

Reaching for the Primitive

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In her article, "How We Aim to Be with Patients," Meadow (1996) paints a picture of what she tries to do as she sits with patients. She speaks of allowing the patient to wash over her in an attempt to discover the hidden feelings, impulses, and habitual defenses that each person brings into her office. She hopes to remain flexible enough to follow each patient as they travel inner pathways, sometimes dealing with present realities, sometimes reaching back to earliest experiences. She acknowledges it is important to keep her own bearings as she follows the patient. And she hopes her patients will forgive her "...limitations when the journey is complete" (p. 153).

Gene, a young man referred for treatment early in my career, tested my ability to do as Meadow suggested. Physical disability, cognitive damage, and epileptic seizures were the result of a traumatic brain injury he sustained as an infant. Gene lived in an adult developmental foster home provided by the agency responsible for his care at the time of his referral.

Young children rely on their parents for love, protection, and to provide for their physical and emotional needs. My patient's mother did not protect him, nor did she provide for his needs. This lack affected Gene's development profoundly. The relationship with the parent assists the child in organizing a sense of self; Gene's experience with his mother as a caregiver ended in a burst of fury within

weeks of his birth that resulted in a fractured skull and traumatic brain injury that Gene only just survived.

The infant who experiences a “good enough” relationship with the parent grows to trust and depend on the parent; these positive interactions between parent and child foster healthy brain development, the foundation of general health and well being. Conversely, the child who experiences an early environment of deprivation, neglect, or outright abuse, is inhibited in its growth. Allan Schore (2011) states,

In contrast to an optimal attachment scenario, in a relational growth-inhibiting early environment the primary caregiver of an insecure disorganized infant induces traumatic states of enduring negative affect in the child. This caregiver is inaccessible and reacts to her infant’s expressions of emotions and stress inappropriately and/or rejectingly, and therefore shows minimal or unpredictable participation in the various types of arousal regulating processes. (p. 80)

Schore goes on to explain that children exposed to this type of neglect and/or abuse do not learn to establish healthy relationships and they are often unaware of their own internal states. This lack of awareness impedes the process of learning to self-regulate. With the adult patient who experienced a parenting style such as Schore describes, the relationship with the therapist takes on added importance.

The young child develops a sense of self through interactions with an adult caregiver; the adult patient who comes to therapy lacking experience with the kinds of interactions that build a healthy ego can, with the assistance of the therapist, develop a stronger, more integrated ego. In therapeutic work with adults, it is again the relationship, this time with the therapist, that assists in this development. Of course, the therapeutic relationship differs from the original relationship with the parent because the patient brings long established patterns of relating to external and internal objects to the analytic relationship. Transference becomes the lens through which the therapist studies interactions with the patient: it is the transference which instructs the therapist in the patient's habitual ways of dealing with the world. How should we think about transference as we examine the dynamics of a case?

As Betty Joseph (1985) describes it, transference is a living, breathing, ever-changing entity which the patient brings to the therapist. As the patient and therapist interact, new dimensions of the transference emerge. Joseph asserts that it is the total situation, in other words the totality of what the patient brings to us, that must be considered as we study the transference.

By definition, it must include everything that the patient brings into the relationship. What he brings can best be gauged by our focusing our attention on what is going on within the relationship, how he is using the analyst, alongside and beyond what he is saying. (p. 447)

Ogden (1991) expands upon this,

The infant not only has a relationship with the mother as object, but also from the beginning has a relationship with the mother as environment. Consequently, transference is not simply a transferring of one's experience of one's internal objects on to external objects; it is importantly a transferring of one's experience of the internal environment within which one lives on to the analytic situation. (p. 593)

As we study the transference, Joseph states, we often encounter and try to decipher experiences that are beyond words. She suggests we can only understand these experiences through the feelings induced in us by the patient. This is where the patient I call Gene and I began. With few words. Too many words would have been intrusive. Gene and I needed to meet in that twilight space just this side of the unconscious. The first few months of therapy seemed to provide a gestation period for Gene. Spotnitz (1985) suggests, "The narcissistic transference may initially have intra-uterine qualities" (p. 205). This was the case with Gene.

During our early sessions, it was as though he had re-entered the womb and once there, existed as a preconscious being. He said little; when he did speak it was

rare for him to convey any feeling. During this period, it was virtually impossible to follow Gene's train of thought even when he was making an attempt to speak.

