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The negative therapeutic reaction in contemporary psychoanalytic psychotherapy.

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THE NEGATIVE THERAPEUTIC REACTION IN CONTEMPORARY PSYCHOANALYTIC PSYCHOTHERAPY

A Dissertation Presented

by

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allowed me to witness the internal struggles that accompany being in relationships with patients who form negative therapeutic reactions. From these interviews I learned a great deal about this topic. More importantly, I was able to learn how these respected practitioners think and feel about the work they do. My hope is that I can pass on a portion of the goodness I observed in these therapists to the patients I will encounter during my career.

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ABSTRACT

THE NEGATIVE THERAPEUTIC REACTION
IN CONTEMPORARY PSYCHOANALYTIC PSYCHOTHERAPY

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The treatment impasse situation known as the negative therapeutic reaction (NTR) has been studied by analytically oriented psychotherapists since Freud. At foundation, the NTR refers to a patient's worsened condition following improvement. Since it appears to contradict many of the basic tenets of analytic theory, such as the curative effect of correct interpretation, the NTR has remained a baffling event to therapists and their patients. Its paradoxical nature mainly derives from the patient's seeming insistence on remaining ill precisely because recovery is experienced.

Many explanations for the emergence of the NTR have been proposed. These include: an unconscious sense of guilt, a need for punishment, envy, pathological narcissism, an attachment to pain, sadomasochism, and preoedipal separation issues. While the earliest examinations of the NTR invoke intrapsychically based explanations, most of the current examinations underscore the interplay between the intrapsychic and the interpersonal. As such,

countertransference phenomena are considered as important as transference phenomena.

The goal of this study was to find out what and how psychoanalytically oriented therapists experience and make sense of the NTR situation with their patients. This work grew out of the belief that the NTR is an increasingly common event in therapy today, given the field's expanded work with patients suffering from severe character disorders.

Using a semi-structered interview lasting up to four hours yielded fifteen NTR cases for analysis. Subjects included experienced psychotherapists, more than half of whom had received formal psychoanalytic training. Methodologically, the interviews were structured so as to discover the meanings derived by the therapists and their patients; significantly less attention was paid to theoretically imposed considerations.

The results are reported in narrative form. Five lengthy cases are presented first.. This is followed by summaries of the other ten cases. Then, the most prominent themes and images are discussed.

These results are analyzed from the viewpoint that psychoanalytic knowledge is primarily concerned with deriving meaning as opposed to causal understanding. Issues regarding "narrative smoothing" and the role of theory in psychotherapeutic practice are applied to the results. With

the discussion of these issues as the context, recommendations are suggested for further research.

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CHAPTER I

INTRODUCTION

Throughout his career, Freud insisted that we view the emergence of clinical obstacles as indicating the need to reassess our theories and modify our practices. In his later years, Freud's attention was increasingly drawn to what obstructs life affirming change, and less so to how such change is brought about. In 1937, Freud advised others to follow his lead: "Instead of inquiry into how a cure by analysis comes about (a matter which I think has been sufficiently elucidated) the question should be asked of what are the obstacles that stand in the way of such a cure" (p. 221). Though Freud was amiss in contending that we know enough about how such change occurs, he was correct in cautioning future practitioners of the need to further study the kinds of treatment situations which result in impasse or failure. The field's growing interest over the last 30 years in treating severe character disorders underscores this continuing need. Within this context, the present project is aimed at the further study of one such category of treatment breakdown.

This study concerns the impasse situation known as the negative therapeutic reaction (NTR)[1]. Originally named by Freud in 1923, the NTR refers to a patient's worsened condition following improvement. Since it appears to contradict many of the basic tenets of analytic theory, such

as the curative effect of correct interpretation[2], the NTR has remained a baffling event to therapists. Its paradoxical nature derives mainly from the patient's seeming insistence on remaining ill precisely because the possibility of recovery is experienced.

Freud initially described the NTR following his work with the patient known as "The Wolfman" (Freud, 1918). Freud noted that the patient had a "habit of producing transitory 'negative reactions'; every time something had been conclusively cleared up, he attempted to contradict the effect for a short while by an aggravation of the symptom which had been cleared up" (p. 69). At the time, Freud compared this reaction to the tendency in children to respond negativistically to prohibitions when they are first invoked.

Five years later, in "The Ego and the Id" (1923), Freud raised these negative reactions - when they are sustained and refractory - to the level of a recognizable syndrome. He wrote:

> Every partial solution that ought to result, and in other people does result, in an improvement or temporary suspension of symptoms produces in them for the time being an exacerbation of their illness; they get worse during the treatment instead of getting better. They exhibit what is known as the 'negative therapeutic reaction.' There is no doubt that there is something in these people that sets itself against their recovery, and its approach is dreaded as though it were a danger. We are accustomed to say that the need for illness has got the upper hand in them over the desire for recovery. (p. 49)

At this point in his thinking, Freud attributed this reaction to a "moral factor, a sense of guilt, which is finding satisfaction in the illness and refuses to give up the punishment of suffering" (p. 49).

In the following year, Freud described the NTR as "one of the most serious resistances and the greatest danger " (p.166) to successful treatment. The sense of guilt is solely an unconscious one, which is manifested by "a need for punishment" (1924, p.166). Freud stated:

> The satisfaction of this unconscious sense of guilt is perhaps the most powerful bastion in the subject's (usually composite) gain from illness - in the sum of forces which struggle against his recovery and refuse to surrender his state of illness. ... It is instructive, too, to find, contrary to all theory and expectation, that a neurosis which has defied every therapeutic effort may vanish if the subject becomes involved in the misery of an unhappy marriage, or loses all his money, or develops an organic disease. In such instances one form of suffering has been replaced by another; and we see that all that mattered was that it should be possible to maintain a certain amount of suffering. (p.166)

Freud's last writing (1937) on this topic is extremely pessimistic. He believed the NTR, along with the related dynamics pertaining to masochism and the sense of guilt, demonstrated:

> unremarkable indications of the presence of a power in mental life which we call the instinct of aggression or of destruction according to its aims, and which we trace back to the original death instinct of living matter. It is not a question of antithesis between an optimistic and a pessimistic theory of life. Only by the concurrent or mutually opposing action of

> the two primal instincts - Eros and the death instinct - never by one or the other alone, can we explain the rich multiplicity of the phenomena of life. ... For the moment we must bow to the superiority of the forces against which we see our efforts come to nothing. (p. 243.)

Freud believed the NTR could not be resolved. The NTR, Freud thought, established the boundary around the ability of psychoanalysis to be curative. However, a year before Freud made this pronouncement, two articles appeared, one by Horney and one by Riviere, which offered a decidedly optimistic prognosis. Indeed, most of the literature on the NTR after Freud portrays the reaction as amenable to change.

In the chapters to follow, explanations of the NTR, in addition to technical approaches, will be explored. This will be done in conjunction with the results of a study I recently completed.

In this study, 15 interviews with therapists were conducted concerning their experiences in treating patients who formed NTRs. In setting up these interviews, a great deal of attention was paid to distinguishing NTRs from other types of difficulties that arise in treatment, such as those caused by unplanned termination or therapist error.

I want to point out from the outset that though the NTR reflects the patient's intrapsychic difficulties, the meaning of the NTR manifests itself in the interpersonal realm of a dyadic relationship. In this paper, it is assumed that the intrapsychic is a viable concept because it connotes what is built up out of prior internalizations of

object related experiences. As such, the keys to understanding how to disentangle the NTR must be sought in the dialogue between the study of individual psychopathology and the study of interpersonal dynamics. In this sense, it is appropriate to think of the NTR as a negative therapeutic interaction. That is, that the NTR emerges in a dyadic context.

My understanding of what constitutes a NTR excludes treatment impasses that result primarily because of technical errors or countertransference "blind spots." Such errors and neurotic contributions of the therapist undoubtedly confuse a clear apprehension of what brings about a NTR. Therefore, a thorough examination of the possible contaminating influences by the therapist must be completed before considering whether a particular treatment impasse is a NTR.

Such a warning is not intended to mean that countertransference reactions are to be considered as impediments to the therapeutic process. In fact, the opposite attitude - one in which the therapist openly (and painstakingly) examines his countertransference - is necessary for the intersubjective act of knowing characteristic of psychoanalytic psychotherapy.

As we will see, the therapist's countertransference experience is often the most viable "locale" for disentangling the counterproductive web of resistance which is the NTR. Put another way, I believe that often, what a

patient is resisting (such as his sadistic wishes or his wish to be punished), ends up being experienced by the therapist via projective relatedness. While this is a metaphoric way of addressing what are in reality nonreified processes, I believe this is a phenomenologically worthwhile way of approaching the dynamics under discussion.

Borrowing from Bollas' (1981) poetic exploration on the expressive uses of countertransference, I think that it is useful to conceive of the therapist as developing a psychic place within his own ego where the patient can now be said to temporarily exist. Again, seeing this as a metaphoric construction is helpful: if we accept (as I do) that humans are capable, experientially, of putting parts of themselves onto and into others, then it follows that we are also capable of containing (and capable of inviting) disavowed aspects of others in ourselves. This containing function establishes a temporarily created object in the therapist. The newly created object can then be a focus of examination for the therapist: He explores his reactions, judgements, and wishes regarding this "part" of himself and in that effort, arrives at new understandings of his patient. Such a process is akin to what has been described as the self-observing capacity of the ego. Ultimately the use of this capacity on the therapist's part requires apprehending what is "of him" and what is "foreign."

While focusing on the NTR, a number of other topics are introduced in order to clarify the meaning of the dynamics

experienced by the therapeutic dyad. These topics include: 1) sadomasochistic character structure, 2) the attachment to pain, 3) envy, 4) guilt, especially in regards to Freud's notion of "unconscious" guilt, and 5) issues related to separation and individuation. Further, I want to point out that these topics, as they inform the development of a NTR, do not exist in isolated form. Rather they exist in mutually influential ways. This will be borne out in the remainder of this manuscript.

The next chapter reviews the literature on the NTR. Chapter III then details the methodology I used to further study this topic. The fourth chapter contains the results of the interviews conducted. This chapter includes four sections. The first section provides data about the therapists who participated in the study. The second section presents five cases in-depth. The third section summarizes all the cases. The fourth section presents some of the most prominent themes and images conveyed in the interviews. The fifth and final chapter presents my conclusions on both the study I conducted and on the concept of the NTR, as it is used in psychoanalytic theory.

NOTES

1. The convention introduced by Asch (1976) of referring to the negative therapeutic reaction by employing the abbreviation "NTR" will be used in this manuscript for the sake of brevity and stylistic ease.

2. By "correct interpretation," I am following Valenstein's (1973) definition. He defines this phrase as "appropriate interventions of an explanatory nature which in timing, form, and specificity seem correct in the context of the analytic data as they have been evolving--and presumably would have been so in the case of a 'good' neurotic patient; that is to say, a patient who is capable of substantive recognitions and responses to the content and transference context of the interpretations, who establishes a well-defined transference neurosis, but who is reasonably consistent in grasping what originates from within and what from without, what is fantasy and what is real, what is past and what is present.

CHAPTER II

REVIEW OF THE LITERATURE

In this chapter, I will review the literature on the NTR. This review will be examined around four topics: 1) inclusion/exclusion criteria for the NTR, 2) overt behaviors demonstrated by the patient who forms a NTR, 3) dynamic explanations given for why the NTR occurs, and 4) technical suggestions advanced as capable of resolving NTRs. First, a few remarks about what is encompassed in these four topics.

The first area requiring attention regards the inclusion/exclusion criteria for the NTR syndrome. As mentioned earlier, therapist induced errors are considered as exclusions; when such errors are discovered they first must be worked through before the question of the NTR should be raised. Yet there is more to the debate about what is a true NTR. Some authors (Sandler, et al, 1973; Langs, 1976; Arlow, reported in Olinick, 1970) hold to Freud's original criteria that the patient's symptoms increase after a correct interpretation has brought about a decrease in suffering. These authors advocate that a broadening of what the NTR connotes waters down the significance of Freud's findings. Other writers (Limentani, 1981; Gorney, 1975; Olinick, 1970; Asch, 1976) contend that post-Freudian elaborations of preoedipally based difficulties necessarily leads to clinically useful ways of enlarging the definition of the NTR. These writers contend that it is necessary to

understand the patient's experience of the therapeutic relationship if the therapist is to make sense of the patient's NTR. This debate regarding what is a "true" NTR and what are considered by some as indicative of other types of resistance will be examined throughout this chapter.

The second way I am examining the literature is by teasing out the overt behaviors described in the reports on NTR patients. In doing this, I will look at what the patient and therapist say to each other, what they feel and think about the relationship, rather than the therapist's theories explaining such behavior. Unfortunately, the literature on the NTR typically includes little about what actually went on between the patient and the therapist, relegating this data to a subordinate position to theory. I believe the NTR is most clinically useful when we gain an appreciation of the myriad of dynamics involved. Put another way, the meaningfulness of the NTR designation derives from the relationships between the many symptoms and defenses characteristic of the patient's personality (and enacted in the therapeutic relationship), rather than viewing it as based on constitutional aggression or an expression of the death instinct. I have found that the best way to approach this richness is through an examination of cases. Indeed, this conclusion played a large part in pursuing the study I will report on in the next three chapters.

Theory, however, can not be entirely overlooked, especially in a field that relies on theory as much as psychoanalysis. Therefore, the third way I am examining the literature pertains to the theories proposed about what causes a NTR in treatment. In this, I will visit the theories proposed by such disparate thinkers as Freud, Klein, Valenstein, Rosenfeld, Asch, Olinick, and Kernberg. While I intend to highlight the discrepancies between these theories, I am just as much interested in locating the similarities among explanations. I believe, that because of the political maneuvering that has characterized psychoanalysis since Freud's disappointment with Jung and Adler, differences in perspective have been exaggerated past the point of reality. If the reader takes on the literature, without prior affiliation to one school of thought (or, for instance, without a prior attachment to being seen as a "true" Freudian), then I think the reader will find that a great deal of similarity exists in the theories proposed. Unfortunately these similarities are too often obscured by differences in language and terminology. If the reader is up to translating one set of terms and concepts, judiciously, yet playfully, into other frameworks, then these common viewpoints emerge much more readily. For me, the guiding principle is that the phenomena under study--in this case, the phenomena associated with the NTR--should not be subordinated to existing concepts, but that the reverse should occur.

