

REFLECTIONS, MUSINGS AND INTERVENTIONS<sup>1</sup>

## A Personal Communication On Psychoanalytic Work

## REFLECTIONS

I have often thought that our lives are a little more than a gathering of days, our childhood lost to both memory and forgetting; for the rest, we scramble to make sense of what happens to us. As a psychoanalyst I have spent my days pondering what it is I do as well as what is done to me. Do my patients affect me by expecting me to be somehow above it all, to be knowing and insightful, compassionate yet strong, intelligent and yet unchallenging to their life styles? For the most part I respond as best I can. But I owe to myself as well as to my patients to ask if my response is “real” or is it a false self, a professional persona I become in order to be known in some knowable way? Who teaches us the ways to be known? Parents, teachers, colleagues, and patients; the “other” in human experience. Include as well a society that has fulfilled Freud’s dire prediction: America, he mused, will make psychoanalysis a private business.

Indeed. A private business with all the need to supply a capitalist rationale: a product, self-understanding and/or adaptability. Something I can sell to “them.” My patients are, for the most part twenty-five to sixty-year olds who come to me hoping that I can do something to “them,” and they will be happier or less sad, less anxious or less likely to fall off the cliff we all walk along but few are able to acknowledge.

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<sup>1</sup> This is a revision of an article which appeared in: Thorne and Herscovitch (eds)1997 *Psychoanalysis Today* – A

And so the question remains, did I go into this profession to free myself or to help others? Is there a difference?

While I am working with someone, I cannot take notes. I do not believe it useful to try to keep track, particularly in a cognitive sense, of what's going on in a therapeutic experience. For me writing either during or immediately after the session, or continually evaluating diagnosis and/or prognosis, is a subtle intrusion into experiencing the patient. (In fact, I get easily distracted when I read case presentations in which there are predictable responses. They do not seem like anything I do.) I remember names and events, dreams and major turning points. For the rest I listen to the patient as carefully and attentively as I am able to. I automatically think in terms of psychoanalytic categories because that is what I have been taught to think in. The psychoanalytic model is useful; I do not think it's the only approach to the psyche, but it is a way of thinking that has helped me in my own personal analysis, and so I organize what is happening with a patient in terms of childhood experiences, unconscious defenses and reactions, transference reactions and levels of insight. Beyond these formulas, of course, I care for my patients, want to help them, as well as want to experience myself being effective., Donald Winnicott writes about the feeling of hating a patient, in his article Hate in The Countertransference – knowing it and not acting on it; knowing it so that you can find its roots, either in oneself or the patient, and in the knowing and in the naming to free oneself of the burden that rage and hate bring. If such emotions are weighing a patient down in the session, if it is weighing me down in the treatment, then I know that it is weighing them down in their life outside of this cell we call a psychoanalyst's office. I live in a secular monk's room where two people dwell, for a gathering of sessions, where one mediates not on a future heaven but on a burdened now and,

frequently, on a past hell. Fortuitously my present office is bright, looks out over a busy street in front and a hundred year old church to the right, with its frequent bell tolling marking the passing of light.

## MUSINGS

The case I would like to talk about, the fragments of which I remember, is one such example of a hell in the past and a burdened present. The treatment has gone on for over twelve years; we are, I believe, close to the end. The incidents I will mention have occurred within the last six months. They have come about, I am sure, through expectable maturational growth and our analytic work together. I will give some history of the patient, recall some interventions I made as well as which the patient made, all in the hope of giving some glimpse into the way human beings have of interacting, i.e., of talking to each other. As I have mentioned I have had a strong desire to understand this talking cure, these words that carry love and hate, understanding and ignorance in their shapes. Maybe because of this fascination with words and how we are had by language, and how we know ourselves by language, I read poetry, all kinds of poets. Perhaps it was the poetry of Freud's writing, even in translation, that initially captivated me. Certainly it was the poetry of Donald Winnicott's writings that led me to read more and more of him and to listen and name clinical experiences in ways that echoed him. That I have been reading him for over twenty years must surely affect my work. And before Winnicott and Freud, I was had by western philosophy, which was my major in college, and by western theology and religious studies, which comprised by masters studies. I read Freud at fifteen, St. Thomas Aquinas at twenty-two; by thirty, I was reading and studying Freud again.

