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PERSPECTIVES ON TECHNIQUE

By Gerald J. Gargiulo*

In my previous column (NEWS AND REVIEWS, Jan.-Mar. '78) I discussed a more restricted meaning of the term "countertransference." My reasons for doing so were to enable a clearer distinction to emerge between therapeutic responses based on a patient's developmental needs and responses based on the analyst's countertransference. The two focal sentences from that column were the following: "(countertransference)...is the analyst's own transference response to a given analytic situation. It may be triggered by the patient's transference or character structure, but it is essentially the unsolicited static the analyst brings to the treatment of a particular patient or, sometimes, to all of his or her patients." And, secondly, "...what can be useful, and what seems frequently to be confused with countertransferential manifestations are all those interventions based on the patient's developmental needs in putting together a self."

Winnicott suggests a useful distinction, I believe, when he speaks about the difference between an analyst not responding to a patient's instinctual wishes but, on the other hand, his need to respond to a patient's developmental needs. To miss responding to certain developmental needs is to condemn the analysis, frequently, to a prolonged exercise in fostering and strengthening "the caretaker self," the "false self organization"--that part of the defence organization which resides in the mind as a distinct entity split off from psyche-soma.

By the very tasks which Freud set himself, he was preoccupied with various oedipal constellations; discernible neurotic symptoms betrayed the fact of a fairly complex level of integration and personalization underneath. Operating within this framework we can note that frustrating instinctual wishes can be a necessary concomitant of growth with sublimatory possibilities; a seedbed for an 'actual neurosis,' an idea Freud never fully abandoned; or a symptom of psychoneurotic conflict. In Freud's teleology of instinctual development a careful examination of the circumstances helps in clarifying these alternatives. Since the therapeutic rubric for oedipal conflicts is articulated through 'clarification,' 'interpretation,' 'renunciation,' 'displacement' and ideally sublimatory resolution, the analyst's role was to augment this process through interpretative interventions. The integrity of the resolution as the work of the patient was guaranteed by the analyst's abstinence. And in this context abstinence has a broader meaning than sexual involvement. It means the avoidance, ideally, of any non-interpretative interventions.

In persons, however, with more serious pathology than neurotic conflicts: in individuals whose sense of personal aliveness has been eclipsed, in those who have no capacity for creative playing in the world, who are so divided within themselves that they are "real" only through a false self-organization or through a grandiose narcissistic defense, to mention a few possibilities, in persons coming to us with these issues, we are dealing with psychopathology based on failures of the very early environment. We may not be able to repair early damage, frequently we are not able to, but the therapeutic process is strengthened, I believe, if we can at least focus on the developmental areas that need addressing.

Developmental needs are varied and complex, and any comprehensive discussion of them as operative within the analytic setting demands a more extended treatment than this column can offer. My intention is to bring into focus a different perspective in our analytic work, confident that one's good analytic sense will start working towards solutions if only we can get a clearer picture of the problems.

There are times when an analyst must withhold a correct interpretation so that the patient can find a 'half-correct' one--but, at least, experience some sense of his spontaneous self in the process. Or, again, before a child can be alone with himself, he has to be able to be alone in the presence of mother, who lets him be alone in her presence. When this

primary experience has not been achieved, it is one of the tasks of therapy to provide this setting. In such a situation as this, to explore the unconscious phantasies of a patient would shatter a more basic and necessary experience of being alone in the presence of a protective, nonintrusive environment.

Once we understand that an individual's experience of his aggression and of his sexuality is not a simple given, but is organized out of the matrix of his earliest experiences with the caring environment, we are less likely to see the unfolding of instincts as some inexorable law and appreciate, rather, that developmental needs necessary to secure a spontaneous, alive self are more basic than instincts.

Therefore as analysts we must learn to play with the building blocks of the self, with all the haphazardness that play sometimes involves. We are trying to help Humpty Dumpty get himself together, as it were, so that he can venture onto that fearsome wall and test whether the triumph of holding himself together will preclude his falling.

(In my next column, promise, a case.)

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NEW PERSPECTIVES ON PSYCHOTHERAPY OF THE BORDERLINE ADULT

Nov. 5 Meeting of Masterson Group -- Part I, Morning Meeting

By Robert N. Mollinger

The first paper, Psychotherapy of the Alienated Patient, was presented by Dr. Peter Giovacchini. Avoiding nosology, he stressed that he approached the problems of the patient he was to present as a "character neurosis" not as a borderline. In focusing on the transference, he showed how the patient, a middle-aged woman, needed to see him as an opponent and the therapy as a battlefield. Having had a chaotic, traumatic childhood in which she had been beaten, the patient, not possessing the adaptive techniques to cope with any other kind of environment, attempted to create a similar one. In doing so, she externalized a frustrating environment, which Giovacchini distinguished from the projection of impulses, affects, and self--and object--representations. He compared this kind of patient to those with a narcissistic character who also create a world, through magical control and omnipotence, to support their narcissistic balance.

In the discussion which followed, Drs. Otto Kernberg and James Masterson both emphasized the need for clear diagnosis. Kernberg noted that one should attempt a descriptive and structural diagnosis, while Masterson stressed the differences between various character disorders. For instance, the borderline has a split object-relations unit (rewarding and punishing) and defends against abandonment and depression, while the narcissist has a fused self-object representation (omnipotent object and grandiose self) and defends against envy and rage. Giovacchini replied that the field of psychoanalysis requires much diagnostic clarification and that he diagnoses from the transference of the patient.

Dr. Harold Searles presented the second paper, Psychotherapy with the Borderline Adult: Some Principles Concerning Technique. In the borderline, the early attitudes of his family go into the make-up of the atmosphere of the therapeutic sessions. In this atmosphere, the patient, particularly one with autistic traits, cannot utilize verbal interpretations because he cannot distinguish between words and activity. Verbal aggression is equated with physical aggression. The situation then requires special techniques. The analyst must leave it to the patient to interpret his conflicts and character. If the analyst does interpret, he should use the patient's own phrases and tone because some patients can only hear interpretations if they come from another person who is "like a twin." The analyst's silence and the patient's response to it become important. The silence might mean to the patient that the analyst is dead, psychotic, senile, inanimate, or critical. Silence is not automatically seen as neutral. In fact, the analyst's silence conveys his feeling