The fourth way I will report on the literature concerns the technical suggestions offered as ways of resolving NTRs. Here, too, I am especially interested in locating the ideas which are consistent, despite apparently different theoretical contexts. Further, I will speak to the tone of the writings reviewed, as "data" informing what constitutes the NTR. For example, I believe both Freud's (1937) pessimism and Horney's (1936) optimism reflect different aspects of the NTR experience from the therapist's perspective.

The material that make up these four criteria rarely stand alone in the way writers on the NTR present their ideas. For example, it is not uncommon that an author on the subject will put forth definitional criteria in the context of the technical suggestions: Based on how a patient reacts to a certain intervention will determine whether the patient is manifesting a NTR. In addition, many authors interweave their theoretical considerations into their discussions of criteria such that both the theory and the criteria derive much of their meaning from each other. I am framing this discussion in this way mainly for the purpose of clarity.

The review commences with a brief re-visiting of Freud's analysis of the Wolf Man. In so doing, I wish to highlight some of the patient's character traits, rather than Freud's interpretation of the case. This then will establish the kinds of issues, especially in the

interpersonal sphere, which commonly arise in the NTR. In the second section I offer a review of Horney's often overlooked contribution to the study of the NTR. Since Horney's descriptive account most clearly captures so many of the ways NTRs become enacted in the treatment situation, I will extensively review her article. In the third section I review the Kleinian contributions on the NTR. Klein and her followers highlighted the influences of the patient's envy, narcissistic functioning, and propensity to communicate via primitive modes of projective relatedness as the foundation for the NTR. I am approaching the Kleinian literature from the vantage point of what it says about the workings of inner processes, rather than as an organized theory of development. In the fourth section I report on the contributions to the literature that derive mainly from an ego-psychological perspective. A common ground for these contributions is derived from an examination of the vicissitudes of the separation-individuation phase of development (Mahler, 1968; Mahler, et al, 1975). Negativism as a defense against regressive fusion with a depressive pre-oedipal mother (Olinick, 1968), and conversely, masochistic acting-out as a defense against separation anxiety (Asch, 1976) are two ideas reviewed in this section. The apparent contradiction of these two notions suggests the complexity involved in a study on the NTR. In the fifth section of this chapter I summarize the multidetermined phenomena that comprise the NTR. In this section,

Limentani's (1981) thoughts on the anxiety which is associated with integration as opposed to disintegration will be highlighted. I believe that an appreciation of this distinction can help the therapist avoid getting caught up in the hostile attacks the patient invariably enacts in the NTR.

Freud's Analysis of The Wolf Man: Introducing The NTR

We are fortunate that it is the Wolf Man case, reported in the essay "From the history of an infantile neurosis" (Freud, 1918), which initiates the study of the NTR. There are a number of reasons why I think this is fortunate. For one, this case, more than any other, ultimately led Freud to posit the NTR as a separable clinical syndrome five years later. Two, according to many[1], this case demonstrates Freud's thinking and craft perhaps as well as any other case he wrote up for publication. The third reason that this case stands out is because the Wolf Man was subsequently followed by other psychoanalysts throughout his long life. The subsequent reports on the Wolf Man provide us the opportunity to check on Freud's interpretation of the case in a manner unique in the annals of psychoanalytic treatment. The fourth, and perhaps most important reason, is that this case established the viability of psychoanalysis in treating severe personality disorders. As Gardiner (1971) noted, the case of the Wolf Man demonstrates "for the lay person as well as the scientist" that

psychoanalysis is capable of helping the seriously disturbed person. Gardiner's book includes a chapter written by the Wolf Man. In this chapter, the Wolf Man demonstrates an almost uncanny perspicacity about psychoanalytic theory, his experience with Freud and the gains he made in his analysis[2]. Gardiner ends his preface by stating, "Thanks to his analysis, the Wolf Man was able to survive shock after shock and stress after stress - with suffering, it is true, but with more strength and resilience than one might expect[3]. The Wolf Man himself is convinced that without psychoanalysis he would have been condemned to lifelong misery" (p. vii).

Freud's record of this case begins with a detailed account of the patient's childhood. Freud initially focuses on a change that occurred in the patient following his parents' absence during a summer holiday. From a good natured, tractable, and pleasant boy, "he had become discontented, irritable, and violent, took offence on every possible occasion, and then flew into a rage and screamed like a savage" (p. 482). Soon after this change in character, the patient developed an animal phobia, which was reproduced in the famous "Wolf Dream." Following the appearance of this phobia, the patient developed an obsessional neurosis marked by extreme piety, which lasted for many years. Each night before retiring, the patient "was obliged to pray for a long time and to make an endless series of signs of the cross" (p.484). Though this neurosis

apparently abated by the time the patient was 10 years old, the patient continued to suffer, necessitating many years spent in sanatoriums.

The Wolf Man's parents were severely ill during his early years. His mother suffered from abdominal disorders, and his father suffered from attacks of depression. Often his father's illness led to long absences from home (presumably to go himself into a sanatorium). Not only was father absent a great deal, but mother herself had little to do with the patient and his sister as a consequence of her own weak health. As a result, the patient was looked after by a nurse throughout his childhood.

In one of his earliest screen-memories (age 2), the patient recalled watching his parents and sister drive off in a carriage while he remained behind with his nurse. Other memories which surfaced included his rage attacks, and the fear he suffered "which his sister exploited for the purpose of tormenting him" (p.483). This fear had to do with his reaction to a particular picture-book in which a wolf was drawn. For the patient, the wolf took on a very menacing position. Freud writes, "Whenever he caught sight of this picture he began to scream like a lunatic that he was afraid of the wolf coming and eating him up. His sister, however, always succeeded in arranging so that he was obliged to see this picture, and was delighted at his terror" (p.483.)

Freud then discusses how the patient was frightened of other animals, large and small, as well. Freud remarks on how the patient would chase butterflies, only to be seized with a terrible fear of them, before screaming and running away. Yet, Freud continues, the patient also uncovered memories of tormenting beetles and cutting caterpillars to pieces. Horses were also reacted to in this dual manner. At times, the patient would become frantic when a horse was being beaten; at other times the patient recalled how he enjoyed beating horses himself. In addition, this vacillating between identifying with the animal being beaten and identifying with the aggressor reemerged in the child's latency years.

I have mentioned the patient's obsessions about religion. In addition to his rituals of prayer and cleansing, the patient was also "obliged" to denigrate God with "blasphemous thoughts which used to come into his head like an inspiration from the devil" (p. 484). During these years the patient also recalled enacting symptoms of a magical nature so as not to become, instantaneously, a beggar or a cripple. Though Freud regards these symptoms as belonging to an obsessional neurosis, one can also see that these symptoms demonstrate the patient's difficulties with maintaining boundaries between himself and his environment. That is, one can hypothesize about the patient's inadequate development of a separate sense of self.

The last portion of the Wolf Man's analysis which I want to raise regards his relationship with his father. Freud notes that the patient's fear of his father became the dominating factor in the analysis. The patient recalled that in his early years, their relationship had been a very affectionate one. His father had been quite fond of him, and liked playing with him. Yet, toward the end of his childhood there was an estrangement between the two. Following this estrangement, in which the patient clearly believed that his sister replaced him as his father's favorite, the patient responded to father as a persecuting object. The patient recalled the many rages directed at him by his father. Freud attributes these rages to father's increasing inability to conceal the pathological features of his depressive attacks.

That the Wolf Man's sessions were dominated by his fears of his father (and one can also see the patient's own anger, disappointment and frustration at the father) with little direct material presented concerning the mother, fits closely with a hypothesis offered by Gorney (1975), that received a lot of support in the interviews I conducted. This hypothesis is that patients who are vulnerable to forming NTRs are much more aware of their upset toward father than mother. Gorney believes that while this upset is based on actual events, it's main salience resides in being a cover for the more influential pathological relatedness in the early mother-infant dyad. Since we do

not have much data about the Wolf Man's relationship to his mother (though we do know both that she spoke disparagingly of the patient in addition to having little to do with her children), it can only be speculated that this hypothesis fits for this case. Yet the patient's belief that his mother seemed uninterested in him throughout his childhood does lend itself to this view.

Without going into further details of the case, I want to underline some other aspects of the patient's history and functioning which anticipate later examinations of the NTR[4]. First, I want to raise the issue regarding diagnosis. Without being overly specific (which I believe would be more of a hindrance than a help), raising the diagnosis does point us in the direction I want to go.

It is clear that Freud struggled with the terminology that was available to him when setting forth a diagnosis. At the time, character disorders, as they are understood today, did not exist in psychoanalytic parlance[5]. As such, Freud restricted himself to the categories of neuroses. Freud does mention, however, that when the patient spent a period of time in German sanatoriums, he was classified as a case of "manic-depressive insanity" (p. 474). Freud, however, disregards this diagnosis. He does so because he never witnessed any disproportionate shifts in the patient's moods characteristic of such a diagnosis. Freud notes instead that this case is akin to others which had been labelled with "the most multifarious and shifting

diagnoses." Today, as Brandchaft (1983) suggests, the Wolf Man would be given a diagnosis in the realm of narcissistic disorders.

Other indications of the characterological (as opposed to the neurotic level) basis for the Wolf Man's condition relate to early and repeated separations from his parents, the intensity of his oral and anal conflicts, the recounting of numerous narcissistic injuries, his entrenched masochistic attitude (serving to defend against unmodulated rage and sadism), and the recovery of traumatic events which occurred during the first year and a half of the patient's life. Such issues as these are continually invoked by later accounts of the NTR.

Having established that the case of the Wolf Man is an appropriate jumping off point for a review of the literature on the NTR, I want to now turn our attention to the writings which were published after Freud had introduced the reaction as a discernible syndrome. In anticipating this material, I want to highlight one last excerpt from the Wolf Man case. In this excerpt, Freud makes one of his few remarks concerning the Wolf Man's posture in the analysis. Embedded in this remark is one of the most common aspects of the NTR. This has to do with the patient's passive defiance of the therapist:

> The patient with whom I am concerned remained for a long time unassailably entrenched behind an attitude of obliging apathy. He listened, understood, and remained unapproachable. His impeachable intelligence was, as it were, cut off from

> the instinctual forces which governed his behavior in the few relations of life that remained to him. It required a long education to induce him to take an independent share in the work; and when as a result of this exertion he began to feel relief, he immediately knocked off the work in order to avoid any further changes, and in order to remain comfortably in the situation which had thus been established. His shrinking from an independent existence was so great as to outweigh all the vexations of his illness.

Here, I am highlighting what is the most typical behavioral presentation of patients who form NTRs: They resist the efforts of the therapist to be engaged in the working relationship.

Horney's Contribution: An Early Template

An often overlooked classic on the NTR was published by Horney (1936). This paper is particularly relevant regarding the patient's overt presentation and manner of engaging the therapist during the NTR. A second contribution of this paper concerns the technical considerations that are derived. Despite being written over fifty years ago, Horney's paper continues to be the clearest examination of the ways a NTR can occur.

Horney initially focuses upon the patient's hostility toward the therapist. She views this hostility and the patient's anxiety as the two fundamental components of the NTR. Horney believes that the hostility and the anxiety are reciprocally related to each other. That is, the more the anxiety is repressed, the more the hostility will manifest

itself directly in the therapeutic relationship, and vice versa. In this regard, Horney agrees with Freud in seeing the hostility as a defense against the anxiety. But this is only true in some cases. In other cases, the hostility towards the therapist is not merely a "surface attitude, unessential by comparison with the patient's recoiling tendency" (p.42). On the contrary, both attitudes are from the same sources, inseparably entangled, and of equal importance. These sources are found in the tension between the patient's ego and superego. Like Freud, Horney notes that this tension manifests itself as an unconscious sense of guilt and need for punishment. The suffering in the neurosis, "therefore, has too valuable a function to be given up" (p. 31).

Rather than hypothesize about the etiology of a NTR, Horney attends to a description and interpretation of the phenomena as it is manifest in the therapeutic relationship. She documents five different reasons why NTRs occur. After reviewing these five reasons, Horney suggests some ways that NTRs can be predicted. She then offers some technical suggestions as to how to overcome the NTR.

Horney first presents a description of the sequence of the reaction which she considers inviolate. She writes:

> In principle, this sequence of reactions is invariably present: first, a definite relief, then a shrinking back from the prospect of improvement, discouragement, doubts, hopelessness, wishes to break off, utterances like: "I had rather stay as I am - I am too old to change" (this from a 24 year old man). "If I should be cured of my

> neurosis I could break a leg and still have something to worry about." At the same time a definite disparaging, with intense hostility. One patient of mine had to think and express one thought throughout the hour - "you are no good." The impulse to berate the analyst more often comes out indirectly: doubts of the analyst; increasing complaints with a tendency to show the analyst he is of no help - all indicating a hostility which may be so strong that if repressed it may show itself in suicidal ideas. (p.30)

Horney acknowledges her initial disbelief that the NTR emerges after a good interpretation. After repeated experiences with the reaction, however, she testifies to Freud's accuracy in seeing the reaction as a response to a good interpretation[6]. Faced with this dilemma, Horney hypothesizes that the reaction occurs in a character structure she calls masochistic. Thereafter, she sets out to document the five ways NTRs develop in treatment with masochistic patients.

The first kind of reaction occurs because the good interpretation is felt to be a stimulus to compete. It "is as if the analyst, by seeing something that had not been seen, is proved more intelligent, clearer-sighted, or more articulate than the patient - as if the analyst had asserted his superiority over the patient" (p. 32). The patient is resentful of the analyst's superiority and belittles the latter as a result. Underneath this reaction is an unconscious rage at the analyst. Horney notes that this kind of reaction is not dependent on the content of the interpretation, but on the skill in which it is offered.