There was often no "story line" or linear progression in his speech. Sometimes he mumbled, as though speaking to himself or to some other being I could not see. It was impossible to hear individual words. I sat, daydreamed, dozed, and wished I knew more. I felt alone. On the few occasions when Gene did speak to me, it was to ask for confirmation of something he said, as though he conversed with a part of himself. During this phase it was important not to disturb Gene. As Hyman Spotnitz (1985) postulates, "The patient wants and needs to relate to an ego-syntonic object." (author's emphasis) (p. 205)

Spotnitz quotes Balint (1959) who describes the ego-syntonic object: "The analyst should not be an entity in his own right . . . in fact not a sharply contoured object at all; but should merge as completely as possible into the 'friendly expanses' surrounding the patient" (Balint, p. 97, Spotnitz, p. 205). Balint might agree that Gene and I were one, and that he needed me to be as still as possible unless and until he contacted me. On those rare occasions when Gene did make a contact, my response was minimal; just enough to return that contact. Spotnitz explains the rationale for this:

The immediate release of efferent impulses into motor activity— acting out—is characteristic of the most primitive mode of functioning. Patients entering treatment for preoedipal problems have a limited capacity to engage in precise verbal release; they tend to discharge their impulses into indiscriminate forms of motor activity rather than speech. This tendency and the attendant dangers create anxiety, and inhibitory tensions are mobilized. In order not to stimulate the operation of the more primitive action patterns, one therefore refrains from exposing these patients to extreme degrees of sensory input or sensory deprivation in terms of verbal contact. (p. 106)

Spotnitz goes on to suggest more specifically:

Rather than the moderate dosages at varying intervals to which the psychoneurotic patient responds, the psychologically healthful diet for the schizophrenic patient early in treatment is usually minimal dosages of communication at relatively long intervals. (p. 107)

Spotnitz and Meadow (1995) further advise:

By not providing the patient with excessive communication, the analyst can maintain the ego-syntonic environment necessary to master his patient's destructive impulses. (p. 59)

There were long periods of time when Gene and I were quiet together; our silence was broken only with an occasional question. We became sleepy together; we shared very little feeling. Frequently, we seemed to lose touch with reality

together. I wondered if I would have seizures like Gene. I experienced physical sensations that aroused a great deal of anxiety about this possibility. During these early days, I often sat with Gene in a darkened room. I could see him only dimly as he slept, mumbled, or talked. Each time, as the session concluded, I realized the room had not darkened; it was my vision that had dimmed.

During this initial phase of treatment, I often felt as though I was in the presence of an infant. Spotnitz and Meadow identify this as a regression characteristic of a narcissistic patient.

In a regression to this emotional level of development predating language, the patient's communications return to the timeless world of infancy with its lack of temporal and spatial continuity and the inability to predict or anticipate events. When regressed, the narcissistic person does not seem to distinguish between inner and outer reality. (p. 57)

Gene slept, he mumbled; he couldn't express his feelings in words. I sat wishing I could understand better, resisting the impulse to hold and pat him, and thinking of lullabies. The lullabies that came to mind while he was sleeping often contained some reference to violence, such as "Rockabye Baby," with its the "down will come baby, cradle and all." Echoes of the violence done to him as an infant?

What was happening during this phase of the treatment? Allan Schore (2011) would suggest there was a great deal of nonverbal communication occurring in addition to the infrequent attempts at verbal communication. Schore quotes Chused (2007) to explain the efficacy of nonverbal, implicit communications.

It is not that the information they contain cannot be verbalized, only that sometimes only a nonverbal approach can deliver the information in a way it can be used, particularly when there is no conscious awareness of the underlying concerns involved. (Schore, p. 82, Chused, p. 879)

Schore describes the mechanics of this kind of communication:

Within the therapeutic dyad not left-brain explicit patient-therapist discourse but right-brain implicit nonverbal affect-laden communication directly represents the attachment dynamic. Just as the left brain communicates its states to other left brains via conscious linguistic behaviors, so the right nonverbally communicates its unconscious states to other right brains that are tuned to receive these communications. (p. 82)

The period dominated by nonverbal communication lasted for months. I wondered whether we would ever emerge from the semi-darkness. However, as happens with an infant, the long stretches of sleeping seemed to serve a purpose. There did seem to be nonverbal communication which eventually produced an

effect. Gradually, Gene began to stay awake for longer periods; he began talking about feelings during his wakeful periods. He reported that he was happy living with his current home providers. This was the first reference to any feeling and certainly the first indication that he was happy about anything. We were moving into a new phase. Harold Searles (1986) describes a symbiotic transference state akin to my experience with Gene.

