, but that the patient perceives the analyst perceiving him; the patient's own sense of identity is strengthened by observing the analyst reacting to him as an individual. (pp. 49-50)

Taking Modell's ideas as my point of reference I am suggesting that in cases where there is a defective sense of identity and self-esteem, the analyst's communications involving empathy with, admiration of, wonder at, concern for, and sometimes anger toward the patient provides the opportunity for a new object relationship and stimulate the narcissistic transference in what could otherwise be, in the experience of the analytic treatment, a repetition of the flat, depressed, unresponsive, and indifferent environment the patient once experienced or, at the other end of the continuum, a repetition of an environment that catered to the person's needs too much and did not tolerate expression of aggression. We know, for instance, that an infant's development will be impeded if the caretaker's love is primarily narcissistic. Kahn (1974) comments poignantly on this and feels that due to an overprotective environment that attempts to meet a child's needs in an almost magically effective way and does not allow for any aggressive behavior, the child, instead of personalizing into a whole self, gets dissociated in its personality structure. Aggressive confrontation feels catastrophic to the ego and the object.

the intense idealization of the infant-child and oversaturated care of his nascent needs lead him to internalize an idolized image of himself, which is henceforth his most dynamic internal object. . . . Hence in all latter life situations such children are trapped in a paradoxical stalemate: they crave to re-find this early model of magical care and dependence, and yet must not surrender to it because it entails annihilation of all possibilities of discovering their own initiative and aggressive potential in their own person. They also have no ego resources of processing aggressive affects and anxieties related to these . . . he is so committed to the fantasy of possessing what he does not have that he negates from envy every effort on our part, as analysts, to facilitate that which he needs. (pp. 272-273)

The comments made above on communications between analyst and patient are not the same as libidinal gratification, nor are they

defensive maneuvers to avoid the patient's aggression. These communications are often, but not always, unspoken, at times preconscious. They are subtle, taking place over the long process of therapy at infrequent but important moments in the analytic process. They can be seen in the gleam in the analyst's eye or tone of voice, a spontaneous gesture, a small dose of aggression from the analyst. They often happen when the patient is ready to receive such communication and not before. They are more often than not spontaneous reactions to and recognitions of a particular patient's unique identity. The patient consciously and unconsciously compares this recognition with negative introjects. Searles (1961) contrasts his ideas about the therapeutic process with those of Leowald (1960). Leowald wrote of the potentiality of a new object relationship represented by the analyst, which helps the patient face the regressive crisis of the transference neurosis, and Searles, differing somewhat from Leowald, saw this potentiality as being built up just ahead of the evolving transference relationship rather than toward the end of the treatment.

Although our patients are in search of love (often attachment hunger), it is also true that many patients have difficulty feeling love and acceptance. This is the paradox we encounter. The masochist clings to masochism. For instance, one severely self-critical patient, safe and on familiar ground in the repetition compulsion, who, feeling mistreated and misunderstood, has over the years informed her friends about her negative feelings about her analysis, tells me in a tentative manner that she said to a friend that I was a kind person. She was then overwhelmed and frightened by the feelings that emerged. The next day she reported a dream depicting her oedipal conflict with her father. She talked about her father in a monotone, which was at that moment a resistance against her transference to me. After the protective nature of her communication was interpreted, she was flooded with feelings and eventually lifted the repression related to her affectionate and sexual feelings for me. Following this the repression lifted concerning her yearnings for her father, and she discovered the protective measures she took to come to terms with her contradictory feelings toward him.

The more disturbed patient may be able to tolerate positive feelings after certain conditions are met in the treatment. One of these conditions relates to how conscious both therapist and patient

are of hateful and loving feelings when stalemates arise in therapy. A second condition is that, within the setting itself, the patient perceives in the analyst the potential for a new object relationship and experiences something from the analyst that makes the patient feel recognized, liked, and valued. The following case study focuses on stalemates in analysis and on issues of gratification so that the ideas mentioned above can be addressed clinically.