The second type of reaction to a good interpretation is based on the content. In this type, the interpretation implies the exposure of some weakness; what we have come to call a "narcissistic blow." Horney adds, "The demands of these patients to be perfect, flawless, beyond reproach, are so excessive that everything that falls short of absolute admiration strikes them as humiliation" (p.35). Even if the therapist uncovers nothing more than the fact they are in a dilemma, or, that they have certain anxieties, or, that there are irrational elements in their expectations, these patients feel humiliated. Here, Horney points out that the hostility the patient experiences is due to the humiliated self-experience the patient has as part of his enduring personality.

Both kinds of reactions thus far discussed arise on the "basis of strong competitiveness" (p.36). The first reaction is a direct expression of rivalry, the second, from grandiose ideas and the need for admiration. Though she very rarely receives credit, it seems clear that later examinations of the NTR which highlight narcissistic character traits, are essentially building on the ideas spelled out by Horney.

The third kind of reaction to a good interpretation is more accurately a response to the relief that it inspires. The relief brings about, according to Horney, the realization that movement is being made toward recovery. Such a realization, or anticipation of further success, is

an ominous harbinger to the patient that he may be led out of his neurosis. This then inspires discouragement, hopelessness, and despair because success "is equal to crushing others, and maliciously triumphing over the crushed adversaries" (p. 37). The patient's internal logic, Horney contends, might be phrased, "If I attain success I shall incur the same sort of rage and envy that I feel towards the success of other persons" (p.37). Thus it is the fear of retaliation that provokes this type of NTR. The patient must therefore back down from all efforts that involve competition. If these efforts are not stifled, then the patient fears annihilation due to his projected envy onto the therapist. The logic used to ward off this danger Horney formulates as: "I had better stay inconspicuously in a corner, or remain sick and inhibited" (p. 37).

It is less dangerous for the patient to enact a masochistic stance (re: being defeated by a competitor, of incurring failures, of being humiliated) in relation to the therapist. These patients do not even "dare" to dream of wish fulfillments or ambitions; "even in dreams (as in life) they feel safer when they imagine that they are humble or defeated" (p. 37). Denoting this kind of NTR as *"a special form of the fear of success"* (italics in the original), Horney differs from Freud in emphasizing the patient's anxiety rather than his guilt. She also expands on Freud by ascribing a special content to these feelings of guilt and anxiety, namely, hostility on the basis of rivalry.

The fourth kind of NTR that can occur is more in line with what Freud wrote about. In this kind of NTR the guilt feelings are more in the foreground. Here, the content of the interpretation evokes the reaction because it arouses the unconscious sense of guilt in the patient. In this kind of reaction, the good interpretation is felt as an accusation. The patient feels constantly put on the defensive so that the therapy resembles a trial.

The fifth kind of reaction, like the first and third kinds, is also evoked by something other than the content of the interpretation. This kind of reaction is promoted by the patient's belief that he is being rejected by the therapist. Because the patient has an excessive need for affection, the interpretation is felt to be a personal rebuff. Horney notes, "Seen from this angle the patient takes any uncovering of his difficulties as an expression of dislike or disdain by the analyst and reacts with strong antagonism" (p.40).

To recap, Horney describes five ways a good interpretation may initiate a NTR: 1) The interpretation is experienced as a challenge to compete with the therapist, 2) The interpretation is experienced as a narcissistic blow because it exposes a weakness in the patient, 3) The interpretation is experienced as progress which must be avoided because it will invite the wrath of others, 4) The interpretation is experienced as an unjust accusation, and

5) The interpretation is experienced as a rebuff by the patient who above all needs the therapist's affection.

These five ways that NTRs can occur, taken together, disregarded the prevailing etiological biases extended by Freud. In doing so, Horney seemed to be trying to attenuate the kind of rigidity that can arise when trying to fit phenomena into too strict a theory. Put another way, Horney tabled embracing specific criteria, in order to witness more clearly the different ways NTRs arise. As will be seen in examining the later literature, many of the disagreements as to what is a true NTR has to do with the choice of fitting the phenomena into immutable criteria or enlarging the criteria to accommodate the phenomena.

Horney's brilliance can also be seen in her advice on technique; it isn't until almost fifty years later that her suggestions resurface in the literature. Essentially Horney offers ways of working through the NTR without effecting premature terminations and/or dangerous acting out patterns in the transference scenario. Horney makes two recommendations: One, the therapist should select out of the patient's material only those aspects which can be related to his reaction to the therapist - only these aspects are commented upon and explored. Two, as long as the NTR persists, the therapist should refrain from making any comments concerning the patient's past.

Both of these recommendations demonstrate the empathic attitude necessary on the part of the therapist. Regarding

the first, the therapist can ease the patient's unmanageable anxiety by placing the focus on the therapist - what he does or doesn't do, say or think - thereby relieving the patient of having to defend against his anxiety through self-recrimination. Focusing the dialogue onto the therapist also conveys to the patient that the therapist can stand up to the hostile attacks, without fear of retaliation. Similarly, the second recommendation is designed to relieve the patient of having to confront his guilt; in these patients during a NTR, invoking the past as a way of understanding the present is experienced as an accusation. Horney adds that the NTR is soluble only if the therapist persists in analyzing the patient's immediate reactions to the "here and now" context.

The Object-Relations Perspective: Envy and Narcissism

In this section I will review the work of a number of authors whose writings have led to a fuller understanding of some of the more primitive influences which contribute to a patient's forming a NTR. These influences include the role of 1) narcissistic pathology, 2) envy, 3) internalized objects, and 4) primitive projective and introjective processes. The emphasis of this section is on etiological considerations, and to a lesser extent, description of the NTR patient's overt behavior.

Abraham's Notion of Narcissistic Resistance

In 1919, Abraham published his seminal paper, "A Particular Form of Neurotic Resistance." This is the first paper to describe clinical reactions to analysis stemming from narcissistic sources, in particular, what became regarded as narcissistic transference resistances. Abraham notes some "special" characteristics of patients who manifest these resistances. It is worthwhile to consider these characteristics in light of the present discussion on the NTR. These characteristics include: One, a concealed "unusual degree of defiance" (p.305) evidenced by a refusal to free associate, that is, a refusal to comply with the "basic rule." Abraham locates the origin of this type of defiance in the patient's early relationship with the father. Two, an unusual sensitivity to "anything which injures their self-love" (p. 305). Abraham writes that these patients are inclined to feel "humiliated by every fact that is established in their psychoanalysis" (p. 305). Accordingly, these patients are continually on their guard. Three, an attempt to change the objective of the analysis from self-understanding to one of narcissistic enhancement. Four, an inability to form a "true" transference to the analyst. Quickly into the therapy, these patients react with a "withdrawal of libido" (p. 306). They "begrudge" the analyst "the role of the father" and are easily disappointed. Their disappointment provokes their withdrawal, mitigating against the development of a positive

tie to the analyst. Abraham writes, "They wish to be loved and admired and since the analyst cannot satisfy their narcissistic needs, a true positive transference does not take place" (p. 306).

Abraham attributed these narcissistic characteristics to a regressive anality, as a retreat from oedipal love, disappointment and envy. Paving the road which Klein was to travel, Abraham highlights the role of envy:

> The presence of an element of *envy* is unmistakable in all this. Neurotics of the type under consideration grudge the physician any remark that refers to the external progress of their psycho-analysis or to its data. In their opinion he ought not to have supplied any contribution to the treatment; they want to do everything all by themselves. (p.307, italics in original)

Abraham further notes that infantile longings and envy are avoided through exertion of narcissistic control. This allows the patient to "keep the power of deciding what they are going to give" (p. 309) to the analyst.

Riviere's Examination of Preoedipal Influences

Riviere (1936) is the first writer in the Kleinian tradition to address the NTR. In important ways, her thesis is similar to those proposed by Horney and Abraham, in its attention to narcissistic defenses. It differs, however, in that Riviere located the origins of these defenses in the preoedipal phase. Riviere thus makes a significant contribution to an understanding of many of the developmental issues that are repeated in the NTR.

Riviere begins by showing that Freud's pessimism about the NTR had been inaccurately assumed to mean unanalyzable. She shows that Freud did not say the NTR prevents working through, only that Freud found the obstacle "extremely difficult to overcome" (p. 304). She further remarks that the difficulty resides in the analyst's failure to understand the material and to interpret it fully to the patient.

The assumption had been that the NTR patient's superego is strong enough to defeat the best efforts of analysis. Riviere takes as her task the unmasking of other factors at work concerning the severity of the superego, which had hitherto been insufficiently understood.

Riviere proposes that the NTR is brought on because of the patient's resistance to assume the depressive position. The resistance is manifested as a narcissistic attempt to omnipotently control the therapist through depreciation and contempt. Fortified by this resistance, the patient hopes to keep the therapist from destroying what are already spoiled and dying internal objects. It is the patient's love for and attachment to these withering internal objects which must be preserved at all costs. Allowing the therapist any influence would be tantamount to destroying the hope that the internal dying objects could be restored.

Unconsciously, the patient believes himself to be the cause of the debilitated state of his internal objects. This, according to Riviere, presumes an abundance of guilt.

The guilt is due to the patient's belief that he is unworthy of help while his internal objects are suffering; he won't accept any help until the internal objects have been saved. Thus, for Riviere, it is a fear of object loss, repeated in the transference, which motivates the NTR. The omnipotent control exerted by the patient is sustained in order to keep the internal objects from dying completely. Reversing the prevailing logic, Riviere contended that the NTR is not an attempt to defeat the therapist. Rather, the patient's prior obligation to rescue damaged internal objects takes wholesale precedence over the patient's ability to accept help for himself.

Before moving on, I want to underscore what I regard as Riviere's main contribution to an understanding of why patients who are clearly in need of treatment form NTRs. This contribution is contained in her ability to move away from a competitive struggle with the patient by viewing the patient's resistance as serving a protective function: The patient is not primarily motivated to destroy the therapy's effectiveness. Rather, the patient's loyalty to his suffering parents (i.e. his decimated internal objects) takes precedence. The bottom line is to not betray the internalized pre-oedipal parents.

In the transference that develops, the contemptuous attitude enacted toward the therapist is more profoundly a way of protecting the therapist-parent. Riviere is able to locate the "good" (i.e. protective, loyal, and caring)

patient amidst the negativity that dominates the manifest presentation in treatment. As will be elaborated on in the Results chapter, the kind of empathic attitude that Riviere recommended is an indispensable element of the therapist's capacity to contain the affect engendered by a NTR patient. This affect - hate, disgust, contempt - and the closely connected states of despair and helplessness, are basic elements of the therapist's experience when in a NTR. Without recourse to an understanding of the patient's "reasons" for being so despicable, therapist inspired counterattacks will undoubtedly result.

Klein's Work on Envy and Projective Relatedness

Though Klein is usually thought of as having a major impact on NTR considerations, she actually wrote only a few paragraphs on the topic. Klein's influence, however, can be found in her essay, "Envy and Gratitude" (1957). In this essay, Klein advances a theory of severe pathology based on excessive envy. She writes, "I arrived at the conclusion that envy is the most potent factor in undermining feelings of love and gratitude at their root, since it effects the earliest relation of all, that to the mother" (p. 176).

Klein's formulations about what inspires envy in the infant's experience has been critiqued elsewhere (see Joffe, 1969). Despite the fantastic nature of some of her assertions (for example, that the infant is born with the ability to infer intentionality), Klein's enduring influence

is a testimony to the way in which she described the inner struggles of her more disturbed patients. Indeed, many of the therapists which we will hear from in the results chapter, voice their acknowledgement of Klein's influence on how they listen to and understand their patients.

Klein contends that due to an inability to split, or keep psychologically separate, anxiety reducing experiences from those that increase anxiety, the infant is unable to build up a viable internalization of the good object. By "good object," Klein means the feeding breast. The breast possesses everything desirable. It is the source of all comforts and is "an inexhaustible reservoir of food and warmth, love, understanding and wisdom" (Segal, 1964, p.40). From a state of deprivation, the infant perceives that while "the breast has an unlimited flow of milk and love" these are kept "for its own gratification" (Klein, p.188). As a result, the infant experiences painful feelings of envy. On the one hand, the infant wishes to take in the breast whole, since it is the source of all goodness, satisfaction and perfection. On the other hand, the infant also wishes to sadistically attack the breast since it withholds gratification for itself. These attacks, Klein says, involve the "greedy scooping out of the breast and of the mother's body ... as well as putting bad excrements into the mother" (p. 183). The infant's excessive envy, fused with greed, is directed toward exhausting the breast completely. This is not only in order to possess all its goodness, but

also to deplete it so that it no longer contains any enviable contents. By this, the infant spoils the envied breast. In sum, the healthy use of splitting has been usurped by the infant's envy. The good breast and the bad breast cannot be experienced separately. Rather, they become fused in the infant's experience. Further, because of the envy, the fused breast becomes an increasingly harmful and persecuting object.

The destruction wreaked by the infant's envy does not stop at spoiling the breast. In Klein's object-relations schema, the infant's envy initiates a vicious cycle in which parts of the self are also the object of destruction. Klein writes: "The very nourishment that has been taken in, so long as it is perceived as having been part of the breast, is itself an object of envious attacks, which are turned upon the internal object as well" (quoted in Segal, p. 41). Thus having introjected the object of nourishment, the infant now needs to project out of himself and into the breast this object. Now the envied breast is further spoiled and efforts to keep the breast psychologically at bay are re-doubled. This results in further experiences of deprivation, intensified greed, and increased envy.

Overall, these processes result in the infant's confusion between that which is perceived as good and that which is bad. Unable to keep good and bad separate, the perception of the ideal object cannot be sustained long enough to be integrated into the ego. The infant thus will

go through life without having established any history of relating to, identifying with, and thus internalizing an expectancy of others as potentially good.

As the envious person goes through life, many defenses will be used in order to keep the envy hidden. Primary among these defenses are projection, idealization and denial, which serve to reinforce the use of splitting. Splitting is now viewed as an unhealthy defense because, in conjunction with projection, the envious parts of self are disowned and thrust into the external environment forever clouding a clear apprehension of goodness outside of the self.