Psychoanalysts are not arcane gurus of the mind pronouncing, with solemnity, what is

hidden in the human psyche. We are all had by our childhoods, informed by our teachers and instructed by our readings. If another wishes to share some of our musings it helps to know some of the sources that have informed those musings. Along with Freud, the authors I remember with the most excitement were Groddeck and Ferenczi, Balint as well as Erikson, Theodor Reik and of course, Winnicott. Some I particularly respect are Otto Fenichel, P. Ricoeur, J. Campbell as well as Meister Eckhart, F. Roustang and Lewis Thomas. Winnicott speaks of the need for a patient to be able to “play,” not the play of games, but the play of interaction. Winnicott also speaks of how even the most “correct” interpretation has its own moment of birth in the treatment, and should not be prematurely delivered by the analyst; a lesson I learned, many times over, with this case. Roustang helped me understand that one can never teach another what words to say, or what thoughts to think; there are no words to say unless one wishes to indulge in religious rituals. Therefore in the following account I will consider it a success if I convey to the reader the kind of “playground” in the treatment that I try to foster.

Before discussing the case in any detail I would like to share one further observation about my way of working within the therapeutic experience. While I recognize transference as a most powerful phenomenon, I am simultaneously very suspicious of it. By that I mean that I believe an analyst should be maximally aware of what he is bringing to the relationship before he makes a judgment that a particular patient’s response or reaction is a manifestation of a distortion of the present in view of the past. Additionally I am extremely wary of what is known as encouraging an idealized transference. I not only do not encourage it, I suspect I positively discourage it by dropping little facts about myself and my human foibles, in order to keep the relationship precisely that, i.e., a relationship. Notwithstanding this, patients will do with this information what they will. I feel better for conducting an analysis within this style of

communication. If patients have a need to distort or skew their experience of me, they will. The stance that the more neutralized the analyst is, the more antiseptic his/her responses to the patient the clearer the transference will be, is, I believe, simply wrong. In fact such a stance, away from the natural personality of the analyst, clouds the transference, as I see it. Michael Balint is explicit in this line of thinking; Winnicott is less explicit although I am convinced that he clearly practiced this way. Only a completely relaxed, comfortable analyst would have thought up his famous “squiggle” game to begin with.

Whether I did psychoanalysis or psychotherapy with this patient, each reader will decide. I find the distinction, when asked by analysts of other analysts, to frequently reflect a religious test as to orthodoxy rather than to functioning. In this vein I am reminded of Winnicott’s response when he was asked what psychoanalysis consisted of. His answer was that that depends on who is doing it.

## INTERVENTIONS

The patient I would like to discuss is presently forty-four years old. I have seen him on the average of twice a week, for approximately twelve years. For the past two years I have seen him once a week with a short fifteen to twenty minute telephone session spaced a few days after our meeting. (Two years ago I moved my office from New York City to a suburb making the trip for patients longer.) It is most difficult, as I mentioned above, to encapsulate twelve years of work. I can say that the patient would, in all likelihood, be classified, when I first saw him, as schizoid with an infantile personality. Although he had a graduate degree he was totally unfocused in his work as well as in his personal relationships; he seemed bewildered by life and by life experiences.

In therapy the patient's life story unfolds as the work progresses. Therefore the history I relate was gathered over a period of years and is an amalgam of the patient's words as well as analytic reconstruction. The patient grew up in an apartment in a large midwestern city, of Jewish parents; he has one older sister. The patient spoke of his mother as continually doting on him the experiences of which he recognized as being destructive. She would, for example, have a potty for him when he was ten years of age, so that if he had to urinate at night he would not have to leave the bed. Furthermore she would heat his orange juice lest it be too cold. She was a paranoid lady who, although she worked in a position where she dealt with people daily, was totally alienated from her extensive family. As my patient was growing up his mother would frequently ask him to un-strap her bras, or help her zip up her dress. She was excessively nervous whenever he crossed the street and would frequently, over his objections, want to go to elementary school to fight his fights for him with other students. The one time she did this caused enormous humiliation to him. The patient recounted how he would wet the bed consistently until he was in early puberty. Occasionally, during adulthood and treatment, he had short periods of wetting the bed again. Of his father he hardly spoke at all. The one consistent memory of his father was of his going on a visit with him to some relatives and returning home on the elevated train, whereupon his father got into the train a few cars ahead of his son with no apparent thought as to whether or not his son got on the train. The patient, aged eight, walked through the train looking for his father, and when he found him got no explanation from him as to his actions. The pattern of little or no response from his father was, in fact, a constant theme. My understanding of the father was of a severely withdrawn and depressed man, totally subordinate to his wife. (After all this time I find it difficult to remember the father's occupation.) The patient recalled an earlier experience when he, four or five years old, and in the

midst of having a fight with his older sister, proceeded to hit her with a baseball bat. The physical damage seems to have been minimal; the parent's response was to give him a mild rebuke. A good deal of analytic clarification was necessary, however, before the patient realized the damage such permissiveness and non-paternal involvement caused.