Jane began therapy with me when she was in her early 30s. I treated her for five years. She started treatment twice weekly, then moved to three, four, and five times a week. She had been in treatment before with two other therapists, the first time following a separation from her husband. Jane had discovered that her husband had been unfaithful. She wanted to save the marriage, but her husband was uncooperative about pursuing treatment. Jane terminated the treatment. A second treatment was terminated after two years. Jane and the therapist seemed to be in a power struggle prior to termination. The therapist went abroad, promising to maintain contact when she returned, but she did not live up to this promise. When she encountered Jane by accident, she told Jane that she had to "cut her loose." Jane then had a related dream. She wanted to go to Europe with a woman anthropologist. The woman told Jane she couldn't go because she didn't know enough. Becoming furious, Jane said the woman didn't know any more than Jane did; I saw this issue of potential betrayal possibly extending into the transference.

Jane described her mother as needy, wanting to be "one with the world." Following is an excerpt from a letter to Jane from her mother: "Thoughts while on the train. I am part of it. A corner of its being. I hear its exalted breath. Its voice reaches me in a streamer of sound. A cry of yearning. I am one with the people on the train, especially the children." Jane did not like this letter but liked the notes her mother left that were matter-of-fact details of a day's events.

Jane's mother felt compelled to close the gap between them after an argument. She wanted to make up right away and always wanted to know what Jane felt. When Jane was younger, her mother would get excited when Jane was cleaning her room, but Jane said she was doing it for herself and not mother. Central to the relationship was the issue of control. In the morning her mother insisted that Jane finish her breakfast, whereupon Jane would spit out her

breakfast and her mother would fly into a rage. When Jane was unable to do her homework, her mother would become furious, pulling her daughter's hair and yelling: "What's the matter with you?"

During Jane's childhood her father provided well for the family. She had some positive memories of her father, but when he was drinking, he continually fought with her mother, and because of the drinking was rarely available. Her mother and father separated when Jane was in her early teens. Jane felt her world was coming apart when her parents fought. At night she buried her head in her pillow, crying herself to sleep. She recalled her father sometimes giving her "slobbering kisses" that repulsed her. He would stare at her from across the room without saying a word. Jane pushed him when he was drunk and at times worried that she had hurt him. She felt nothing for him, she said, when he sobered up. He tried to reconcile with her, but she refused, although she did accept money, which she felt was coming to her. This was his punishment. She described a violent streak in her father, a trait that showed up in her husband. Jane was also violent at times with her son. Although her father died when she was in her late 20s, she never mourned his death. Many of Jane's dreams revealed an unconscious preoccupation with her father. In one dream, Jane is sleeping with her mother, waking up terrified when a man breaks into the room. Another dream suggests problems around omnipotence. Jane flies through the air by an act of will but often crashes to the ground.

Jane felt she couldn't compete with feminine women. These feelings were similar to those she had in high school when she felt like an outsider. She remembered verbally attacking a girl she envied, making fun of the girl's breasts.

In terms of her goals in life, Jane wanted to finish college. Soon after beginning treatment with me, she entered college and was very apprehensive about failing.

FIRST PHASE OF TREATMENT

In the beginning phase of treatment Jane projected many of her feelings, and my interventions addressed these projections and transference reactions. For example, if I smiled upon greeting her, she wanted to know what I was laughing at. I said that it seemed to

me she did not expect I would be pleased to see her. I would ask what she thought I was laughing at. Did she feel critical of herself? I said it was sad that this was the only reaction she could expect from me. In her silent moments she experienced me as attacking her because she wasn't talking. I pointed out that she seemed to expect I would react just like her mother did when she couldn't do her homework.

Separations from me were very difficult. Sometimes she felt she would die. She dreaded weekends and vacations. On some vacations she wrote to me to maintain contact. At times on the final session of the week, which happened to be Friday, she would refuse to leave the room, threatening violence and suicide. I interpreted the displacement of her feelings from her former therapist and suggested that she might be unconsciously trying to ward off a repetition of abandonment and betrayal by leaving me first. I also explored how this abandonment might be a repetition of an earlier trauma. Jane had some ability to make this connection. I suggested that she might be scared on weekends because in her disappointment and anger at me she wiped me out and therefore I was no longer there. I suggested that her perception of me as critical and uncaring protected her from feeling anxious. By keeping me distant she wouldn't feel vulnerable. This initial work in treatment helped to build some working alliance with Jane.