Klein regarded envy and the defenses against it as the underlying source for why patients form NTRs. Like Riviere, Klein found that these patients feel undeserving of help. Klein, however, believed that underneath this feeling is an intractable hate of goodness itself. NTR patients feel malice toward the therapist because they sense the therapist's goodness, effectiveness and love. Yet, like the infant's perspective discussed above, these traits of the therapist are at most perceived to be incompletely accessible to the patient. The therapist's "goodness" is doled out at his own pace - the therapist controls what he will give to the empty hungry patient. In the transference, depending on a therapist is akin to putting one's life in the hands of another who is seen as arbitrarily and capriciously responsive. Such a dependent stance is

experienced as fraught with the potential for destruction. The patient's resistance is therefore a protective measure utilized to spoil the therapist's powers; the therapist is rendered impotent to provide any help. Each interpretation must be turned into a useless utterance. Through the patient's envy and the defenses against it, all hope must also be destroyed as the sense of possibility is intolerable.

In Klein's terms, the patient defends against the danger of success in therapy by manically triumphing over the therapist who represents the good object. The triumph occurs primarily through devaluation of the therapist. For the patient, however, there is a severe price to pay. As a result of the patient's triumph, fears of persecutory retaliation are evoked, which also then must be warded off through increased attacks on the therapist. Klein's thinking on this matter is a bit muddled. Essentially, she seems to be saying that a primitive type of guilt (for Klein, this is a preoedipal level of guilt located in the superego) is created when the patient set out to destroy the good object as an infant. This guilt remains split off throughout the patient's development. In therapy, the split off guilt is projected onto the therapist. It is then a major source of the persecutory anxiety which the patient fears in relation to the therapist. It is the therapist, then, who is perceived as grudging the patient any goodness or success.

Overall, Klein's description of the many related processes in which the patient's envy remains split off, informed her observations of the patient's inability to accept with gratitude the interpretations offered by the therapist. She concluded that the splitting off and projection of envy onto the therapist is an important hindrance to working through because the therapist is constantly mistrusted since he is again and again turned into a dangerous retaliatory figure.

A Note on Projective Identification

Before leaving Klein, one other point is worth making. In 1946, Klein introduced the notion of projective identification. In essence, Klein thought that this process described the prototypical mode of communication between the mother and her infant. In projective identification, parts of the self are not only projected out, but through the interpersonal pressure involved, these parts of the self are actually placed into, not onto, the object. The object then experiences itself under the sway of what has been put into it. In her discussion on envy, Klein uses the term projection, not projective identification. However, the way she uses projection is more in line with the controlling element entailed in projective identification. This is raised here because many later writers (e.g., Rosenfeld, 1975; Gorney, 1975; Finnell, 1987) rely on the notion of projective identification in order to make sense of the

disquieting experience that occurs during the period of the NTR. Indeed, Klein's impact on current therapeutic practice, as evidenced in the interviews I conducted, is due largely to her explication of primitive processes of projective relatedness that are thought to occur when treating severely disturbed patients.

Rosenfeld (1983) considered projective identification to be so basic a concept that he wrote: "In analytic work today the analysis of projective identification into the analyst ... plays such a prominent part that we can no longer imagine how an analyst could work before 1946" (p. 262). Jacobson (1971) also cited the importance of "introjective and projective mechanisms (p. 300) in the treatment of severe character pathology. Since such severe pathology is thought to play an important role in the development of the NTR, projective identification can be expected to occur in these cases.

In a related fashion, Olinick (1964) stressed the NTR patient's ability to induce feelings of sadism in the analyst. Such intense sadomasochistic dynamics will undoubtedly provoke a nontherapeutic reaction in the analyst, if the analyst is unaware of their presence. Olinick stated that the analyst must therefore make conscious to himself the sadistic and/or masochistic wishes induced by the patient. Such a process should, according to Olinick, take the form of containing these dystonic feelings and when appropriate interpret their interplay. In some

cases, as Finnell (1987) remarked, the therapist's own narcissistic difficulties will prevent such neutral handling of this subtle process. Unless this countertransference enactment on the therapist's part is processed and brought under conscious control - and used in appropriate therapeutic interventions - the treatment will remain under the domination of the patient's NTR, and is doomed to fail.

Rosenfeld's Elaborations on Narcissism and Envy

Although we can infer that Klein worked with issues deeply related to pathological forms of narcissism, she did not use the term. It remained for her followers, especially Rosenfeld (1964, 1971, 1975) to extend the relationship between narcissistic pathology and the NTR.

Rosenfeld (1975) proposes that the NTR is fundamentally a result of the conflict between the longings of the infantile dependent part of the self and the omnipotent, narcissistic part. He writes:

> I have observed that the negative therapeutic reaction is due to a powerful counterattack of the omnipotent narcissistic and often megalomanic part of the patient which was felt to have been dislodged from its dominant position through the progress of the analysis and which reasserts its power by attacking and overpowering the infantile dependent part to re-establish the status quo and to regain control of the ego. (p. 223).

Rosenfeld characterizes the NTR patient's attempts at controlling the therapist as deriving from the need to maintain infantile omnipotence via projective

identification. To the extent that the therapist can modify this narcissistic control, a breakthrough can be made in contacting the dependent part of the patient. The NTR occurs because of the patient's desperate attempt to protect against such emerging feelings of dependent helplessness.

In Rosenfeld's theory on narcissistic disturbance, the patient denies differentiation between self and others. The lack of differentiation serves the purpose of denying any need to depend on the therapist. The act of dependency, in these character structures, translates into the need for a loving object who is also envied. Seen in this way, one can think of the NTR as occurring because the patient's envy has gone unanalyzed. Thus, to Rosenfeld, the infantile part of the patient is equivalent to the infantile envy of the feeding breast. In a case example, Rosenfeld reiterates what happens when the therapist makes contact with this infantile envy:

> This (contact) threatened to expose the emptiness and delusional quality of the narcissistic structure which actually may break down at such moments. The attack on the dependent self serves to reinforce the delusional possession of the breast which is basic to the narcissistic structure which denies any need and envy of the breast. Progress in the analysis of such patients can only be made when the narcissistic omnipotent structure finally breaks down and the underlying infantile parts of the patient, with all his needs, feelings of frustration, and envy can be fully worked through in the transference situation. (p. 226)

The author concludes that analyzing the earliest roots of the patient's envy is the most important element in breaking through the NTR. The capacity of the patient to take in and retain the therapist's interventions, instead of immediately spoiling them, is the central therapeutic factor in tackling the problem of the NTR.

Kernberg on the NTR

Kernberg (1984) stresses the importance of preoedipal conflicts, severe aggression, and structural issues involving the earliest self and object relationships in the etiology of NTRs. He states that the feature most frequently met with in NTRs consists of "unchanged grandiosity in severe narcissistic structures" (p. 242). This feature manifests itself in a few different ways. Some patients with this feature dehumanize the treatment situation by denying any emotional reality to the transference. Other patients who present with this feature will retrospectively deny the help they have received from the therapist. These latter patients experience all the improvement that has accrued as due to their own efforts. This is typical of those patients who form a NTR some time after the therapy began. These patients may then improve to some extent, but only in spite of the therapist. These patients end the treatment with a "total devaluation of the analyst while still carrying away their self-originated

improvement in an unconscious 'stealing' of the analyst's work and creativity" (p. 242).

Kernberg also raises the patient's envy of the therapist as a way of understanding the need to defeat the latter. It is worthwhile to review Kernberg's way of conceiving of the patient's envy. Unlike the previous writers who have addressed the influence of envy, Kernberg incorporates the patient's non-transference relationship to the therapist as informing the patient's envy.

Kernberg notes how a therapist, in continuing to help a patient, in the face of an obvious opposition to such help, will act to reinforce the guilt and envy which prompted the resistance. This is due to the patient's resentment and envy of the therapist's persistent dedication and commitment. Even when the patient is attempting to defeat the therapist, the latter continues to try to be of help. In contrast to the patient's previous experiences of having his hatred responded to in kind, he is now faced with a situation which increases his anxiety. This will result in an increase in the guilt associated with mistreating the therapist. The patient's attempts to defend against the guilty feelings will, therefore, also become intensified. Thus, a vicious cycle is provoked.

Conversely, if the therapist does counterattack, this too, will prompt an increase in guilt, quickly denied through an increased defense against the guilt. This is because the patient feels responsible for inducing the

counterattack. Kernberg observes that this defensive maneuvering typically manifests as sadistic triumph over the therapist. Unfortunately this chain of events reconfirms the pathological interactive cycles all too familiar to the patient.

The Ego-Psychological Perspective: Separation, Masochism and Negation

Again, I want to emphasize that I see a great deal of overlap between the various angles taken on the NTR in the literature. Kleinian analysts invoke envy as the fermenting ground which later flowers into the NTR presentation. Ego-psychologists invoke pathological separation dynamics and preoedipally based identifications with the maternal figure as the foundation for later manifestations of NTRs. Linking these two perspectives is the belief that the patient's experience is one of fundamentally lacking in the qualities necessary to embrace life, while also experiencing others as obstructing the patient from attenuating these lackings. Further, both schools of thought attempt to appreciate what the infant is experiencing as it begins to develop a sense of its own identity in the first year or two of life.

Olinick's Work: Negativism and Therapeutic Management

In his often cited classic, Olinick (1964) reformulates the NTR as a special case of negativism. He observes that certain patients react with a "resoundingly dramatized

'No!'" to "valid and properly timed" interpretations that contain the "tacit promise of understanding and eventual autonomy" (p. 542). The 'No!' utilizes a "combination of defense in which denial by action or acting out, negation, and negativism are prominent" (p. 542). The communicative aspects of this reaction emphasize two notable features: 1) the ability to stir the emotions of the therapist, and 2) the non-verbal nature of the negativism.

To Olinick, the reaction is not merely an exacerbation of symptom patterns, but is more deeply rooted in character pathology. This pathology is typical in those patients who "plead" for affection, assistance and nurturing yet "violently" disown their dependent strivings and needs. Such a conflictual combination of wishes and needs is often masked by an increase in sadomasochistic behavior. Often, the therapist's inexperience in managing the sadomasochistic provocations lead to intractable treatment disruptions such as premature terminations and transfers to other therapists.

Olinick highlights the interactional component of the NTR. He regards the patient's negativism as not being directed so much at the issues raised by an interpretation, but as directed at "the person of the interpreter in an intensification of the transference" (p. 543). Further, while the transference is overtly negative and hostile, it is "latently or uunconsciously positive" (p. 543). Such positively tinged feelings, however, must be warded off in the extreme. This is because such positive feelings

involve, following Anna Freud's thesis (1952), a regression to a primary identification with a love object. In NTR patients, Olinick contends that such an identification is feared as a "loss of intactness, as an annihilation of self" (p. 545). He proposes that the patient's "dreaded helplessness" is grounded in an "ambivalent identification with a depressed, preoedipal maternal love-object" (p. 545).

From the patient's perspective, the NTR is a battle for control. Positive feelings are equated with passive emotional surrender and enslavement to a depressive condition "dreaded as death and destruction" (p. 545). Negative feelings, conversely, are equated with maintaining (and hopefully, eventually achieving) the struggle for autonomous identity. Herein lies the paradoxical nature of the NTR. Though the therapist's interpretations, as Olinick frames them, are intended to increase the patient's autonomy, they are experienced by the patient as a directive to submit to the therapist's authority. Any and all remarks by the therapist, therefore, must be met with a negativistic response.

Via the negativistic response, the patient "offers himself as a reciprocating partner in the dialectic of sadomasochism" (p. 546) in which some degree of control remains with the patient. This control invariably operates via projective processes. In raging against himself, the patient "dramatically and effectively evokes the experience of helplessness, guilt and rage" (p. 546) in the therapist.

When the "induction by projection" is successful, the depression now resides in the therapist. In such a relationship it is necessary for the patient to negativistically defend against that which has been induced in the therapist. The 'No!' is a communicative measure designed to stave off the same dependent depression and masochism originally experienced in the preoedipal relationship with the mother. For NTR patients, "sadomasochism projects depression and negativism rejects depression" (p. 546). Olinick concludes:

> When the negativism is thus admixed with sadomasochistic components, with rage and destructiveness from and against the introjects, and not least, also admixed with a flair for the dramatic or alloplastic in behavior, we then have the negative therapeutic reaction. I may now denote this reaction as a depressive, sadomasochistic rage, which is projected and induced in the other person, in a desperate attempt at defence against the expectation of inner loss and helpless regression. Negativism is the linkage between the various parts of the picture, the common denominator among the varied elements.

Olinick's remarks regarding the technical management of a NTR patient highlight the need to "point out systematically and consistently, and with infinite patience and tact" (p. 546) that the patient's negativism is obstructing further understanding. That is, Olinick emphasizes that the principles of treatment are not dissimilar to those generally advocated in other character analyses. He does note, however, that the often repeated

statement that the analyst must remain calm and understanding in the face of the patient's skillful provocations "says too much in too few words" (p. 547).

Olinick emphasizes the peculiarly vulnerable position the therapist finds himself in, thereby exhorting the therapist to be ever more aware of his tendency to "overcarry" the empathic identifications formed with the patient. Olinick's exhortations essentially amount to advising the therapist to be ever vigilant about the possibility that he is re-acting out of what has been induced via the patient's sadomasochistic attacks. While admitting that the interpretive work around the transference-countertransference enactments do not necessarily follow a successive removal of layers of defense, Olinick does regard three aspects of the working through as inviolate.

First, the patient must reach the understanding that his 'No saying' is an automatic response. When this is accomplished, attention then should turn to the patient's attacks and characteristic use of projection. This process is usually the most time consuming feature of the treatment, as it is typically fraught with the therapist's own counterproductive contributions. The therapist, for his part, must analyze his own reactions of guilt and depression. Such reactions in the therapist are often inspired by his own defeated need to be helpful. The therapist therefore needs to effectively contain his

therapeutic zeal; the need to rescue the patient, being a neurotic countertransference reaction, must yield to the therapist's own analysis. When successful, the therapist can then become available as a "guilt-free introject" (p. 547). When this occurs, the final therapeutic task - analyzing the primary identification with the depressed preoedipal mother - can be fruitfully attempted and worked through.