So much of the borderline patient's ego-functioning is at a symbiotic, pre-individuation level that, very frequently, it is the analyst who, through his own relatively ready access to his own unconscious experiences, is first able to feel in awareness, and conceptualize and verbally articulate, the patient's still-unconscious conflicts. Though these conflicts inherently "belong" to the patient, they can come to be known to and integrated by him only through his identification with the analyst into whom they have been able to flow, as it were, through the liquidly symbiotic transference. (p. 191)

Prior to the advent of more wakeful time on Gene's part, I began to experience more feelings as I sat with "sleeping baby Gene." Initially, I felt very little. I was often aware of sadness or mild annoyance. Occasionally boredom. Now I experienced sadness, grief, rage, boredom, affection, and sometimes a deep desire to be rid of Gene. This foreshadowed an increase in Gene's ability to express his

feelings. As he awakened more often, I began to hear about wishes, longing, and fantasies. An example of such a session:

P: I met a friend today. Crystal.

A: Where did you meet her?

P: At the bowling alley. She went to my school. . . . She graduated the same time as me. She was three years older . . . she knows me. If I went to live with Crystal, she would know how to treat me. She would make me calm.

She would keep me from getting wound up and I wouldn't have seizures. . . . She would help me stay calm and take good care of me. And she would tell her husband about me because she knows me. She remembers me from high school. She knows how I am.

He exhibited more feeling in this session and subsequent sessions as he talked more. In the session quoted above, Gene's longing was palpable. He appeared to be on the verge of tears. What Gene could previously communicate only nonverbally, right brain to right brain, he now began to communicate in words. As he shared more of his inner life, Gene's verbal ability improved. He spoke in complete sentences more often, he used more sophisticated vocabulary, and his narrative contained clear language and recognizable meaning more of the time.

Though he began to bring more feeling into the room, Gene was still resistant to experiencing a full range of feeling. As Searles stated, through the connection

afforded by a symbiotic transference I was made aware of the deeper feelings that Gene was not ready to experience. He demonstrated his resistance to feeling with repetitive talk and actions. In the therapy room, his repetition was confined to talk. He repeated in several ways. The first was literal. He spoke in sentence fragments filled with repetition. His language regressed at these times. An example of this kind of repetition from session number five:

Not get worked up . . . worked up . . . about seeing my friend
. . . friend Pam. Not get worked up . . . before seeing her . . . before
I visit her. Don't think about . . . things in my mind. Things that
happened a long time ago. Forget about what happened . . . at
Angie's . . . before I visit her. About Rudy putting ice down my back.
Seizures do happen and I'm not to blame. I called my father . . . he
said that. I'm not to blame.

The second form of verbal repetition was his choice of topic. The content of his sessions was repeated endlessly. A single incident might be told and retold during one session as well as from week to week. The occurrence mentioned in session five that involved an acquaintance putting ice down Gene's neck, was part of Gene's discourse for many sessions. The third form, the themes of danger, containment, and deprivation, was ever present in the session. There were hidden messages in Gene's discourse, but there remained a lack of feeling.

Regarding this lack, Gill (1994) would remind us of Freud's thoughts concerning the relationship of resistance and repetition. He postulates,

Freud's emphasis that the purpose of resistance is to prevent remembering can obscure his point that resistance shows itself primarily by repetition, whether inside or outside the analytic situation. (p. 116)

What was Gene resisting?

As Gene began to reveal more about his childhood trauma, the feelings remained absent. He was able to describe what he had apparently been told about the cause of his physical handicaps, but he seemed to have no real understanding or feeling about the fact that it was his mother who damaged him. The details of the incident changed each time he told the story. Gene reported in a monotone,

My mother. She threw me. She dropped me down the stairs by accident and broke the chemical in my brain. She didn't like. . . . I was crying like a baby. So she dropped me down the stairs. She didn't want me then. She dropped me.

Gene had been too young to understand the implications of the trauma suffered at the hands of his mother. He had sustained severe physical injury deliberately caused by his mother, the very person who should have protected him. At the time, this childhood event was beyond Gene's capacity to understand. Now, he seemed to be attempting to engage with it. He repeatedly brought this event into

the session. The repetition was symbolic of an inner conflict: to surrender and allow the arousal of feelings which could overwhelm his psyche or to resist knowing and repress the emotions surrounding his knowledge of the traumatic event.