About one year into treatment Jane revealed a fantasy. It was a sign of trust that she could talk about this fantasy. She had her arms wrapped around my neck with her head snuggled against my chest. Then there came a moment in the fantasy when she had had enough and wanted to push me away. At that point she became afraid. She felt that if she did push me away I would go away forever.

SECOND PHASE OF TREATMENT

In this phase of treatment the resistance became so great that the working alliance broke down constantly. Jane became frightened by her wishes (the fantasy) and the expectation of rejection and abandonment. Also her fantasy revealed the lack of resources to say no if she had had enough. This was the problem with people—they became too important to her. For two years most of my interven-

tions were countered with "So what? So what does that do for me?" She attacked me constantly because I did not care about her, could never love her. I was important to her, but she felt she could never matter to me. Why tell me her feelings? I belonged to a world in which she could never fit. She had been sucked into treatment, suckered into depending upon me, and it was all a cruel trick. I was a cruel, selfish person who could never care about her. I wanted to keep her sick so I could have a job, and therefore it was in my interest for her not to get better. She could never be like my friends. Jane felt deeply ashamed. She didn't fit, and I was the cruel doctor ignoring the pathetic patient who just got the crumbs. Her refusals to leave the room became more frequent. The transference did not have an as-if quality to it. The more the alliance broke down the harder it was to resist the countertransference pulls.

The following analytic work was done over approximately two years while under a constant barrage of attacks. I interpreted her behavior, saying that attacking was a defense against her fears of being close. I interpreted her reactions as reliving feelings toward earlier figures in her life (her mother and father) who frustrated her and toward whom she also felt envious. I asked whether she was angry because she felt left out and didn't fit. I wondered whether she expected attacks from me because she wanted to attack me for leaving her out and then expected retaliation. I suggested that she felt she drove me away because of her angry feelings and consequently felt she was bad inside. I interpreted her accusations that all I wanted was her money as a way of disowning needs that she found unacceptable.

I knew I was helping in some way, but at times felt useless and was overwhelmed by this patient's plight. I sought supervision from a very skilled psychoanalyst with many years of experience working with highly disturbed patients. I was assured and given comfort when it was suggested that this was a universal phenomenon with patients; that Jane would have induced similar reactions in most therapists; and that many therapists would have unconsciously discharged this patient. Nevertheless I still felt helpless and incompetent. Each "So what does that do?" was like a knife in my chest. Many months of analysis revealed that my difficulties with Jane resulted from repressed feelings and identifications with this patient.

I needed to feel competent, and because I was so thwarted, felt deeply ashamed and guilty. I began to understand how at times some interpretive interventions mentioned in the paragraph above were defensive. On the other hand I knew that some were helpful. For instance, Jane was intensely envious, hated me for having what she wanted, yet couldn't take in anything because of fears of engulfment. She suffered from paralyzing fears of rejection, and she told me later that she understood and was able to use some interventions that pointed to her conflicts about feeling loved. However, in some ways my interventions were repetitive behavior patterns on my part that duplicated reactions of significant others in Jane's past. For instance, I may have needed Jane to make me feel good about being a therapist, like Jane's mother had to feel good through Jane. It obviously was a complicated issue because in part Jane unconsciously wanted me to react like significant others to prove she was right, since there were many secondary gains derived from her pathology.

Earlier in this article I described the patient-therapist relationship as a practicing phase for the patient. Winnicott (1955) states that with neurotics we can take for granted a certain level of ego development. With other patients it is the setting that becomes important. Interpretation of the transference was helpful in the beginning of Jane's treatment in terms of self-object differentiation. However, it was also essential for both patient and therapist to live with the murderous aggression and learn that both could survive. It is through this practicing stage for the patient and therapist that structuralization of the ego takes place. There were times when I didn't feel defensive and could withstand Jane's attacks. As Stone said, the analyst has to have the ability to withstand the potential countertransference situations for long periods without giving up hope.