Valenstein's Thesis on the Attachment to Pain

Valenstein's (1973) contribution to the NTR literature is remarkable for its simplicity in delineating etiological considerations and for its pessimistic conclusion concerning the potential for therapy to significantly alleviate the patient's suffering.

Valenstein proposes that the core of the NTR derives from the patient's unconscious motivation to experience pain in relationships. This motivation signifies "an original attachment to painfully perceived objects and inconsistent ones at that" (p. 389). The author's premise is that in the development of such individuals, early pleasurable experiences with the primary object do not occur often enough to consolidate into love and a sense of trust. Rather, the opposite occurs. For these patients, early relations with the primary caretaker are predominantly painful and recur consistently. As a result these early experiences crystallize in the direction of attachment to

pain and distrust of others. The painful affects are "then held to, both as a defense and as an instinctually charged concomitant of object experience" (p. 389).

To Valenstein, this nuclear determinant of the NTR is located much earlier than superego formation. It originates in the preverbal interactions with the preoedipal mother. As the infant is unable to establish a sense of constancy in relation to a positively valued object, pleasurable experiences can not be anticipated. In fact, as Valenstein notes, the opposite expectation prevails, namely, the development of an affinity for painful affect.

In the course of treatment with such an individual, the transference "becomes the very site of the patient's predilection to exact a singular quality of pain from human relationships" (p. 366). This predilection may manifest itself in many different ways corresponding to the "more sophisticated object-oriented experience deriving from beyond the oral phase" (p. 389). That is, the patient will seek out painful relations not only in orally derived ways, but also in ways derived from anal and phallic functioning. Thus, the transference enactment may suggest a relationship based on 'who eats whom' just as much as it may suggest 'who controls whom' or 'who dumps on whom, who pierces whom, who shafts whom,' etc.

Valenstein notes that interpretations aimed at elucidating the patient's predilection for pain will be "nonmutative and relatively ineffective" (p. 390) because

the core of the conflict is preverbally organized. He further states that "such disturbances are even strongly resistant to interpersonal, experiential, nonverbal measures" (p. 390). In such cases, all the therapist can hope for is that the patient gain a measure of insight into the way he has "habitually abused relationships to realize an inner emotional experience which was paradoxically fulfilling" (p. 390).

Asch's Work: Pathological Separation and Therapeutic Management

Asch's (1976) investigation of the NTR attempts to bridge Freudian conceptions of superego pathology with Mahler's (1968) delineation of the separation-individuation phase of development. His vantage point centers on viewing the NTR as an intrapsychic conflict that develops during the preoedipal years and is sustained by specific ego and superego pathologies. He posits three varieties of NTR that he had witnessed in his clinical work.

The first type of NTR refers to a distortion of ego development that occurs in response to a special pathology of the ego ideal. Asch notes that while Freud's conception of superego functioning included the conscience and ego ideal, Freud stressed only the role of the conscience in his work on the NTR. Asch, conversely, focuses on the ego ideal. He notes that the ego ideal includes remnants of the narcissistic omnipotent self image in combination with the

introjected idealized aspects of the loved parental image. The major anxiety thereby associated with the ego ideal is related to a "primary fear of loss of the mothering object" (p. 386). Thus, Asch moves the focus away from the anxieties related to castration and oedipal conflict, to those anxieties related to object loss characteristic of preoedipal experience. The malformation of the ego ideal results in the "development of a masochistic aim in the ego's function of object relations" (p. 386). For patient's manifesting this type of pathology, the superego is regarded as an internalized object representing a powerful mother who requires submission. Asch labels this variety of the NTR as "the masochistic ego" (p. 385).

The second variety of NTRs relates to Freud's category of 'unconscious guilt,' but is expanded to include "preoedipal crimes" (p. 391). Asch notes that guilt can be "attached retrospectively to any event along the developmental hierarchy" (p. 391). Thus, a patient may feel guilty due to the fantasy that the birth separation irreparably damaged the mother. Another manifestation of preoedipal guilt could derive from the fantasy that mother's phallus was mutilated. Asch described these fantasies as "familiar" to most analysts, which are now "more understandable" in light of Mahler's observations on the vicissitudes of separation-individuation.

Asch especially focuses on Mahler's examples of "traumatic dissolutions of the symbiotic mother-child

relation" (p. 392) in his positing this variety of NTR. He notes that many NTR patients maintain guilt ridden fantasies that had been fortified by the patient's mother "who had failed to resolve this developmental phase with their own mothers" (p. 392). These mothers cannot tolerate separation in their own children. Instead they are narcissistically attached to their offspring in a manner that conveys to the child that he is the chosen one. Inevitably frustration and disappointment follow such heightened expectancy and vengeful fantasies are stimulated as a result. The "discovery or remembrance of the mother's wound" in the context of the destructive fantasies evokes guilt, "often with some identification with the victim" (p. 392). Asch further notes that the greater the disappointment and rage, the greater is the strength of the identification with the victimized mother.

Such pathologically intense symbiotic ties result in an accumulation of aggression which cannot be neutralized for use in separating from the mother. Thus, according to Asch, reliable self and object representations do not develop. He wrote: "This may explain the tenacity with which the early object relation with mother is maintained in these patients, as well as the intensity of aggression that is turned against the self in order to protect the object" (p. 393).

Modell (1965) wrote about a similar kind of separation guilt when he described certain patients who unconsciously perceive autonomous strivings as resulting in the death of

the internalized object. These are patients who appear depressed because of their continued relation with the object, rather than its loss. In these patients separation is experienced as an overt expression of hostile impulses; the object is therefore protected by renunciating all normal moves toward establishing a separate sense of self.

The third variety of NTRs that Asch delineates derives "from the negativism of oral and anal conflicts" that are "used to defend against either anal submission or oral fusion fantasies" (p. 394). This type of patient presentation is similar to that which Olinick (1964) documented. The patient's negativistic attitude dominates the relationship with a helping other. The patient's fear that he will be required to submit to the narcissistic needs of the other motivates him to negate all that is offered him. Submission for these patients is equated with the loss of identity.

Typically these patients experience interpretations as implicit demands that such submission is required. As such, accepting an interpretation, no matter what its content or correctness, is felt as a threat to the patient's integrity. Only by rejecting the interpretation, and more broadly, only by failing in the therapeutic relationship, can this type of patient maintain an identity separate from the therapist.

While delineating these three varieties as distinct, Asch believes that typically any NTR will involve significant elements of all three varieties. As all three

are derived from pathological relatedness to the mother during the transition from symbiotic attachment to the establishment of a separate identity, Asch's contentions are conceptually consistent.

Asch considers the analysis of the NTR to be "similar to the usual therapeutic approach with depression" (p. 398). Like Olinick, Asch highlights the necessity of analyzing the patient's introjects and transference projections in order to avoid treatment failure. The core of the transference established involves the projection of the sadistic superego onto the analyst "followed by the attempt to provoke the analyst into a punitive (sadistic) response" (p. 398). This makes the countertransference problems "more prominent in NTR than in the treatment of any other emotional disorder" (p. 398). Asch concludes that the aim of the patient's provocations is to "create an attitude in the analyst inimical to the analysis" (p. 399).

The analyst, in Asch's model, cannot escape being effected by the patient's provocative sadism. It is therefore most important for the analyst to consistently maintain his analytic calm and neutrality so that when the analyst is inevitably compelled to respond from his countertransference dis-ease, his "transient defection" from the analytic attitude "has more significance by contrast" (p. 400). If the therapeutic alliance has been sufficiently established, then such a "defection" can help to bring the patient's sadistic fantasies into the analysis.

The key to eventually work through the early destructive identifications established with the primitive love object revolves around the patient's being able to use the analyst as a more benign introject. Asch maintains that typically this can occur in the analyses of NTR patients. There are occasions, however, when the "preoedipal difficulties are too basic to be modified with treatment" (p. 404). Asch's reasoning is that in some transference situations, the projection of the sadistic superego component onto the analyst ends up providing "too much gratification" (p. 404) for the wished for sadomasochistic relationship. Under such circumstances, it may become necessary to terminate treatment as soon as possible. Otherwise the patient's "masochistic impulses may increase, with an acceleration of self-destructive behavior to dangerous proportions" (p. 404). In these cases termination should abort such harmful activity because it interrupts the stimulating involvement with the transference object.

In discussing the need to analyze the component parts of the NTR, Asch briefly mentions that the analyst will initially represent the discounted father figure who is "pushed aside and denigrated" (p. 399). Though this comment is not elaborated upon by Asch, I think it is necessary to reflect on it further. My reasoning is this: All accounts of the NTR emphasize the patient's devaluation of the therapist. As a transference enactment the devaluation may be grounded in preoedipal or oedipal experiences; the

devaluation may be directed at the mother or at the father. If derived from the earlier experience, the meaning of the devaluation for the patient will be quite distinct than if its derived from the later, and vice versa. This is an obvious truism that should not need further comment. However, most of the articles that focus on the NTR as a preoedipal pathology do so without considering the effects such early pathology may have on the oedipal phase. Two other contemporaneous accounts of the NTR (Gorney, 1975; Rothstein, 1979) do note the interaction of preoedipal and oedipal pathology in the development of patients prone to forming NTRs. These accounts will therefore be addressed next.

The Interaction of Oedipal and Preoedipal Pathology

In a panel report, Olinick (1970) recounted the positions taken by a number of prominent analysts who attended a symposium on the NTR. One of the main controversies surrounded the question of defining the NTR as a preoedipal or oedipal clinical issue. Some of the panelists (notably Brenner, Loewenstein and Arlow) stressed oedipal factors. Others (notably Olinick, Tower and Loewald) stressed preoedipal issues. Although it seems to me to be over schematized to define a clinical issue in this either/or manner, such a distinction abounds in the literature. Rothstein (1979), and to a lesser extent, Gorney (1975), attempt to redress this issue.

Gorney on the Role of the Father

Gorney sees the development of the "specific constellation of vulnerabilities" that lead a patient to form a NTR in treatment as predominantly preoedipally based. However, he does address the father as "a secondary figure" in the child's development. Though "secondary" is still too limited as a generalization, his remarks are otherwise instructive, especially regarding what happens in the treatment of a patient prone to forming a NTR. He writes:

> In the cases I have treated, the pathological vicissitudes of guilt have been further exacerbated in the relationship with the father. Given the early disappointments with the mother, these individuals early on turn to their fathers, particularly during the oedipal period, as a longed-for maternal surrogate and identificatory object. In the family constellation, the fathers characteristically tend to be superficially seductive but are basically controlling, punitive, and emotionally distant. The pattern I have observed involves an initially positive response to the child ... followed by often brutal criticism and guilt-evoking rejection in the context of preadolescent struggles for autonomy. *Because of this devastating secondary disappointment, most [NTR] patients ... come into treatment complaining primarily of their father, unleashing a degree of rage, frustrated longing and guilt-suffused pain which is most striking.* (p. 301, italics added)

Rothstein on Oedipal Victory

Rothstein's (1979) premise is that a number of male patients who are referred to as narcissistic personality disorders have often incurred intense and confusing oedipal situations that are experienced as victories over the father. Such situations are associated with a "spectrum of feelings: elation, intense castration anxiety, guilt, as well as disappointment in and longing for a victorious, admirable father" (p. 189).

Rothstein harkens back to Freud's description of patients who have a propensity to act out during analysis. Freud (1916) noted that for these "criminals" the acting out "was accompanied by mental relief" (p. 333). To Freud, the relief was motivated by "a sense of guilt derived from the oedipus complex, and was a reaction to the two great criminal intentions of killing the father and having sexual relations with the mother" (p. 333).

For Rothstein the crucial idea is contained in the word "intentions." He believes that these patients "experienced a reality that comes closer to actualizing these intentions" (p. 186). His argument is fourfold : One, these patients were born into families in which the mother viewed the father as a failure; in many cases, according to Rothstein, the father was in actuality a failure. Two, these mothers treated their sons "predominantly as narcissistic objects by overvaluing them as long as they promised to undo the humiliation of father's failure" (p. 186). Three, these

patients experienced "an actual seduction" by their mothers. Four, the fathers frequently employed corporal means of limit setting.

These four factors leave the child intoxicated and frightened. He is intoxicated by the implied oedipal victory which has the further ramification of interfering with mourning his grandiose self, a process that normally occurs in the transition from preoedipal to oedipal functioning. The child is also frightened and enraged at the mother for treating him as merely an extension of her own needs. He remains terrified that she will destroy him if he does not perform in the ways she decries. Lastly, the child continues to fear father's retaliation for his symbolic victory. Combined, these factors contribute to the child's intense castration anxiety.

In delineating the above composite, Rothstein suggests that the sadistic attacks directed at the therapist during the NTR - the cruel devaluations and the attempts to render the therapist completely ineffective and impotent - may be directed either at the therapist as transference mother figure or at the therapist who represents the father. Determining the transference context, albeit, one that is ever shifting, is crucial if the meaning of the sadomasochistic enactment is to be located. If this meaning is not accurately established, then the therapist will unknowingly contribute to the patient's intensified acting

out; ultimately, Rothstein remarks, the treatment will end in failure.

Summing Up: The Multidetermined Nature of the NTR.

In summing up the diverse literature on the NTR it is clear that little consensus exists concerning how to define the syndrome, what criteria should be used to proscribe its boundaries, what its etiology consists of, and finally, to what extent psychotherapy can prove successful in alleviating the suffering of the NTR patient. This overriding conclusion was also reached at two major conferences held respectively 20 years ago (Olinick, 1970) in the United States and ten years ago (Limentani, 1981) in England. It is also the conclusion reached by Finnell (1987), who just published her review of the NTR: "A Challenge to Psychoanalysis."

Limentani's article deserves further attention regarding this lack of consensual agreement. After briefly reviewing the points raised by the other symposium members[6], the author presents two NTR cases of his own. Following each of these presentations, he demonstrates how the clinical material could be understood from many of the vantage points espoused since Freud, and presented in this chapter. Notions related to unconscious guilt, sadomasochism, intense negativism, envy, narcissistic disturbance and traumatic separation were all viable

explanations for the way the author's patients reacted in the treatments he described[7].