Although he could not allow those feelings to surface, Gene was progressing in communication. His greater facility with language coincided with the initiation of talk about seizures and disability. He was able to discuss his abilities and limitations:

Sweep, mop, do the toilets. But slowly. I can't be on my own. Because of disability—brain damage. I can't learn very well. Some things, some subjects I can learn, but I can't think fast. I think slowly.

During this same session, Gene described his perception of childhood events:

P: I woke up with two visions.

A: Two visions?

P: Yes. Then one vision stopped working. This one. (He pointed to his left side.)

A: What happened?

P: The electricity in the brain shut off on one side. It happened when I was five years old. On June 8, 1977, I woke up with one vision. From brain damage. But it can go back on.

(I felt a surge of hope. His or mine?)

P: When I exercise it starts up again and swirls around in here.
(Pointing to his forehead.) It mixes all up. When it mixes up I might have a seizure.

A: What happens?

P: I fall down. On the floor. Like a baby. I go blind and can't see for a while. Then I crawl around.

A: On the floor?

P: On the floor. I crawl around like a baby. And after I crawl for a while, I can walk like a grown man. That's what happened when I was a kid. I crawled around the stairs and through the hall into the kitchen. I wanted to grow up and walk like a man, but it didn't work out so well.

(I was suddenly filled with hopelessness. Ours?)

A: Why not?

P: Brain damage. Disability.

As Gene continued to talk more and sleep less in sessions, his interactions indicated that a narcissistic transference was forming. Gene displayed these characteristics of this phase of the transference:

—He expressed the feeling that people could read his thoughts, and that people were talking about him.

—Psychic discomfort occasionally caused him to leave the room; he usually returned a short time later.

—He demonstrated an attitude of extreme suspicion, of remaining on guard in a potentially threatening environment. (Spotnitz, 1985, p. 207)

Throughout this phase of the treatment the transference of early feelings onto the therapist was promoted by exhibiting the attitude that Gene had the right to resist. His defensive patterns were respected and only treatment-destructive resistance was addressed. Spotnitz refers to this transfer of early feelings as “objectification of the ego” (p. 206).

The purpose of the process known as objectification of the ego is to allow the patient to project his own feelings onto the analyst. This eventually allows reconstruction of the relationship between the patient and his primary objects. As Spotnitz describes the process, “In short, the process of objectification of the ego helps the patient to relate verbally to the analyst as an object like the ego, someone the patient can hate and love as he hates and loves himself.” (author’s emphasis) (p. 207)

The specific purposes that were kept in mind during this process were:

1. To permit any attitude expressed by the patient to stand uncorrected.
2. To encourage the patient to verbalize his perceptions of external reality instead of concentrating on what he thinks and feels about himself and his ego.
3. To take pressure off the ego as much as possible and shift it to the object.

(Spotnitz, pp. 206, 207)

As we worked together, and I learned more about Gene's patterns of resistance, he expressed a greater variety of feelings in our sessions. However, anger had not entered the room; I needed to find a safe way to help him bring anger and frustration into the session. I had an opportunity to do so during session #303. When Gene arrived for his appointment that day, I could hear him in the waiting room before I opened the door. He was yelling. I invited him in, suggesting that he tell me what he was yelling about.

From session #303:

He entered the treatment room, took the couch and started yelling about his anger.

P: That Luke is a trouble maker! I don't want him for a case manager any more.

A: What did he do now?

P: Moved me from the Herald Apartments. To Angie's. There's an alert there. There wasn't one before.

He talked about the alert for a minute, then his talk degenerated into mumbling and I could only catch an individual word intermittently. Finally, I asked a question.

A: There's an alert?

P: Yes. JR put it there. They didn't have one before. I'm going to do damage to it. I'm going to do damage to Angie's house.

A: You are really mad!

P: Yes, I'm mad. Angie did something wrong to me. I can't be around by her. I'll do damage to her house like at the Herald Apartments.

A: What did Angie do wrong?

P: She triggered me. I'm going to trigger her. Make her head stop working right. I'll do that to her. And I'm going to get into a fight with the police. I'll fight them. With the Greene County Sheriff and the Middletown police. I'm going to Greene County Court.

A: What will happen there?

P: Get admitted.

A: Get admitted?

P: To a nursing home. They'll admit me. I'll fight with the judge. And the governor. I'll start a fight with him. They don't know about me. Greene Valley Human Services. I'm not having them any more. I'll get a new legal guardian. Kris can be my guardian. They don't know about me. About what my mother did wrong. She threw me against the wall. She threw me. Against the wall. She didn't put me in the crib she threw me. She hurt me.