A comment of Winnicott's (1955) about the analyst's mistakes seems applicable:

There builds up an ability of the patient to use the analyst's limited success in adaptation, so that the ego of the patient becomes able to recall the original failures, all of which were kept recorded. . . . The clue is that the analyst's failure is being used and must be treated as a past failure, one that the patient can perceive and encompass and be angry about now. . . . Whereas in the transference neurosis the past

comes into the consulting room, in this work it is more true to say that the present goes back into the past and it is the past. Thus the analyst finds himself confronted with the patient's primary process in the setting in which it had its original validity. (pp. 297-298)

In my work with this patient it was the setting that was as important as the patient's awareness of conflict. Jane's self-attacks in part protected her from attacking the object, and it was through externalizing the pathological introjects that she was working this through. Through this part of the therapy Jane would occasionally tell me that she knew that I was trying to help her. She said she was afraid that her attacks would drive me away. She said she needed my persistence. She did not seem to be made anxious by my occasional admissions of anger toward her since admissions such as these were direct and served to recognize the patient. For instance at times Jane asked if I were angry. I said yes, and she said she had sensed it and felt better. Through my own analysis I began to observe how angry I was and the extent to which I found these feelings unacceptable. I thought a therapist was not supposed to feel so angry at a patient. As I became less judgmental and more accepting of my feelings, several things happened. I felt less responsible for Jane. I was not her mother. I didn't have to care for her. This freed me. My fear of my aggression diminished, and I felt less responsible for the results of the sessions. I also did not feel that the "bad" sessions were a reflection on my competence. I believe I accepted the hate that this patient's mother couldn't accept in herself when her daughter was in fact behaving in a hateful manner. I began to feel for her and recognize that she indeed was not doing that much to deserve the extent of my rage. Accepting my hate shed light on the conflict and to a large extent resolved the problem on my part that derived in part from induced feelings and in part from unconscious guilt, transference, and identifications.

In the midst of my attempts to understand what was happening between Jane and me, I attended a conference where Andre Green discussed the treatment of a patient. He talked about the dyadic relationship between mother and child and conceptualized what he saw as the internal workings of the psyche before real object relationship takes place. He spoke of a closed circuit of cathexis. He thought about the mind as not accepting contradictions or differences. There is a unity in everything. But at the same time there is no unity. A

"yes" would at the same time contain a "no." There is no introjection without projection. There is a unity in contradiction. Time doesn't exist. The analyst is a potential object, not yet experienced as a separate person.

Green said that for a long time he could not understand why his patient would not accept his interpretations. She would spit out everything he said just like she spit out the tomato and rice her mother forced on her for breakfast. As Green became aware of his patient's conflicts, he was able to make an interpretation that his patient accepted, and his patient then informed him that she could only take things in surreptitiously.

As I listened to Green and his description of the process of treatment, I wondered why his patient had been unable to take in his interpretation at that particular time. Was there a process that had gone on between patient and analyst? As I thought of the similarities and the frustrations I felt with Jane, I asked Green if he had had to go through a process of uncoupling in order to understand what was going on, and he answered in the affirmative.

Had I been more aware of my participation would the outcome be different? Yes and no. I believe (along with such analysts as Searles) that in working with patients suffering from severe identity problems and disturbances in self-esteem, the core of the analyst's problems will be touched, and then, as part of the therapeutic process, growth and repair take place as long as both parties to the process can become conscious of their conflicts.

In the tyranny of control there is no allowance for separation. This control saps the life from whatever potential there may be for experiences separate and independent from the object. Uncoupling, essential for growth on the one hand, runs the risk of depression, loss of omnipotence, and despair about this loss. When both patient and therapist are in a struggle, anxieties related to uncoupling or merger are less likely to surface. In fact, the attacks of a patient like Jane will further the potential for narcissistic injury in the analyst, and the consequent need for affirmation. In addition, the struggle is about the conscious wish to be loved but at the same time functions as a defense against the wish. The patient unconsciously draws the analyst into the pathological way of relating.

As I became conscious of my inner processes I could resist the countertransference pulls. If Jane wanted to talk, it would be up to

her. I would be there if she needed me. In previous sessions, tension often hung like a thick cloud in the room. But the following sessions were pleasant. I enjoyed the moment-to-moment experience. My attention drifted from Jane to the furniture, to the textures of the fabric in the room. I didn't care if Jane talked. I drifted to the noises outside, and I watched the way the sunlight played about the room. In the infrequent moments when Jane spoke, I responded. But for the most part I was silent. She seemed less tense than usual. I felt connected, then disconnected. I was calm and experienced a sense of freedom.