Rather than get caught up in arguing for one or more of these explanations, the author attempts to locate the common factors underlying the patient's NTR which may manifest in any of the ways described above. First he notes that the NTR patient becomes extremely anxious in response to some favorable development in the therapy, and that the anxiety makes itself known by the patient's acting out in the transference. This is the first common factor. The second common factor, according to Limentani is to be found "in the overwhelming evidence that the patient is defending himself against a danger or threat" (p. 388). The patient attacks the therapist and the therapy on these occasions. These attacks are regarded not as primarily motivated to exact pain in the therapist, but as the patient's best line of defense.

Limentani remarks that earlier in his career he had favored the view that the threat experienced by the patient was due to a faulty synthesis of split off parts of the self. While not discounting, in this regard, the challenge to the patient of learning to live with something unacceptable or unlikable in themselves, such instances in the NTR are "amenable to the ordinary care and attention of a well conducted analysis" (p. 388). Some such splits, however, were not found to be so amenable to analytic work. In these cases the NTR was repetitive to the point that the

analyses were interminable. Limentani asserts that in these latter cases, "I believe we are dealing with a defence associated with the threat of unendurable pain and psychic suffering ... The pain is remembered sufficiently clearly to be avoided at all costs, but the memory of the event to which it relates is often neither accessible or available" (p. 388).

Limentani then notes that his dissatisfaction with the use of the concept of integrative failure was dispelled by a paper by Gaddini (written in 1981, but unpublished). Gaddini takes Winnicott's (1974) notion of the difference between non-integration and disintegration as his starting point, noting that disintegration presupposes some degree of integration. Gaddini distinguishes between those splits which follow integration and those splits that occur when no integration has yet taken place. The latter are more amenable to therapeutic intervention. In either case, the anxiety associated with the split regards the loss of the self. Integrative efforts are experienced as a "fatal step beyond return, which is the passage from survival, even if precarious, to the final catastrophe" (Gaddini, quoted by Limentani). It becomes useful then to distinguish between anxiety associated with non-integration and anxiety associated with integration. The latter "represents the true pathological aspect: it is stronger than the anxiety of non-integration, and prevents the natural developmental process, and contributes in an essential way to the

maintaining of the non-integration state as an extreme defence" (Gaddini quoted by Limentani). This sheds considerable light on understanding the meaning of the anxiety to the patient, and allows the therapist a conceptual tool to try and clarify the meaning.

But, as Limentani correctly points out, this still leaves the therapist in the dark as to why so much hostility is released by NTR patients who are so clearly distressed, anxiety ridden and overwhelmed by their psychic suffering. The author concludes that the hostility is an expression of inner tension and danger that is intended to mobilize the analyst's attention, while challenging his capacity to contain the patient's worst fears. It is therefore "an opportunity for turning what is unquestionably negative into something positive" (p. 388).

NOTES

1. For example, Jones (1955) points out, that the Wolf Man is "assuredly the best" of all Freud's case reports for "Freud was at the height of his powers, a confident master of his method."

2. These shocks and stresses refer to his life in war torn Europe in the first half of this century. Gardiner (1971) details this in his biography of the Wolf Man.

3. Brandchaft offers a very interesting account of the Wolf Man's recollections of his analysis by Freud. Brandchaft reinterprets the analysis along the Self-Psychology advocated by Kohut (Kohut, 1979; Kohut and Wolf, 1978). Essentially, Brandchaft locates the curative factors in the therapy within the mirroring and idealizing transference enacted by the patient and responded to with great interest and acceptance by Freud. That both Freud and the patient clearly liked each other and respected each other - and often shared these opinions openly throughout the treatment underscores Brandchaft's interpretation.

4. It is not lack of appreciation of Freud's enduring genius that leads me to posit an alternative way to examine this case. Indeed a latter-day alternative hypothesis is supported by Freud's own prescient words: "Naturally, a single case does not give us all the information that we would like to have. Or, to put it more correctly, it might teach us everything, if we were only in a position to make everything out, and if we were not compelled by the inexperience of our own perception to content ourselves with a little" (1918, p. 476).

5. Wilhelm Reich's (1933) Character Analysis was not published until 15 years later. Even after its publication, Freud and his most fervent supporters, denounced Reich's ideas.

6. Limentani briefly reports on some of the contributions at the Third Conference of the European Psychoanalytic Federation held in 1979. These contributions were presented under the unifying title of 'New Perspectives on the NTR.' Unfortunately these presentations are all cited as "unpublished" in Limentani's bibliography. My efforts to determine whether these presentations were published have thus far proven inadequate.

7. Finnell's (1987) summation is similar. Calling the NTR a "multidetermined but not unitary clinical phenomenon that has generated much controversy," Finnell reviews the interpersonal and intrapsychic elements that are dynamically involved. She highlights the interpersonal conflicts between longings for fusion and the wish for separateness as

central and sees the intrapsychic dynamics of envy and narcissism as critical. The aggression, revenge and oppositional reactions interfere with therapeutic progress which may range from temporary to characteristic ways of responding by the patient. Finnell also regards the transference-countertransference situations as being made difficult by the use of projective identification.

CHAPTER III

METHODOLOGY

Introduction

My first task in preparing to interview therapists was to arrive at a working definition of the NTR. This was difficult because the literature defines the NTR process on two different levels: descriptive and explanatory. Moreover, both the descriptions and explanations of the process are derived in two ways, intrapsychically and interpersonally. Thus, there are a number of perspectives from which the NTR can be examined. Since my main goal was to study how therapists today experience and make sense of the NTR situation--irrespective of their particular analytic orientation--the definitional criteria I ultimately arrived at had to allow for the inclusion of these different levels of examination.

Preparation for the Selection of Subjects

In developing the criteria I was using, I had to be clear what was anchoring these different levels. As we have seen, the NTR pertains to those clinical situations which have the common feature that the patient resists getting better. Further, we know that this resistance is of a special kind. Narrowly defined, it is linked to paradoxical worsening following correct analytic work or improvement.

Broadly defined, it is linked to an ongoing resistance to recovery, where the resistance is not a response to iatrogenically produced impasses.

I thought it necessary to frame the resistance in relational terms, as I believe that the core meaning of the NTR is located in what the patient is communicating, via his resistance, to the therapist. As a starting point, I conceived of the communicational intent of the NTR as a class of utterances that conveyed a lack of trust, based on the patient's perception of the therapist as dangerous in some manner.

For impressionistic purposes, I employed examples of how this lack of trust might be metaphorically communicated. For instance, in oral terms it could be communicated around metaphors of poisonous food; in anal terms, it could be communicated around metaphors of control; in phallic terms, it could be communicated around metaphors of seduction. I also found it necessary to mention concepts that are typically regarded as intrapsychic factors, such as guilt, masochism, narcissism, envy and negativism. Similarly, I noted the kinds of concepts that are more interactionally based such as transference-countertransference manifestations and projective-introjective relatedness. Finally, there was also a need to underline the quality and intensity of the NTR situation, typically experienced by the patient and/or the therapist: hopelessness, despair, resignation, etc.

Taken all together, these different angles on the NTR were communicated to potential subjects when I requested their participation. Typically the request was in the form of a letter (see Appendix I) which was followed up by a phone call. For some of the therapists who I knew from my previous clinical placements, I only telephoned.

Despite trying to cover all the relevant angles, I still found it necessary to discuss further what was intended by the criteria I was using, before a therapist was able to determine whether s/he had indeed experienced a NTR in her/his practice. Typically, it was a matter of my accommodating to the language the particular therapist was most comfortable using. Thus, if I was speaking to a classically oriented therapist, I found it useful to include notions related to superego and ego pathology. Or, when I was speaking to someone more versed in the object relations language, I found it useful to mention topics related to the role of internalized object representations. Or, when I spoke to therapists who were more familiar with a developmental framework, it was useful to talk in terms of separation-individuation issues. Again, these discussions were in order to locate a common ground so that the person I was speaking to could clearly ascertain what it was I was addressing in this study.

Confidentiality

The issue of confidentiality loomed large throughout the study. Initially I related to each participant that I would not be requesting any information that could potentially identify the patient. Aliases were assigned in some cases, though it was more typical that the therapist merely used third person pronouns. I found, however, that confidentiality was not a clear cut issue. For example, though I purposely did not ask about the patient's occupation, a couple of times the therapist found himself in a bind precisely because the patient's occupation was relevant to the NTR description. At such times, I told the therapist to err on the side of caution, even if it entailed making vague comments. I also expressed that at these times, the therapist should feel free to derive conclusions without presenting his reasoning if such reasoning involved specifying such identifying data.

That we are currently in a period of increased malpractice suits influenced the data collection. Two therapists raised this concern when declining to participate. Two other therapists who did participate asked to see their interview transcripts before giving their final consent. Fortunately, both of these therapists felt secure with what they read and gave their consent to be included.

Overall, the way I dealt with the issue of confidentiality puts an added burden on the reader. In a case report format, typically the author is able to describe

certain patient characteristics (e.g., physical appearance) such that the reader can form a working image of what the patient looks and sounds like. In this study, I have minimized the presentation of such information. As a result, the reader has to fill in many such details on his/her own.

Related to the issue of confidentiality are the more basic issues of privacy and trust. Not only was I asking therapists to make public their work, I was asking them to do this around therapies that were, by definition, difficult to conduct, or perhaps, resulted in failure. I can only speculate on whether such a context influenced those therapists who declined to participate. (It seems natural to me that therapists would wonder if I would ascribe neurotic difficulties to them as a basis for the NTR.) Yet, a number of therapists who did participate spontaneously remarked on how they noticed in themselves an initial resistance to my request. Typically, these therapists spoke of their resistance in terms of their own narcissistic fears. Further, the oedipal structure of my request - the student-child asking the therapist-parent to talk about a "negative" therapy - seems relevant, but again, can only be speculated about.

Subjects

Fourteen therapists were interviewed about their experiences treating patients who evidenced a NTR of a

sustained nature. One of these therapists agreed to describe two separate NTR experiences. I therefore collected fifteen NTR examples to analyze.

Originally I considered interviewing only psychoanalysts. I enlarged my potential subject pool mainly in order to increase my chances of finding practitioners who would agree to be interviewed about a subject so sensitive in nature. This was fortuitous, for even by increasing my subject pool to include psychiatrists, psychologists and social workers, I had a lot of difficulty reaching an adequate sample size. There were a number of reasons for this difficulty. For one, many of the therapists I contacted stated they were too busy to be included in the study. The second most commonly given reason given for not participating had to do with the inapplicability of the NTR designation: Several therapists said they had not been witness to a NTR in recent years, while two other therapists stated that they did not accept that the NTR concept was sound.

After being declined by the first eight therapists who I wrote to - none of whom I ever had any prior contact with - I decided to approach practitioners who I knew from an agency I had worked at previously. These practitioners had seen me present my own therapeutic work at case conferences and had witnessed my reactions to the work they had presented. These therapists agreed to be interviewed with little or no hesitation.

At this agency I was able to schedule three interviews. After completing these interviews I then contacted therapists affiliated with the institution where I had interned. There I was granted five interviews, three of which were conducted with therapists who had served in some type of supervisory capacity to me during my internship. Since these three therapists had supervised my work in a hospital setting, they agreed to describe cases that pertained solely to their private practices.

I continued to write to therapists whom I did not know. Again, a number of them declined, but now some responded favorably. The distinction between those who declined and those who said "yes" is clear. Those who agreed to be interviewed were therapists who had worked with, and not just known of, the people (committee members and friends in the field) who had recommended them to me. This personal connection appears to have been decisive in the responses I received.

The Interview

I devised a semi-structured interview containing six sections (see Appendix B). The first section included questions that were intended to get a sense of who the therapist is as a professional. After asking the therapist's age, I inquired about his academic background, his membership in professional organizations, his length of practice, his type of practice responsibilities (i.e.

percentage of time doing out-patient work, supervision, etc.), and the type of patients seen in treatment. After these questions I then spent a bit more time finding out about the therapist's orientation, the major influences on how he approaches and thinks about his work, and his current professional interests. In addition to gathering this information, this section of the interview was intended as a "warm up" period, where both the therapist and myself could get comfortable with one another.

The second section introduced the main topic of interest, the NTR. I began this part of the interview by stating that I was interested in hearing about the drama of the NTR as it unfolded, including both what the therapist and the patient were experiencing. Follow-up questions pertained to when in the overall course of treatment the NTR emerged, the therapist's thoughts on what provoked it, and whether it ever was resolved.

The third section focused on the patient. Here, I asked for a description of the patient: presenting problems and reason(s) for seeking treatment, developmental history, prior treatment history, prominent transference reactions, and communicational style. I mentioned that I was just as much interested in how the therapist came to understand and know the patient as I was in the content of the responses. To get at the relational context, I also asked how the patient experienced himself and the therapist, and what roles seemed to be assigned to each from the patient's

perspective. I underscored that I was interested in getting a sense of how the patient responded to the therapist and to the therapist's interpretations.

The fourth section focused on the therapist. I explained that I was interested in what the therapist thought and felt about himself treating this particular patient, and the kind of countertransference reactions experienced over the course of treatment. I also stated that I was interested in how and why these countertransference reactions were evoked.

The fifth section focused on issues related to the presence of narcissistic pathology. This section included questions related to the patient's idealization, grandiosity, devaluation of the therapist, and dependency. I also asked if the patient spoke of or seemed envious of the therapist and whether the patient's envy played a role in the development of the NTR.

The sixth section brought the interview to a close. I asked if the therapist thought that any important aspects of the NTR had been overlooked. I then inquired about the therapist's reactions to the interview process and whether he had any recommendations about how I could improve the interview.

Procedure

Starting with my proposal orals, a shift in my perspective on the study began. This shift was

characterized by a movement away from a hypothesis testing approach to an increasing emphasis on the exploratory nature of the study. Underlying this shift was a philosophical change having to do with recognizing that my approach to the study had been grounded in inappropriate applications of causal thinking.