From my notes for session #303:

In spite of the angry feelings which he expressed, Gene did not recognize what he was able to do differently in this session. At the end of the session, he burst out, "I don't know what my feelings are! I don't know how to tell them." This was surprising because he had done a good job talking and bringing his feelings into the room today. Even so, he did seem somewhat agitated at the end of the session in spite of the talking. Perhaps Gene recognized that he had not discharged enough of the anger he was feeling.

Gene brought more feeling to the session quoted above, but he had not directed it at me. That was also about to change.

I knew that it was important to observe Gene's anxiety level and to carefully gauge the level of stimulation appropriate for him during each session. He needed enough stimulation to continue progressing in his ability to communicate in words. Too much stimulation could provoke action in the session. This remained an important factor to keep in mind throughout the treatment. Below is an excerpt from a session when I misjudged Gene's capacity for frustration. My intervention prompted him to leave the therapy room.

Session #305

Before I opened the door to the waiting room, I could hear Gene speaking with John. He mentioned 5:30. I wondered if he remembered that I leave the office at 5:30. I wondered if he planned to ask me to drive him to his father's house as he had last week. I was anxious about this possibility. When I opened the door, Gene came into the treatment room and took the couch without looking at me. He immediately began talking about the agency and what they did wrong.

P: I need to get admitted. Not going back . . . that's not the place for me. I can't be there. Angie did something wrong to me. The state shouldn't move me back in there. . . . I shouldn't be there. I got caught by the police. The agency made me do something wrong.

A: They made you?

P: Yes. To the neighbor and his girlfriend. Secret acts. They were doing secret acts on me. I was doing sexual acts on them. . . . I need to be admitted. Only the doctors can approve that. Not the court. I'm not going back there. I need to go to Dad's. That's where I belong. At Dad's. And then I'll get admitted. The doctor will admit me then and put me in a wheelchair.

A: Which doctor?

P: Dr. Thomas. He knows about the medication. To lower it down. And Dad can't do that. My grandparents told Dad he made a mistake. That he shouldn't do that. He did something wrong to me when my mother threw me across the wall.

A; He got rid of you.

P: Brain damage. I have brain damage. Epilepsy. Brain damage and tumors. That's what causes epilepsy. But my grandparents got old. They got cancer. . . my grandpa was stronger. He lived longer. He was stronger. Dad is strong. And Carol is stronger. She doesn't have gray hair yet. Not too much. Dad does.

A: Like me.

P: Yes. You're getting old. . . . Carol does have some. She's getting old. She's too old to have any more babies. So I can't do it to her. Can't get her pregnant. . . . I got you pregnant.

A: When did that happen?

P: In school. You did sex on me.

A: I did?

P: Yes. And I fell down. Grand mal. You did sex on me. And two other students. I fell down. Sex acts.

A: What was it like?

P: Going dead. Going dead. I was on the floor. I got triggered. When I do it, I get triggered. Bad spells. That's why I have to go to Dad's. I told them . . . I'm quitting. Not going there any more. Not coming here.

A: Should I get rid of you?

P: NO. I'm getting rid of you. You're fired.

(He was getting up off the couch, having no trouble sitting up or standing from the couch. This was different from the usual way he gets up.)

P: I'm not coming any more. I'm tired of these solutions! I'm not going to see you any more. I'm quitting. . . . I'm going to Dad's. I'm not coming back here! (All of this in a loud, angry tone.)

He left the treatment room. I closed the door, feeling extremely agitated. I paced the treatment room for a few moments to help dissipate the tension in my body. Finally, I decided I could check to see if Gene was in the waiting room. He was. I joined him. There was no one else there. I asked, "Has John come back?"

P: No.

A: Would you like to come back in? (It was not yet time for the end of the session.)

P: No.

A: Should I sit here with you while you wait for John?

P: Okay.

In a few moments, he began to talk. He talked about going to his father's house, about getting admitted, about having sex in my classroom, and about secret acts. He used most of the remainder of the session during this conversation. As he talked, he looked me in the eye and spoke softly and, it seemed to me, earnestly. He seemed determined to help me understand something about him in a new way.

P: I have to be admitted. No legal guardian, so I have to be admitted.

A: To the hospital?

P: Or a nursing home . . . no, the hospital. They have to take me and put the medicine down. . . . This is life and death. I'm not ready yet. Life and death. So I have to be in a wheelchair. They have to push me. I won't be able to use my legs, so I need a wheelchair. And my arms, I won't be able to use them. Or feed myself. They'll have to feed me.