Jane wrote me a note about her reaction to one of our sessions:

I'm afraid to tell you this because you might blow it, but don't talk. . . . When I left the session, I was furious. I thought of getting hit by a car and then I felt like throwing a rock through your window. . . . Then things were floating around in my head . . . giving, taking, abandoning, sinking. . . . Then I thought, he did give me something: myself. . . . I didn't feel better after therapy, but different, less despairing, hopeful. . . . I felt better after therapy than I have in months. . . . I don't have to fight off feeling close to you, because I don't feel close . . . even though we are definitely separate, we are a part of a whole, that is, in fact, happy. . . . I want to talk about this letter. . . . But I'll talk about it in my own time.

A number of things happened. Jane could feel safe once I was able to resist the countertransference pulls. Jane was able to experience feelings that she usually had to ward off. She was not threatened by a loss of identity. She and I were able to be alone in each other's presence. As a child she was unable to achieve this state. Her mother's need was to be close, to control, never to be separated. Consequently Jane suffered the horrible feeling of being an extension of someone else rather than being responded to as a person in her own right, and one of the consequences was the development of a counteridentification so that nothing positive from her mother could be taken in.

THIRD PHASE OF TREATMENT

Jane became more comfortable talking about her feelings once I understood her fears and could relax from rescuing her and myself. In the next phase she was alternately guarded and more open. As

much as every patient needs to survive his or her "practice of self-cure" (Kahn, 1974) and needs to preserve a core of the self that is never in communication (Winnicott, 1963), there also exists a desire to be known and to know that the analyst is not afraid of knowing (Laing, 1965).

Jane was interested in human history and evolution. One day she brought in a book, the cover of which caught my eye. On the cover was an eagle poised in flight against a beautiful blue background. When I asked Jane what she was reading, she told me about the content and the author. The author was a naturalist, dedicated to the study of nature and human history. Jane and I discussed his works in session. She became angry because, she said, it was another example of her giving but getting nothing. One day Jane told me of a visit to a museum. As I listened to the way in which she described her experiences I was very moved by her sensitivity, her unique form of expression, and her passion for life. At that moment, Jane told me she felt she could never make an impact on me. I said that was interesting given that I was so moved by her. She later told me that she knew I was moved by her but couldn't tell me at the time.

Obviously Jane was in conflict. She couldn't acknowledge what she knew—a paradox. Yet the fact that Jane knew she had made such an impact made all the difference in the world to her. She told me that when she began to feel liked it became threatening because then my response became too important to her. There is little to hold onto in life if we can't believe that we have made an impact on someone important to us—that we matter. This is what I referred to at the beginning of this article when I said that if certain needs are not gratified, development cannot proceed. I am not referring to the analyst's reactions designed to seduce patient's away, for instance, from their angry feelings. Rather, I am speaking of that silent communication, over a period of time, of admiration and respect, of recognition and wonder, of feeling for this other person. This is what eventually made this patient feel she mattered. Jane noticed me noticing her. I was moved by and concerned for her many times through the course of treatment while at the same time having certain countertransference reactions. For instance, Jane ran out of the office one Friday. The other sessions during the week were tolerable, but Fridays were terrible for Jane because of the long weekend. As I left the office I saw Jane ahead of me. She was leaning

against the building sobbing. We spoke for a short period and then parted. It was a comforting moment in the midst of terrifying separation experiences for Jane.