Throughout our work together I spoke of the oedipal seductive behavior of his mother; the overdetermined, sexual and aggressive meanings to his bed wetting, and of the rage and desolation he must have felt at being abandoned by his father. This abandonment left him bereft of a masculine image, but also left him to his sexually seductive mother. The patient recalled, frequently, that when speaking with his mother he was constantly admonished not to trust anyone, even family; that the only thing that mattered was money and that people really did not have any feelings for each other. Although making a lot of money was stressed, he was also urged to get a civil service job so that he would be secure. Furthermore, he was admonished that he should only marry a Jewish girl, since non-Jewish people were untrustworthy and frequently meant harm. (The patient had come to see me after being with a Jewish woman analyst for approximately five years. I have never been able to satisfactorily evaluate that work except to feel that it was not harmful in any way. Was his subsequent choice of me a move away from his paranoid mother's world?)

Theodor Reik once remarked that he did not understand analysts who spoke of liking their patients initially; he found that he was more prone to like the patient near the end of treatment than the beginning. This was certainly true in this case for me. It took a number of years for me to feel connected to someone whose affect was initially flat, who had childish demands on the world around him, and who used, extensively, concrete language. Although the flatness of the patient's communications caused me concern, confusion and frequently boredom,

we would work on issues centering on his infantile mode of response to his jobs, his bosses and/or fellow workers and occasional love relationships. Flatness is a difficult experience to convey. Although the patient was bright I came to feel that a part of me had to be kept in hibernation, so to speak. If I interacted with what seemed to me an appropriate therapeutic pace, I was clearly beyond the patient's ability to hear and integrate. Repeatedly, therefore, I would have to remind myself and discipline myself to go slower. Throughout our work together the patient had a number of work positions and, although he whined and was demanding, he had some spark of wanting to get involved effectively in the world.

For many years the only way he was able to speak to this issue of effective involvement in the world was to be jealous and angry with me. These feelings showed themselves for the money I made, the position I had, the house I had, the family I had, the car I had, and on and on. With paranoid accuracy he had guessed both the number and sex of my children and their approximate ages. When he did this, my response was merely to confirm his guess and to go on to his reactions to my family constellation. He would stay with his reaction for a few moments before going back to his conviction that if I had anything, which he wanted, or if other people had what he wanted, they and I were taking it away from him. This was such an emotional conviction for him that any intellectual awareness he had of its falseness was meaningless. On one occasion he accidentally met, for a few moments, both my wife and I as we were visiting a museum. In the next session, he not only offered a rather perceptive analysis of her manner but of her age and occupation as well. By the time this happened we had been working together for a number of years. My reflections were of repeated wonderment at how he had not been allowed to separate from his mother, at how he had been symbiotically fused to her; excited and frightened by her all at the same time. And consequently how these factors had delayed *the closure*, to use

Freud's term, of his unconscious. Freud speaks of such a closure occurring around puberty; in this case this was greatly delayed. I think it was this factor that enabled him to have an uncanny ability to read other people. Predictably as he became more operationally productive in the world of work and relationships, this "ability" receded.

As I write this I am also aware that intermingled with my, at times premature interpretations about his Oedipal phantasies and realities, it was important for me to be somewhat "unknowing." When I work with a patient who is overly concrete and symbiotic, it is usually helpful not to be the powerful mother/father/world since my knowledge, or presumed knowledge, can easily intimidate the patient into complying with my interpretations, or worse, be experienced as a narcissistic injury. If I know too much I not only know parts of them that cannot be known, but in the "knowing," so to speak, I can be experienced as violating an internal haven; that area where we are alone with ourselves. Winnicott speaks to this issue when he talks about the true-self potential and the capacity and necessity to be alone. When I realized that my Oedipal and pre-oedipal interpretations about anger at his father or confusion as to his boundaries were essentially getting nowhere, I simply dropped them. We worked, as indicated above, on everyday issues, of which there seemed to be an endless supply. I conveyed to the patient the realization that if we continued to work together, he would have to help me help him, if he would ever get to where he wanted; that is, to feel real and effective in the world and be able to love someone.

About the eighth or ninth year of our work together the patient began asking me for some books to read that might help him understand the psyche in general as well as himself. He spoke of the numerous self-help books he was reading and asked me what I thought of them. For the most part I did not know of the specific works but I encouraged him to read whatever gave him

any further sense of self-understanding. (A few of them, which I did know, I did comment on.)