His eyes were getting redder and redder. Occasionally, a tear would fall from his left eye.

A: They will have to take care of you.

P: Yes. Take care of me. I need a new home provider. . . . I need someone. Dad's getting too old. And he did secret acts on me.

A: I don't really understand what that is. Can you help me understand about secret acts?

P: Dad and Carol whispered. Dad whispered in my ear at the wedding. About what I shouldn't do. And I shouldn't say the wrong thing. At the wedding. And Carol didn't want me up to the house. And you did secret acts on me. In the classroom.

Gene was weeping openly now. Tears ran down both cheeks. He began to talk about getting admitted again. About life and death. I felt tears pricking at my eyes. I felt sadder than I had felt with Gene in a long time. I had not seen him cry before.

This session changed something important in the dynamic between Gene and me. It ushered in a period during which it was necessary to deal more often with treatment destructive resistance. Gene took more control of his attendance; instead of simply coming out of obligation or compliance with the wishes of his case manager and day workers, he began to make choices about attending. He started missing sessions or coming late. He frequently called at the last moment and

requested a phone session or announced that he would not be coming to his session that day. Often, the day worker would help him call or call for him.

On one such occasion, his day worker called to inform me that Gene would not be coming to that day's session. When I asked whether Gene would like to talk on the phone rather than miss that day's session entirely, the day worker offered that option to Gene. I could hear Gene's response in the background. He roared, "NO! I don't want to talk to that BITCH!" I wondered whether staying away from the session was Gene's way of protecting me from his rage. This strategy on his part would be characteristic of someone who relies on the narcissistic defense.

As Gene was able to exercise control over his attendance at therapy appointments, two developments occurred. First, he returned to regular attendance, rarely missing a session. Second, he seemed to regress to a time when he was a student. The feeling was "This time I will get it right. This time I will grow up without the handicaps I have suffered all my life." Gene arrived at each session with a notebook and pen in hand. Often he had written a page or two that he requested I read. After I read it, he usually elaborated on the content of the journal. Next, he alternated between writing and talking. It was almost as though I had assigned the writing. This sharing of the writing, and then talking, became the new

format for sessions. As this continued, Gene communicated more and more directly.

After a session during this period, I commented in the progress note:

During this session, Gene seemed to wish to communicate adult to adult. His speech was straightforward and earnest. There was less repetition than in other recent sessions and he seemed optimistic in some way I can't quite define. Perhaps it was the way in which he talked. I had the feeling he was working to be as clear and mature as possible. There were very few lapses into delusional thinking.

An excerpt from the session described above:

P: I'm on Medicare because of what happened to me when I was a baby. It's Dad's fault. Dad and Mom were together. Dad did something wrong to me. He verbal abused my mother. She threw me down the stairs. But it was Dad's fault. Not my fault. Dad did it. He verbal abused her. And she dropped me down the stairs. Gave me brain damage. That's why I'm handicapped. Disability. My mother threw me down the stairs. When I was just a baby.

A: She really hurt you.

P: Yes. And Dad did it, too. He verbal abused my mother. In Cornish, Maryland. I was a baby. But Dad did something wrong to me. And he didn't want me. He won't give me money now.

(I had the feeling that Dad was withdrawing from Gene and Gene was missing that contact. Gene seemed to resent Dad's lack of interest in seeing him.)

A: Has Dad given up?

P: Yes. He has. He gave up on me.

A: Why would he do that?

P: He doesn't like me. He didn't like me when I was a child.

A: Why wouldn't he like you?

P: Because I was being negative.

A: How were you being negative?

P: I wasn't growing up to be an adult. I wanted my mommy. "I want my mommy, mommy, mommy. Mommy. I want my mommy." (He said this in a high voice.) That's what I said when I was just a kid.

Following the onset of this new phase of the treatment, the atmosphere in the room was often one of mutual exploration. At other times, I was the student studying and receiving instruction in the language of Gene's inner world. He was attempting to teach me. As he did so, he also worked to complete a piece of writing he seemed to regard as assigned by me because it was essential to our work. There remained moments of isolation, times when I was alone in the room. These moments were usually the times when he was writing and talking simultaneously.

He seemed to be forging a new kind of connection. He could not yet express what kind of connection he desired.

Discussion

Working with Gene was not easy. There were times when the countertransference feelings were almost intolerable. Gene had difficulty tolerating feelings as well. As a result, a great deal of our early communication took place on a less-than-conscious level. As I became more aware, more emotionally attuned to Gene, and more able to tolerate feelings, I experienced a greater range of thoughts, emotions, and impulses. Upon reflection, many of them could be attributed to Gene.