Patients experience our feelings at certain moments in treatment, and this serves them as the love that is enough. It holds the patient through the tortuous process of treatment and then dissipates because patients, after analyzing intrapsychic conflicts, realize their wishes can never be fulfilled. The hope for a new object relationship is affirmed by the perception of feelings coming from the analyst, when the patient is ready to perceive them. This in turn brings up yearnings toward the analyst; the narcissistic transference develops; and then the narcissistic rage, terror about being alone, and grief at not being the center of the other's world can be worked through. One can never be completely protected from the world's impingements, nor would one want to, because there is also the striving for mastery and independence that I believe is as strong as the wish for protection. As the therapeutic process takes place the analyst experiences many reactions toward the patient. In speaking about the therapist's feelings for the patient, Searles (1961) states:

he responds to the patient, during the therapeutic session, as being of boundless personal importance to him, and becomes progressively unafraid to acknowledge this on occasions when the patient needs this acknowledgement . . . the therapist even feels the patient necessary to complete himself . . . a feeling which the mother could not accept or relinquish . . . we need to realize that the core of any human being's self esteem is traceable to the healthy infant's experience that he is indeed needed to complete the psychological wholeness of the mothering person; it is there I have come to believe, that the core *raison d'être*, for each of us, is to be found. (pp. 538-539)

A key phrase is "a feeling which the mother could not accept or relinquish." The analyst has to be able to acknowledge and relinquish. This is why the analyst's training, particularly analysis, is so important. Alice Miller (1981) has some interesting observations concerning the analyst's unconscious motivation as to choice of profession. The analyst wishes on the one hand to be the center of the patient's world and yet wants to avoid aggression from that patient.

Jane wrote a fantasy that sheds light on her conflicts. In it she is thrown from a train carrying self-absorbed people, who don't look at each other, into a desert. In this desert she encounters a cold

globe and a wall. Frustrated by the wall, she pushes the ball through the wall, and the ball breaks in half. In each half are large green mountains and valleys. From one half flies a huge eagle. Jane gets onto its back and flies through the sky. The eagle reminded her of the eagles in front of Grant's Tomb upon which she used to sit and pretend to ride. In her fantasy, the eagle takes her to a place where a wise old woman is surrounded by brightly colored disks. Jane watches as the woman throws the disks one by one into the air, making beautiful patterns and colors in the sky. Jane wants to do this, but she is afraid. The woman persuades her to try. Jane takes a disk and throws it, then hears a thundering crash and a violent storm breaks out. As the old woman gathers her things to leave, Jane attacks her and starts to beat her up. She wants to know why the storm broke when she threw the disk. She continues to attack the woman until the storm separates them. Jane then begins to swim. The rain stops, and she feels a sense of tranquility. As she swims with steady strokes, a feeling of exhilaration comes over her. It is a joyous, life-giving force. The eagle flies down, and Jane climbs onto its back and flies into the sky, falling asleep to the gentle flapping of the eagle's wings.

The wise old woman suggests the idealized parent who has the potential of being used as a teacher. She is the good mother who could have helped Jane with her self-esteem, narcissistic needs, feminine identification, and sexuality. Jane's mother was unable to provide the kind of relationship within which Jane could grow. Her mother was angry at her when she couldn't make progress and herself needed to be held and at one with the world. Jane was so angry and disparaging of her mother that she couldn't accept what was there to identify with.

The eagle is probably a symbol of the omnipotent, protective, hovering father, who stands by ready to step in when the going gets too rough. Jane does battle with the wise old woman while the eagle is present, yet doesn't intrude. The father has an important function as a transitional object. Jane was disappointed early and abruptly by both parents. As a child she didn't have enough of an opportunity to participate in the feeling of comfort, security, and protection that comes from a feeling of closeness with the idealized parent and subsequent gradual disappointment. She could use her therapist as an idealized figure whom she could now direct and control and

thereby feel omnipotent. The patient creates the therapist in his or her idealized state, providing for a while comfort and security from the impingements of the world. What the patient creates is derived in part from a fantasy about the analyst, and in part from the interaction between them. The omnipotence is there for as long as the patient needs this protection. The patient dissolves the omnipotence when ready.