In addition, I mentioned some works by Winnicott, M. Klein, authors he was familiar with since a good friend of his was in the analytic world. Ordinarily, if there is an “ordinarily” in working with patients, I would discourage the intellectualization that such an approach could cause. I felt, however, in this case that the patient needed a good deal of strengthening of his intellectual grasp of human development in order to handle the primitiveness of his emotional development. It is also possible that during this time, which lasted for two years or so, I was exhausted and frustrated at the patient’s slow progress and wanted to bring in some “co-therapists” to help with the treatment. I had had to come to terms, not only in this case but also in others, with the reality that some analyses would go on considerably longer than my own and that this was not necessarily a statement about my ineptitude.

I would, on occasion, find myself quite angry with both his mother and father, (anger is probably too mild a word). They had left me (they resided in Florida) with an angry, jealous, paranoid, bright and injured child, and I was somehow supposed to bring him back to a normal life. Both mother and father were hardly “good enough” to use Winnicott’s terms. My frustrations were only slowly worked through as I experienced the patient’s utter commitment to keep coming to therapy and to keep trying to work through the ghosts that haunted him and the gates that blocked his entry into the mature world. Somewhere in the back of my mind I remembered that the patient’s maternal grandfather had, at age fifty, become a lawyer, after many years in a blue-collar job. This fact, which would prove a most helpful model for my patient was, for whatever reason, blocked from my awareness until the crisis that occurred during the summer of his eleventh year of treatment.

By the time I went on my three-week August vacation, at the end of his eleventh year, I

felt that the treatment had progressed well. The overly concrete language had lessened, i.e., there was more emotional vitality in his speech and in our communications. The patient was settled *into a* good paying civil service job. (Until he had more emotional flexibility, this was actually a good choice despite mother's shadow.) He was simultaneously preparing for an alternate career. We had spent much time working on his personal relationships and he had, as of two years ago, married. The marriage was a happy and satisfying one; his wife was pregnant with a much-wanted child. The jealousy and rage at me seemed to be somewhat lessened, to my relief, although I was puzzled as to how this would finally be resolved.

On my second week of vacation I got *an* urgent call from the patient. When I returned his call I was met with a thoroughly enraged person who informed me that he would be stopping treatment since he had failed to get the raise he was expecting at work and another worker had gotten the position he wanted. I succeeded in conveying to him my appreciation of how upset he must feel and that it would be helpful to give himself a few more sessions before deciding that treatment was to be stopped. Although he agreed to this, two lengthier phone sessions during the remaining weeks of my vacation were necessary, since the patient was convinced that I had personally let him down with this turn of events. The intensity of the patient's regression surprised me and I knew that this was going to be a fight to the finish. It was as if the paranoid enraged mother had taken over and pushed aside all the work we had done. When I returned in September I was met with a sullen, enraged but somewhat receptive patient. By "somewhat receptive" I meant that about ten minutes of each session he would allow me to show him that I understood his rage but that it had little to do with therapy, his job, or me. I mentioned that ultimately he could spend the rest of his life reactivating his mother inside him, or he could recognize that the world is not a hostile place. It (the world) is, I said, merely indifferent. To

personalize it with his hate was his doing. This statement of the world as indifferent to him seemed to capture his imagination, and he would repeatedly come back to it as he began to “neutralize” his experiences of disappointment. (During the beginning of this turbulent time the patient had mentioned that he wanted me to refer him to whoever had been my analyst. My response was that he wanted his grandfather back.) Each morning, for a period of about six to eight weeks, I received an angry sullen message on my tape machine to the effect that he was going to quit and never come again, or that he was so depressed that he had to speak to me. When I would speak with him, for a few minutes, he would either go into rages at the unfairness of his life and the treatment he got from his parents, or he would rage at me saying that I must hate him and that I should stop it. I would quietly assure him that I felt for his anguish, and that I did not hate him. I spoke to the fact that the persons he felt hate from were his manipulative seductive mother and distant father.

After about eight weeks of my refocusing interpretations of many years’ standing and offering as much understanding as I was capable of, the patient began to repeat back to me, as if for the first time and with a sense of personal ownership, many of the themes the treatment had touched upon. Eventually he was able to hear that he had been beating me up with his reactions and phone calls, similar to what he must have felt growing up when his mother would never let him be. As he was able to internalize this awareness I said to him that I did not enjoy being beat up and that he would have to find other ways of handling his frustrations. I said this not only for self-evident reasons but because I felt (for the first time?) that the patient, as he was emerging from this dark angry place, *was* able to cross-identify with me, that he could experience what was happening to me and not just to himself. He was able to understand that in making me the bad world he was cutting off any chance of living happily. The patient was (finally?) able to

experience the hatred he had *inside himself* for the world as “other;” he saw his imitation of his mother’s attitudes, and began to appreciate the fact that there were objective reasons why his colleague was given the advancement that had little to do with himself. Progressively he understood that his rage would just perpetuate his feeling injured, that it was a way of not dealing with the world, *similar* to the way his parents did not deal with the world.