There was a session fairly early in the treatment that helped me appreciate the intensity of the emotional roller coaster Gene endured every day. It was a session in which Gene demonstrated how precarious his grip on reality could be. That his impulsive behavior was often driven by anxiety became apparent to me only after an induction propelled me into action: On that day, Gene was late. When he finally arrived, it was immediately obvious that he was worried. He began talking; the story poured out. There had been a car problem. Now he was unsure who would pick him up and when he should expect them. As he explained, I began to feel

panicked. Questions raced through my mind. “What if no one came for him? Could he sit in the waiting room until someone arrived? Did they know he wasn’t sure how he would get home? Who should we call?” It seemed imperative that we make a call immediately. We did so well before the end of the session. After Gene made his telephone call, after the session ended and after he left my office, I learned that he was picked up promptly, right after the session, by his home provider. The call we felt compelled to make from my office had been made appropriately, earlier in the day, and the arrangements for his ride had been explained to him.

Reflecting on the events and emotions of this session, I began to comprehend the tremendous amount of anxiety that perpetually filled Gene’s mind. He could not sit through our session that day without acting on it. This was conveyed to me in a form that was raw and urgent enough for me to glimpse what he lived with constantly. Gene’s communication needed to take the form it did because he did not have the words to adequately express his thoughts and feelings. He found the most effective mode of delivery for his message. Chused (2007) would remind us that this mode of delivery ensured that the information conveyed could be used. Experiencing the intensity of Gene’s anxiety myself allowed me to understand more fully what he experienced.

The increase in my ability to tolerate countertransference feelings was important to the treatment. As Gabbard (1991) and Carpy (1989) remind us, “the tolerating of intense feelings in and of itself may produce change in the patient.” (Gabbard, p. 633) Initially, as my tolerance increased, I gradually became more aware of a greater range of countertransference feelings. As I experienced more feeling, Gene slowly began to express more feeling.

An important aspect of the transference-countertransference dynamic at this time was containment. As Gene progressed in his ability to communicate, my role was to study what he projected and to observe my own reactions. Again, Gabbard offers perspective on this process. As he notes, I spent time identifying my own internal states, attempting to diagnose Gene’s internal object relations, and finding associations among the various aspects of the dynamic in the room.

I was aware, for example, that the lullaby “Rockabye Baby,” which so frequently came to mind in the initial phase of treatment, may have been a reflection of Gene’s mother’s wish to kill him. It was not until much later, after many hours of reflection, that it occurred to me that it might also be my own wish to be rid of Gene, to murder him myself. And I spent even more hours on reflection before I wondered what part Gene had played in his mother’s attempt to murder him.

Winnicott (1949) stresses the importance of the analyst's awareness of hatred for the patient. Without an awareness of her own hate, the analyst cannot choose to, or find ways to, use the feeling appropriately. Gabbard (1991) reminds us that the danger of retaliation or withdrawal exists when hate is not managed properly by the analyst.

My awareness of hate was important in Gene's treatment for a number of reasons. Two of them are discussed here. First, I represented his mother, who demonstrated her hatred for him with disastrous results. Second, if there was no awareness and therefore no containment of hatred in the dynamic between us, there could be no love in our relationship. Winnicott speaks to this:

Would it not follow that if a psychotic is in a "coincident love-hate" state of feeling he experiences a deep conviction that the analyst is also only capable of the same crude and dangerous state of coincident love-hate relationship? Should the analyst show love he will surely at the same moment kill the patient.
(p. 70)

The last statement was surely true for Gene. He expressed the fear of connection and love in many ways. Eventually, he could put this fear into words. He insisted that the agency which assisted him with transportation, housing, and daily living activities was wrong in their approach. He stated that they should not offer "seizure training and stop trying to get people to connect to me. Loving me." When

questioned further about this, Gene replied, "They have been trying to get people to connect to me. They have to stop. They're trying to get my home providers to connect to me. They can't do that." He elaborated, explaining that it would cause him to have seizures if people continued to love him, to try to connect to him. He commented that one of his high school teachers had understood what was needed. Mr. Butler had instructed the other students not to pay attention to Gene.

Clearly, connection was dangerous. The connection with his mother had nearly killed Gene. Other relationships had ended in abandonment. When Gene's father remarried, he moved out of the family home where he lived with Gene and his brother. He left Gene to be raised by his grandparents. When Gene's grandmother became ill, his grandfather decided they could no longer care for Gene. A social services agency was contracted to find an adult foster home for Gene. After leaving his grandparents' home, he lived in four adult home care situations. Three of them were families. All three of them eventually abandoned Gene. Connection came to mean loss.