FOURTH PHASE OF TREATMENT

This phase of treatment produced yet another difficulty. Jane began revealing her affectionate and sexual feelings in relation to me. I noticed a feeling of discomfort that I didn't feel with other patients. I thought it would become too frustrating for her. She felt it was cruel of me to encourage her to talk about her wishes because she needed me and I didn't need her. She felt she would be stuck forever and never be able to leave. This time I was able to identify the cause of the problem with more ease than with the first stalemate. I saw that I identified with Jane. I feared that if I encouraged her to express her wishes she would be stuck forever and couldn't leave. I became aware that some of my difficulty repeated issues from my own life experiences. As I became aware of my conflicts I could encourage Jane to tolerate affects related to fears of abandonment and separation that she was unaware of as a child. I began to experience affectionate and even sexual thoughts about Jane that were new. Of course Searles (1959) has much to say on the subject:

there is a direct correlation between, on the one hand, the *affective intensity* with which the analyst experiences an awareness of such feelings—and of the unrealizability of such feelings in himself towards the patient, and, on the other hand, the depth of maturation which the patient achieved in the analysis. (p. 291)

My feelings were responses to a change in Jane's developing sexuality. I began to think about what it would be like to live with Jane, marry her, share talks about art. For the first time Jane wore dresses to sessions. I was aware of being afraid of being flooded with feelings and aware of fears that I would do something with my feelings.

As I became aware of countertransference issues I was more capable of helping Jane express her wishes, and the stalemate would then dissolve. When Jane hinted at our going out on a date, I asked

her to talk about the date—what might it be like? Where would we go? This time she could engage these questions, and she began to notice how frightened she felt. She became less concerned about whether I would gratify her and more interested in her inner conflicts. This was a major change in her treatment. She was beginning to see she felt afraid of receiving what she said she wanted. There was more of a shift to the intrapsychic. She began to see how complicated her wishes were. She talked about her apartment and brought in pictures to show me and read letters aloud. In some letters there were references to sex but without penetration or orgasm. She told me I was a fatherly figure to her and said one didn't have sex with one's father.

My persistence in wanting to know what Jane felt about things was in contrast to the passivity and indifference of her father, and my not acting on my feelings (i.e., I didn't give her "slobbering kisses") made it safe for Jane. It is tragic that some fathers, fearing their own sexual feelings, defensively turn away from their daughters, especially around the approach of puberty. This turning away brings a terribly abrupt end to a love affair, and the consequences for self-esteem and for feeling feminine and attractive are endless. It is also tragic when, due to discomfort, a therapist says, as a reaction to anxiety and fears of intimacy, we can't do that here (e.g., go out on a date) just as a patient may be coming out of his or her sensitive shell. Searles (1959) discusses this phenomenon and the possible effects on therapy:

the ego impairment of many patients resulted when these patients entered the oedipal phase because . . . the beloved parent had to repress his or her reciprocal desire for the child, chiefly through the mechanism of unconscious denial of the child's importance to the parent . . . the parent would unwittingly act out his or her repressed wishes in the form of unduly seductive behavior towards the child [Jane's father's slobbery kisses] but then, whenever the parent came close to the recognition of such desires within himself, he would unpredictably start reacting to the child as being unlovable, undesirable. (pp. 302-303)

Eventually Jane became more comfortable with her affectionate and sexual feelings. In the beginning of treatment she had felt that all I cared about was the money, but she came to accept feeling liked by me. She no longer hated herself for her needs. On different

occasions she said, "I know I am difficult and you are helping me. I need your persistence." Now Jane could cope better on weekends. In the beginning of treatment she had felt "unplugged"; I didn't exist, and she was all alone. During the weekly sessions she was not as anxious, but in sessions before the weekend she used to threaten suicide or become depressed. As I mentioned earlier, sometimes she would refuse to leave the room. Toward the end of treatment Jane could comfort herself by thinking about what I might say to her.

For instance, Jane reacted in an interesting way immediately following my setting limits with her about paying her fee. She was with a group of people on a trip and liked the electricity of the group, but decided to go for a walk alone. She felt lost and became frightened. Then she comforted herself by saying she would be all right. Suddenly she observed the world around her differently. She was full of delight. She noticed how red the cherries were, how wonderful the leaves looked. Objects were crystal clear. She took a chance on her intuition and found her way back to the group. Jane was able to let go of an internal feeling state that served as a defense against her anxiety about being alone. This enabled her to see the world, feel its presence, and acknowledge her joy at discovery.

Jane was entering the world. For the first time she began to notice families having fun together, and she began to grieve over the deprivations she had experienced in her family. She observed fathers holding their daughters on their laps, and families sharing activities. Instead of her characteristic defensive anger, she cried for the first time over what she had missed. One reason she had protected herself from feeling accepted was that this would stir up such intense longings.