The domain of psychoanalysis, as Home (1966) pointed out, is concerned with the category of meanings. Causes on the other hand, belong to categories appropriate for understanding facts typical in the domain of the physical sciences. When I was initially designing this study, I was heavily influenced by my search for causal knowledge pertaining to the NTR. The most prominent questions guiding this initial phase of the study included: What provokes the NTR to occur? Is the NTR predominantly a based on preoedipal or oedipal disturbance? Is the NTR primarily a result of narcissistic pathology? Is the NTR, at foundation, a reenactment of the patient's envy?

These questions are of course legitimate, but only when they are founded in the meaning of the NTR to the patient and the therapist. Further, the meaning can only be discovered in the intersubjective act of knowing that is the hallmark of psychoanalytic psychotherapy. The meaning can not be deducted *a priori*, which is essentially what I was attempting to do: I read through the literature, derived some hypotheses, and then looked to the literature to find support for these hypotheses. What I was leaving out in

this process was the patient's and the therapist's experience of the NTR together with each other. It is out of this shared experience that meaning is derived. A literature review, can only infer such meaning.

The Interview Process

When I began to interview therapists, I was consciously trying to table my inclinations to find causal knowledge, so I could immerse myself solely in what the therapist was describing. This was not an either-or process, but more of an evolution in which I became increasingly able to maintain an expectant, open-minded position. Descriptively, I was trying to assume what Freud (1912) called "evenly-suspended attention." This is not intended, however, as just a description of what I was doing, but also represents the theoretical posture I was taking vis a vis the process of collecting the data.

The analogy between my relationship to the data and the therapist's relationship to the patient is intentional. As Bion (1967) advocates, I was moving more toward an inner position that was "beyond memory and desire." My memory of what I 'knew' about NTRs would only get in the way of being able to discover what each therapist was conveying to me. Similarly, my desire to invoke hypotheses would also only get in the way of hearing what the therapist was describing, thereby distorting my experience of the therapist's presence and his words.

Taking such a position during the interviews was not easy. Rather, it was fraught with much doubt and anxiety. These doubts and anxieties often took the form of the following questions: Will I be able to discover any coherence in the data? Will I ultimately be able to say anything of relevance? Will I be able to make a worthwhile contribution to the field (which is the main purpose of doing a dissertation)?

Bion noted similar anxieties and doubts which register in the therapist who is facilitating immediate experiencing in the search for the unknown. Duncan (1981), in writing on Bion, remarks that being 'beyond memory and desire' involves being capable of experiencing uncertainties, mysteries, and doubts without reaching after fact and reason. It is a position that Duncan believes "occurs in the shadow of an inner persecutory anxiety" (p. 346).

It was necessary to recognize the insecure position I had taken. Otherwise I would have been more prone to act in ways to rid myself of my dystonic feelings. What sustained me was primarily due to the ongoing experiences I had of the interviews themselves. As I progressively embraced the stance Bion advocates, I became increasingly aware that the interview experiences, for myself and the interviewee, were increasingly richer, and had more texture and depth. Most importantly, by not anticipating nor wanting to hear certain material, I was drawn closer to the meanings of the NTRs as these meanings emerged in the interviews.

In terms of the interview protocol, what occurred was a process whereby I rather quickly loosened my grip on making sure I asked every therapist the same questions. Essentially, I internalized the list of questions; when a specific question was put forth it was done spontaneously in order to clarify what was being conveyed. Further, by internalizing the questions in this manner, I was better able to meet the therapist where he was positioning himself in relation to the task at hand. By the fourth interview, the structure of the meeting had evolved to the point where I simply stated that I was most interested in hearing what the therapist thought and felt were the main ingredients of the NTR drama, in terms of the patient's inner world, the therapist's inner world and the mutual influences of the patient and therapist. Invariably I found that this statement led the therapist to discuss most of the major elements of the interview protocol plus some elements I had not anticipated. It became very natural for me to sit and listen, whereby both the therapist and myself could follow our (often shared) associations to the material being discussed.

An unexpected outcome was that a number of the questions I had concerning the elements of the NTR situation became reframed into questions about how the therapist worked. For example, I had earlier hypothesized about the role of projective identification in the development of the NTR. What developed for me was a different cognitive set,

in which the more interesting question became something to the effect of: "Do you find the concept of projective identification useful in understanding the meaning of the patient's communications?

The domain of this study therefore became enlarged. Though still grounded in the NTR situation, I learned a great deal about how these therapists work and reflect on their work: How they use themselves as analytic instruments, how they incorporate theory into their experience being with a patient, and what kinds of experiential data are relevant to them.

Consistently these interviews were heavily marked by experiences of discovery, often as much on the therapist's part as on mine. The sense of freshness and aliveness was, in fact, remarkable. Many therapists noted with joy that they had learned a great deal about the therapy they described during the interview process. As a result, most were glad to set up additional meetings to further discuss the cases they were presenting. For example, one therapist agreed to meet on three different occasions. Though we both felt that he had extensively covered the therapy, he mentioned at the end of the second meeting that he wanted to think more about the role of the patient's envy, that he had not considered this fully enough prior to our meeting. We then scheduled a third meeting in which he described what he had arrived at concerning the patient's envy of him and how that had figured into their relationship.

Approach to the Data

Each interview was tape recorded and transcribed verbatim. After all the transcriptions were completed, I approached each one as an entity unto itself, whereby I avoided making comparisons between interviews (since comparing is a process based on memory and desire). Further, I consciously avoided making interpretations of the data while I was preparing the write-up of the results in order to maintain a position situated as close to the data as possible. I also avoided imparting my own theoretical leanings in preparing the results chapter. When theoretical constructs are employed, they derive from the therapist's explicit remarks. The outcome of this process is contained in the next chapter.

CHAPTER IV

RESULTS

The results are organized into four sections. The first section contains the information related to who the subjects are as professionals. The second section presents five case studies. The third section provides summaries of all fifteen NTR descriptions. The last section then reports on some of the more frequently mentioned intrapsychic and interpersonal dynamics described in the interviews as a whole.

Therapist Profiles

Overall, fourteen therapists agreed to be interviewed and eighteen declined. Of the fourteen who agreed, one is female, the others male. Of the eighteen who declined, six are female, the rest male. The interviews ranged in length from one hour to four hours, with a mean slightly over two hours.

By occupation, the fourteen subjects have the following degrees: psychiatrists - eight; psychologists - five; social worker - one. In addition, four have completed analytic training, two were finishing their analytic training, and three others had received extensive analytic training (four years) in programs not formally designed to confer analytic licenses.

The youngest therapist interviewed is 35 years old; the oldest is 63. Seven of the therapists are in their late 30's, four are in their 40's, one is 50, and two are in their early 60's.

All therapists have had experience in both inpatient and outpatient settings except for one therapist who had not worked in a hospital. Similarly, all but one therapist maintain private practices; the other has been at two outpatient settings for the last eleven years. The number of years practicing after being licensed ranges from two years to 35 years, with a mean of thirteen years. This is somewhat misleading in that a number of the therapists interviewed had extensive training prior to licensure. Except for the therapist with two years experience, all the other therapists have practiced for six years or more.

All therapists reported having experience treating a wide range of psychopathological conditions. Interestingly, while all have had a great deal of experience working with character disordered and psychotic patients, most described having less experience with a neurotic population. Clearly, this sample of therapists is more interested in severe forms of pathology than otherwise, a comment I frequently heard in the interviews. This is also reflected in the training experiences described. Many of the therapists, after receiving their degrees sought further training in hospital settings in a post-doctorate capacity.

The question related to orientation was often responded to with a preface such as "I'm informed about various schools of thought and I try to use them accordingly," or "Within the psychoanalytic realm, I consider myself eclectic." The notion of using certain general constructs such as a "classical" approach or an "object relations" approach depending on the individual patient was also mentioned a number of times. Another therapist, who is in psychoanalytic training at an institute that he described as Freudian remarked that his orientation "might distort more than it reveals." He quipped that though he considers himself a Freudian analyst, he "didn't stop learning in 1939." He then listed nine different influences including one of the other therapists I interviewed.

Given the diversity of influences mentioned, there are still two general conclusions. One concerns the frequency with which Freud was mentioned. In fact, a number of therapists made a point of mentioning that Freud's work serves as the foundation for their work. Nearly just as often, the response I received concerned the influence of the British School, notably Winnicott and Klein. This is worth noting, in that I have often seen it remarked that American therapists, or at least psychoanalysts, have not had exposure to the British School of object-relations theorists. For the sample of therapists who participated, this assumption is not accurate. I also want to add that three of the therapists who mentioned Klein, remarked that

they did not agree necessarily with her thinking about developmental timetables (i.e. that the infant is born with certain capacities, internal objects, etc) but found her descriptions of internal processes clinically useful on a day to day basis.

I should mention that due to time constraints, I was not able to find out about "influences" for four of the therapists who participated. With this in mind, the other writers mentioned more than once included Kernberg, Kohut, Schafer, Langs, Khan, Lidz, and Sullivan.

Case Studies

In organizing the results of the data collected in this study, I looked to the literature to see if an adequate guideline of how to categorize NTRs had been proposed. Unfortunately, I have not been successful in locating an appropriate classification schema. Most of the early, and some of the later literature treats the NTR as a monolithic phenomenon. This is true of Freud (1923, 1937); Klein (1957); Riviere (1936); and Levy (1982). Conversely, the most recent contributions (e.g., Finnell, 1987; Limentani, 1981; Gorney, 1975) avoid positing any such classifications, highlighting instead the range of patient pathologies which can lead to a NTR. In fact, of the literature reviewed, only two authors attempt a specific classification schema. The first is the three "varieties" proposed by Asch (1976). The second regards the three categories discussed by

Kernberg (1984). While these contributions have much to offer in their attention to the kinds of developmental pathologies which are re-enacted in the transference, as classification schemas, they can not be adequately applied to the data collected in this study.

Asch's contribution is remarkable in highlighting the role played by defective separation and individuation development. As reviewed earlier, he suggests three etiologies or "roots" of the NTR, those derived from: 1) the masochistic ego, 2) unconscious guilt (including "preoedipal crimes"), and 3) a characterological defense against regression back to symbiosis with a depressed preoedipal object. Though his clinical acumen has much to offer, the data I collected do not adequately enough support these distinctions. Many of the NTR descriptions I collected display prominent elements of two, and often all three of Asch's categories.

Kernberg also posited three types of pathology underlying the NTR. These pathologies derive from 1) an unconscious sense of guilt, 2) unconscious envy, and, 3) an unconscious identification with a sadistic object that requires submission as a condition for attachment. Like Asch, Kernberg suggests that these pathologies are exclusive of one another. That is, they are typical of different personality types. The first implies masochistic personality structure, the second is found in narcissistic personalities, and the third is typical of most borderline

personalities and some schizophrenics. But again, the data collected here does not suggest such a clear delineation. More often than not, the individual descriptions contain prominent features of more than one of the pathologies Kernberg presents. Thus, it is not useful to follow Kernberg's schema either.

The problem I am facing (typical of psychiatric nosology in general) is reminiscent of Bateson's (1972) discussion of "logical types" wherein different levels of explanation are confounded with one another. Grossman's (1986) review of the use of the term "masochism" is instructive in this regard. Grossman points out that psychoanalytic terminology has gone through so many transformations that our current usage of terms like masochism often results in imprecision. Grossman shows how, in the example of masochism, the term is used to denote genetic determinants, dynamic derivations, and affective conditions - three very different levels of explanation. Certainly a similar vagueness applies to other prominent terms in NTR explanations such as narcissism and guilt.

With the above in mind, I cannot present an adequate classification schema; such a task faces the whole of psychoanalytic investigation and is therefore larger than that which can be attempted in this project. But I am still left with the question of how to organize the presentation of the data.

Like Asch[1], I am most impressed with the variety of NTRs that can occur in therapy. As such, I found a wide range of patient pathologies that can be thought of as vulnerabilities (Gorney, 1975) to forming NTRs. In what follows I am presenting this range in its originally collected form. In doing this, I will also be presenting the main constructs used by the therapists themselves regarding how they think about and define the NTR designation.

As a way to suggest the range of pathologies which lead to NTR situations, I begin by presenting two separate cases described by the same therapist. The occasion to hear about these different cases arose out of a discussion that took place at the close of the first interview with this analyst. In this discussion, the analyst mentioned that he had presented a case that fit with the broader criteria I proposed when I introduced my request to him to participate in the study. He stated however, that he personally restricts his understanding of the NTR designation to that which Freud originally proposed. He then kindly agreed to present an example of a NTR that fit closer with his restricted use of the term so that I could have the opportunity to compare and contrast these two different cases. Since these two cases begin to show the range of treatment situations which I call NTRs, the presentation of the results will commence with these descriptions.

The NTR as a Resistance to Separation

One of the pitfalls I am attempting to avoid concerns a too rigid demarcation between what is and what is not "truly" representative of the NTR definition. Thus, I include this case as illustrative of the NTR, not because I am convinced the therapy as a whole meets the criteria, but because certain aspects of it definitely do. In this way I am following Freud's (1923) often quoted statement that the NTR "in a lesser measure ... has to be reckoned with in very many cases, perhaps in all comparatively severe cases of neurosis."

At the outset of the interview, the analyst mentioned that he chose this case to discuss mainly because it was "dramatic" and had ended without being "resolved." He noted that when a NTR is resolved, "it kind of fades into the course of a treatment situation." The analyst also stated that he was presenting this particular case because of a recent situation which necessitated his having to transfer the patient to another therapist. As such, closure on the question of whether the impasse could have been resolved is moot.

Introduction and Background

The patient is a married middle-aged mother of two children who was referred for therapy by her personal physician. The presenting complaint was psychosomatic in origin, having to do with a longstanding problem related to

difficulties swallowing. The patient had been in therapy previously "with someone who had tried to do hypnotherapy on her." The therapist was immediately impressed with this woman's presentation, in that "she had no idea of what was inside, which was, on the one hand, emptiness, and on the other, tremendous rage." Diagnostically, the therapist saw her as "on the border" between schizophrenia and a severe borderline personality disorder.