Gene feared and avoided connection; he also longed for love and connection. Initially, he could not express this desire. Later I began to hear about the love he felt and wished for in return. He spoke of Angie, a young woman who shared her home

with Gene for several years. Below is an excerpt from the notes taken following a session in which Gene expressed his longing.

Gene talked about Angie again, about wanting to live with her. He said that she could have a job. He could stay alone until she got home to fix dinner for him. He said that he couldn't have sex with her because she couldn't have any more children. At age 42, she was too old. He said he wanted to be with her. Near the end of the session, Gene burst out, "I loved Angie so **very** much!"

I replied, "Yes, you did." This produced a long silence. When he did not speak, I intervened, "I think you still do."

"Yes, I do. I love her. I wish I could be with her. She would have to get rid of JR. And stop talking about the past. She would have to think about the future."

In a later session Gene declared his love for me, "I get triggered when I think about you. About that I'm in love with you. I'm in love with you."

Though there was more feeling in the room and greater expression of the longing which Gene usually kept hidden, the objects of Gene's longing were just that. Objects. They were objects, not subjects. Gene did not perceive them as separate individuals with their own thoughts and feelings. Ogden (1991) refers to this as the paranoid-schizoid mode. He describes the paranoid-schizoid position:

In a paranoid-schizoid mode, the individual has achieved only a rudimentary sense of himself as an interpreting subject and, therefore, the other is similarly experienced as an object as opposed to a subject. Consequently, there is little capacity for concern for the other. (p. 595)

In the session just quoted, Gene spoke wistfully of loving Angie. On other occasions, he ranted about her wrongdoing. In his mind, she was either the good mother or the bad mother. There was no middle ground. Ogden explains that this kind of splitting is typical of the paranoid-schizoid mode.

Over time, it became even more evident that aspects of Gene's way of being in the world were characteristic of the paranoid-schizoid position. Ogden states that it is a "relatively ahistorical experiential state since the use of splitting renders one's experience of oneself (in relation to one's objects) discontinuous." (p. 595) This encourages a continual rewriting of personal history as well as a sense of self and other that constantly shifts. Gene's account of his mother's murderous rage, which left him disabled, changed from one telling to the next. Sometimes he reported she dropped him down the stairs and it was an accident. Other times he stated she threw him down the stairs. On rare occasions he told the story of a deliberate attempt to harm him by throwing him against the wall. Eventually, he revised this tale in a new way. His father was to blame because he "verbal abused" Gene's mother.

Ogden elaborates on the paranoid-schizoid position in his explanation that an absence of the sense that one's experiences can be thought about leads to psychological defense which "tends to be enactive and evacuative in nature." (p. 595) Gene's behavior was often impulsive, explosive, and seemingly designed to discharge intense feeling.

Conclusion

Though he did not often regard his objects as subjects, Gene progressed during our work together. At the time of our initial appointments, Gene operated largely in what Ogden would term the autistic-contiguous realm. His interactions with the world were sensory and based on imitation. Later in the treatment, his mode of operation most often resembled the paranoid-schizoid position. Others were objects. They were either good or bad depending on his perception of how they treated him. He began to view himself as a person with thoughts, motivation, and responsibility for actions, but only in the most rudimentary ways. His notion of occurrences in his past changed from moment to moment.

Although the paranoid-schizoid position does not allow for guilt or remorse since others are not valued or even perceived as thinking beings, there were momentary glimpses of the possibility of concern for another and remorse when he

behaved in ways that caused harm to others. As Gene's language became less primitive, he displayed more emotional maturity.

As the nature of Gene's inner world changed, there were comparable changes in the countertransference. Initially, I experienced feelings that were limited, amorphous, and difficult to categorize as subjective or objective. Later, I developed a greater awareness of the feelings in the room, my own as well as Gene's. I could more often attribute them with some confidence to Gene or claim them as feelings I brought to the session. I experienced a bit of the rage and frustration Gene's mother may have felt as she handled him during the first weeks of his life. The ability to tolerate intense feelings, particularly fear and rage, continued to be an important area for my focus as the analyst. While Gene resisted tapping the well of rage that surely existed within him, I had to be willing to follow when he was ready to do so. As Winnicott suggests, "If we are to become the analysts of psychotic patients we must have reached down to very primitive things in ourselves" (p. 70).

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