I was fortunate enough to say two particularly helpful things during this period. One was to ask him why he kept ignoring his grandfather whom he knew well, who lived well into his nineties, and who in the middle of his life totally changed careers, i.e., became involved productively in the world. Perhaps the patient’s clue to me about wanting to see my analyst was a signal that he would be able to hear and use this reference to his grandfather in a helpful way. The patient took to my statements *with* a sense of bewildered enlightenment and brought in many stories of his grandfather, showing his admiration of him and his desire to imitate his mastery of life.

My second intervention, which proved useful, was to say that he owed me some reparation for the years of jealousy and anger and for these last few months of hate. I would not accept any presents, which at first he thought I meant. I clarified that one cannot just throw people away without making reparation. I said this because I was trying to show him, I hope in not too heavy handedly a manner, that it is possible to show concern for another, which concern could channel productively the guilt feelings over the rage and hate which had been expressed. This concept, “on the capacity for concern,” which Winnicott develops in his writings, was at the base of my statement. (How effectively I conveyed it will ultimately only be manifest in retrospect.) With this statement he seemed to understand that he had to find and remember me as the good world if he ever hoped to live in the good world. His manner gradually lightened, he

began to joke with me much more and he gave himself interpretations, as I mentioned above, about his *previous* schizophrenic type of thinking, his symbiotic as well as oedipal tie to his mother, and his rage, now significantly modified, at his father. He continued advancing in his new business venture and began to muse about moving back to his city of birth since his new business, in the computer field, would allow him to do that. He joked that now that he was about to be a father he would have to take care of and actually think about someone else.

In the course of a few months after this crisis he grew a beard and began to sound more mature, i.e., his voice developed a more mature resonance. His childish stance towards the world was changed and, so, therefore, his physical demeanor actually matured. He let the realities of life register on him.

## EPILOGUE

Although the case will go on for a while, I think we have passed through the eye of the storm. The sessions feel more real, the patient feels more real. Rage and hate of this particular variety, however, runs deep. The solution, if one can use such a simplistic formulation, will be his achieving and sustaining a capacity for reparation and a capacity for concern. I believe his child will help him greatly in this regard. At present, I feel empathy for him with many positive feelings. I frequently find myself imagining his leaving and living a productive life.

I will be twelve or fifteen years older when our gathering of days will come to an end; he will be freer and more loving, more able to use the world. I will be the wiser, if a little more tired, for having worked with him. And after a while, if things go well, I will not only appreciate, further, the positive things that happened but the mistakes I made and how they fit into the treatment. In fact the decisive move away from paranoid rage and righteousness is, I believe, a

patient's willingness and capacity to use and allow for our errors, rather than vengefully retaliating for our mishaps. That this patient has stayed this long and worked this hard is the best promise that our work has some positive and lasting meaning.

#### POSTSCRIPT

I have rarely written case reports; I have been greatly concerned, so I told myself, with the issue of confidentiality. I am convinced, additionally, of the impossibility of the task. Are we reporting a case's progress or creating a novelette? Secondary revision, as any clinician knows, is not limited to dream work. Having completed the present manuscript I was extremely wary of reading **it** to the patient. I had, in the present case, less concern about the issue of confidentiality since I believed I had disguised the material sufficiently; I was wary as to what such a reading might do to the work in progress and to any possible reenactment, in the treatment, of his sense of specialness. I attempted to handle this concern by asking a few respected colleagues what they thought my obligations were. That is, given the particular perspective of this article, was the patient's permission a necessity and/or how would the patient experience my reading the article to him? A majority seemed to think it ethically necessary, some thought it unwise for me to read the case. My concerns, nevertheless, were not lessened.

Obviously, and as was soon confirmed, something else was going on. This became clear during one session when I, unable to resolve my ambivalence, decided to read the material to the patient. What became transparent was that my concerns over the patient's experience of specialness were not validated; my feeling of loss over separation, however, was. I realized this when the patient, upon hearing the case, was quite moved and said that he felt held by me during the reading. He was, he continued, aware that our final working together time had arrived and

that my summarizing the treatment was the beginning of closure. He knew that he would miss me and, with some unbelief, that I would miss him. He spoke of being able to experience personal relationships as real and this was clearly opening up a whole new life for him. He understood that I had not ignored him, had not walked away without a backward glance, as well as the fact that our common goal was for him to feel real and to live his own life.