Jane then used difficulties in paying the fee as an excuse to terminate treatment. Her need to terminate seemed to be a major resistance to further exploration of the grief that she had just begun to experience in therapy. It was also a resistance to working through the idealizing transference and perhaps a way of turning the tables on me (this time she leaves me) to discharge some aggression and to protect herself from further vulnerability. It seemed important to her to maintain a sense of being in control and therefore less vulnerable and dependent. Searles (1961) traces stages in treatment that both patient and therapist go through and believes that there is a time for the patient to leave and the therapist must be prepared for

this. It is not uncommon for patients to move on to different therapist to take them to another developmental level.

About six months after treatment ended, Jane wrote a letter telling me about the journals she had kept in which she recorded her experiences with me as well as with other therapists. She was amazed that the themes were so familiar. She said she could read them now without feelings of shame and self-hate about her needs. She had not understood what was going on with herself, she said, because "my child needs were woven into my adult needs. One of the most important things you said to me was very simple: 'You have conflicts about being close to someone. That's why you are not involved with anyone.'"

She went on to say: "The recognition of the fact that I had conflicts was so obvious, but it helped me because it created a perspective, something I could work with. I kept that thought and it helped me." That Jane was able to acknowledge her internal conflicts was quite an achievement considering that when she started treatment it was only the world that was her problem.

Jane said she was in therapy again and on her way to resolving her problems. But she added:

I feel like tugging on your sleeve and saying: "Wait for me. Will you marry me when I grow up?" You know, I don't hate these feelings anymore. It is my time to say goodbye, my time for closure. Feeling liked by you meant so much to me because it came from you. I didn't expect it. Small as these memories are, I want to hold on to them and treasure them. They are mine. They are very important to me. You have fulfilled the role of the eagle. If you remember the story, the eagle came from his world into mine, assumed proportions bigger than life, and brought me back to where I directed him. I got off his back and walked to where the woman was sitting. The eagle did not appear in the story until the battle was over, the sea calm, and the storm stopped. Then he flew over her as she swam to shore with strong and steady strokes. You know, you are like a surrogate family to me. My desire to work things out with you is the same as wanting to resolve conflicts with my family. You are really closer to me than my own family. My father is gone. Yes, I know my mother is there. I'll get to her. That's going to be rough.

Three years after receiving this letter, I received a phone call from Jane. She said she was still in treatment, was teaching full time, and had received a fellowship to continue graduate work. She was happy

now, she told me, and felt herself on an equal basis with people her age.

In summary, in the ideal situation patient and therapist come together, experience feelings toward each other, and then separate, each being able to accept and relinquish the past. When stalemates occur that interfere with movement in therapy, the analyst's awareness of his or her participation in the repetition compulsion of the internalized pathological object relationship (or part-object relationship) can relieve stalemates and free the patient to develop. The patient's angry reactions to the analyst's failures provide the momentum for new structuralization of the ego. Self-object differentiation takes place through awareness and tolerance of angry feelings. This often occurs before loving feelings can be experienced, particularly with patients who have fears of loss of boundaries. The concept of abstinence has been misunderstood particularly in the treatment of the severely disturbed patient who might experience total abstinence as abandonment. The core of abandonment feelings, narcissistic rage, and depression often have to be analyzed at a much later time in treatment. Abstinence does not mean that the therapist suppresses feelings that the patient may need for a developing sense of identity and self-esteem. These feelings are often not expressed, yet patients perceive them in the therapist and experience them at a time still important to their developmental needs. The notion of gratification encompasses the admiration, wonder, concern, care, and angry feelings that the patient perceives the analyst is feeling over the long process of analysis. Whether it is anger or love, the perception of the analyst's feelings is an affirmation of the patient's unique identity that holds the patient through the difficult times in treatment, acts to stimulate repressed feelings and longings, serves to engage a narcissistic transference, and provides some affirmation that builds identity and self-worth. The analyst must keep this paradox in mind throughout treatment—regardless of what the patient says he or she needs. There is conflict inherent in the situation. It can be terrifying to feel loved.

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