Childhood and Adolescent Development. Prior to her birth, the mother had been in an automobile accident. As the mother was unmarried, the patient's maternal grandmother cared for both the patient and the mother after they came home from the hospital. For a number of years mother had to stay home, presumably due to the injuries she incurred in the accident. The therapist characterized these years in the child's life as involving "an incredibly close symbiosis" with the mother.

At age five, the patient and her mother went to live with a man whom the mother was involved with but not married to. At age eight, "suddenly" the grandmother got custody of the child and "took the child from the mother." Details as to what prompted this event are unknown. What became clear in the therapy hours was that the child believed she herself was what "caused the grandmother to, in a sense, legally kidnap her." This belief stemmed from the grandmother's many remarks to the child "that if she misbehaved or did something wrong, she would lose her mother." The therapist

perceived that the patient "had the sense that it was her omnipotent wishes and fantasies, if not behavior" that caused her to leave her mother.

Throughout the next five years, and without warning, mother would visit every month or so. To the daughter it seemed as though mother "would appear out of the blue and then disappear." Such unplanned visits helped the daughter maintain the wish that mother would "come and take the patient away from the grandmother."

At 15, grandmother died. Regarding this event, the therapist was again struck by how "the patient ... thought that she had killed the grandmother, because she had wished it." At this point, the patient returned to live with her mother, with the "fantasy" that life would be like it had been when she "was two or three." Yet, "by this time the mother was almost a total invalid." Instead of receiving the mothering that she so sorely missed, the patient "then had to care for the mother."

The patient developed "a false presentation a la Winnicott" that manifested itself clearly in her life as a student. She was "always trying to perform well academically" to win over her teachers' love, while underneath the facade was constantly "feeling totally inadequate." To her classmates, she appeared "quite schizoid." The therapist remarked, "It was like this quiet, crazy person inside this nice appearing, well meaning, pleasing young girl."

Adult Development. As a teenager, the patient married a man "who was to replace the mother and make her whole again." Though she never was able to recapture the longed for "blissful reunion," "luckily" the husband "stayed around to protect her." The therapist stated, "otherwise, she would have fallen apart and become psychotic."

As an adult, the patient "would spend days going to the gravesight of her grandmother who was buried hundreds of miles away." In time, the therapist found that these visits were motivated by the wish to visit the mother whose gravesight was unknown. Throughout adulthood, the wish to return to mother remained as strong as it had when she was first taken from mother at age five.

The Therapeutic Relationship

After an initial period of "guardedness" the patient "became very dependent" on the therapist. The dependency experienced was, according to the therapist, "certainly" of preoedipal origins. This was suggested by how the patient "couldn't maintain an image" of the therapist during separations." The trauma of separation was so severe, that she "would get increasingly suicidal," especially when the therapist went on vacation. The extent of the interpersonal pressure experienced by the therapist was evidenced by his "extraordinary"[2] response to the patient. During vacations, he "would usually contact her a couple of times." This was

"for both our well-beings, because otherwise I would be just preoccupied" with whether the patient was still alive.

The "primitive" quality and intensity of the patient's rage dominated the treatment relationship. The therapist noted that often "there would be a fear reaction in me in which she would attack me" during the therapy hours. He further stated that the patient "was the kind of person who would come into a psychiatrist's office with an axe." Attending to his fears and associations made it clear to the therapist that "her tremendous defense against aggression was also very problematic."

With the above formulation, the therapist saw the treatment goals as a function of the following three questions: "One, how do I maintain a therapeutic alliance? Two, How do I maintain a holding environment? Three, how do I get to the rage?" The therapist stated that he thought of these goals in terms of the work by Winnicott and Klein.

The therapist recognized that not only would a psychoanalysis be detrimental to this woman's condition, but that a talking psychotherapy would also be inappropriate. As such, he instituted a play therapy model, using techniques in which "she would bring me dolls, put them on the floor, and get into rage attacks." In this way, the therapist "got to" the patient's rage; these rage attacks, however, were still far removed from any kind of working through process.

For one thing, the patient "would always feel guilty" after one of these episodes of "wanting to nail me to the cross [or] rip out my genitals." The patient "would always have to call" the therapist afterward, "because anger in her fantasy, always meant that mother would leave her." Interpreting to the patient the connection between her guilt and her rage did not seem too useful. If it "hit the mark she would get angry, and if it didn't, we would talk about the fact that she wasn't getting angry." Overall, "the rage seemed unending."

Interpreting to the patient the connection between her rage and her "abandonment" by mother, or interpreting this connection within the transference (when the therapist was going away on vacation) had no discernible impact on the patient. The patient's NTR was seen by the therapist as her inability to entertain these comments as having any meaning for her. This inability, according to the therapist, was sustained throughout the therapy, leaving the therapist with a strong sense of stalemate. He described the NTR as based on "her fixation" and "her wish not to give up the internalized symbiotic mother, that then became reactivated in the transference."

The "Broad" NTR: The Fantasy of Fusion

The following excerpt captures the flavor of this woman's NTR:

> She didn't want to separate. ... She didn't see any problems with fusion

> intellectually. I mean, if she could see problems, for her that would be great. But she was unaware of any anxiety about merging--that was her desired state. That's what she wanted. ... Universally, one would have terrible fears and anxieties about merging, but she did not exhibit those.

The quandary the therapist faced, like in so many other NTR situations, seems to defy a logical way of conceptualizing how to proceed. On the one hand, the patient would be rageful at the therapist's "insistence" at being separate. (This was not a verbal "insistence." Rather, the limits of the therapeutic framework insisted on their separateness.)

On the other hand, the rage remained "split" off from the patient's experience of the therapist as all good. The patient could thus continue her merger fantasy with the therapist-mother without anxiety. When the rage would surface, it was an expression of her "omnipotent fantasies that she was somehow to blame for the separation." These fantasies, if not created by the grandmother's admonishing words and deeds, were certainly reinforced by them. Structurally, we can think of this as a manifestation of a "superego forerunner" (Klein, 1957) or as the internalized object related to a "pre-oedipal crime" (Olinick, 1964)[3] committed against the mother. Thus the rage she experienced when the therapist informed her of the upcoming termination, was inwardly directed at the internalized grandmother. Within this framework, the patient could continue to

experience herself as completely "in control" of the therapist's actions, to the extent that she was the cause of his plan to relocate to another part of the country.

That the therapist was not able to continue the treatment begs the question of whether this NTR could have been worked through. His own remarks on the matter highlight his uncertainty. He expressed not being sure whether the therapy relationship could have provided "enough of a container" for this woman's "unceasing rage" or whether she would have needed to be hospitalized.

In my second meeting with this therapist, he remarked that the notion of guilt is useful in understanding this patient's dynamics. Here, the guilt is expressed, not in the usual sense of competition and rivalry, but as a function of the fantasized injury to the mother due to the move to separate. He stated that the mother relayed the message, loudly and clearly, that the daughter had to remain with mother, otherwise something horrible would happen to mother. In this way, we can understand this woman's NTR - that is, "her wish not to give up the internalized symbiotic mother, that then gets recreated in the transference" - as occasioned by her guilty burden.

The NTR as Motivated by Unconscious Guilt

The purpose of presenting this next case is to show the range of clinical problems that can become manifest as NTRs. In the case above, preoedipal dynamics highlighted the NTR.

In this next case oedipal dynamics are paramount. This is not to suggest that individuals operate solely at one of these levels. In fact, the results of this study suggest that NTRs most commonly feature both oedipal and preoedipal difficulties. Thus I am presenting these two cases for comparison in order to suggest the wide range of problems which are recreated in the NTR, rather than as typical NTRs.

Introduction

This case is illustrative of what Freud (1923) originally described as the NTR. The phenomenon in which the patient's condition worsens instead of getting better following correct interpretive work is the basis of this type of NTR. In manifesting such a reaction, the patient is primarily motivated by unconscious guilt.

The patient is a "happily married" successful businessman in his early 50's. The patient was referred for treatment by an internist. His presenting symptoms were "anxiety when speaking in a public situation" and depression. The therapist also mentioned that two years prior to beginning therapy, the patient had a sarcoma of his testes. Though the patient "had to be castrated," according to the therapist, "it was cured physically." In contrast to the patient described above "who had a borderline personality organization" this patient is "more neurotically organized."

The "Narrow" NTR: Guilt and Oedipal Crimes[4]

The NTR was characterized by the patient "literally [having] physical symptoms on the couch, which was more of a hysterical conversion reaction, as it turned out." Following an interpretation, confirmed by the patient as correct, the patient "would start moaning and grabbing his stomach." As the treatment unfolded, the therapist and the patient together came to understand these symptoms as a "manifestation of an unconscious fantasy having to do with his identifying with his mother." The therapist elaborated his understanding of the patient's identification in the following manner:

> In his unconscious fantasy, he would be stabbing [his mother] with a knife in the stomach for having sex with his father. And through his symptoms he was bearing his guilt [and] his aggression toward his mother for having chosen his father over him. It also came out that he was afraid of getting castrated for having such wishes--also wishes to kill his father off. This was underlying his symptom about standing up in public. Also when he was away, he would be afraid that his house would be broken into. Which would be, unconsciously, what he imagined his father was doing to his mother--breaking into her house, into her vagina. He recalled eventually, with great anguish, hearing his parents have sex in the next room. So it also had a primal scene.[5]

By focusing on the transference that developed, the therapist began to unravel the genetic determinants of the patient's hysterical symptoms. Slowly, even fitfully, the patient's aggression became manifest in the transference.

Closely following upon the aggressive reaction, the patient became increasingly anxious. The therapist then recapitulated the sequence of questions that he brought to bear upon the patient's reaction. First, the therapist wondered if the anxiety was the patient's way of communicating a "fear of retaliation." The therapist stated this interpretation was corroborated "to some degree, but as we explored that, [the patient] still would be very anxious and have physical symptoms." So the therapist began to wonder if the patient's anxiety was masking something else, perhaps a guilt reaction. The therapist thus made interpretations along the lines of: "What right does he have to get better, if he harbored such terrible thoughts toward me?" The patient's response was quite striking. The therapist remarked that the patient "would start sighing and crying" before exclaiming "I'm such a terrible person." Following such exclamations the patient's symptoms would abate. In this way, the therapist and the patient began to corroborate the correctness of the interpretations regarding the patient's unconscious guilt about getting better.

Shortly after the therapist and the patient corroborated the transference interpretations, however, the patient's symptoms resurfaced in more dramatic form. The therapist understood this reaction as a re-doubled effort to ward off acknowledging the guilt toward the primary objects, namely his mother and father. That is, the therapist saw the resulting increase of symptomatic behavior as part of

the "working through process." Thus, the therapist shifted the object of his interpretations from himself to the patient's parents, from a focus on the transference reenactment to a focus on the hypothesized genetic determinants. In so doing, the guilt feelings which had been "isolated" from the patient's consciousness were brought to awareness. The therapist portrayed this working through process in the following way:

> My understanding is that when I made a correct interpretation, because of his guilt, mostly about his aggression toward mother or father, he would then have more symptoms [and] more anxiety, until we understood that he was feeling guilty. Then, when the symptoms were even worse ... I would say [to the patient], "Y'know, it seems once again, you are feeling guilty about your anger toward your father, and your projection of your anger onto him." Then, as we understood that dimension of it--that is, his guilt about getting better--then he would improve. But if we didn't come to understand his guilt about getting better, then he would have been stuck in that NTR.

Having established the dynamic basis connecting the patient's oedipal difficulties to his aggression and underlying guilt, the therapist was able to successfully return to the patient's fear of improvement as underlying the return of symptomatic behavior. Because, as the therapist noted, this patient's unconscious guilt was accessible, and therefore, amenable to interpretation, this NTR reaction was able to be worked through. In fact, the therapist stated that the patient "had what you could call a cure."

Countertransference

One of the remarkable aspects of working with this patient is that the therapist found he was "enjoying it." For the therapist, "It was more like playing, in the Winnicottian sense of play." Contrasting his experience with this patient with the woman patient presented above, the therapist said, "With the other patient, it felt like a life and death struggle, this [patient] wasn't like that at all." The therapist noted that the male patient "would respond to interpretations" and "knew he was a separate person."

These and other comments by the therapist make it clear that his efficacy and potency as a therapist were rarely in doubt. Remarking on the projective elements of the interaction, the therapist mentioned that the man would project out aspects of his own superego (i.e. - that the therapist "was going to castrate him"), which were not too difficult to accept, seeing as how the therapist knew that this was not his ambition. With the other patient, however, the projective aspects of the communication had a different intent and effect. The intent being "to infuriate the therapist" and the effect being that the patient "thwarts you through your therapeutic ambition."

Summary

The purpose of presenting the two cases above was to show the range of developmentally based difficulties that

can become recreated as NTRs in therapy. In presenting this range, I also pointed to some of the kinds of countertransference responses that get brought into play when the NTR situation dominates the therapeutic process. Now I will present three more NTR descriptions from the data collected. These will be presented more in-depth in order to suggest the complexity of dynamics that are typical of NTR situations. All three cases demonstrate the confluence of oedipal and preoedipal difficulties in the establishment of the NTR situation. In addition, these cases will be elaborated on in order to show how each therapist was able to successfully use his countertransference reactions toward a fuller understanding of what their patients' misery was all about.

The NTR as a Resistance to Relatedness

In this next case, the dynamic understanding of the NTR is the reverse of that which characterized the first case presented above. In the first case, the NTR was characterized by the patient's unconscious refusal to entertain an experience of self as separate and autonomous. That patient's NTR was portrayed in terms of the patient's ongoing merger fantasies with caretaking others. In the following case, the NTR is characterized by the patient's opting for illness, rather than risk further involvement in the therapeutic relationship.

From the outset, this case demonstrates the powerful effect of the patient's split off aggressive affect in the development of the NTR situation. From the beginning, the therapist was aware of somehow being annoyed by the patient. In fact, the therapist stated at the outset of the interview that he chose to describe this case because "the disturbing thing ... right from the start was the presence in me of a great deal of negative feeling about the patient." Though this therapist does not claim that his negative feelings were entirely attributable to the patient's aggressive projections (he draws a more complicated picture suggesting how his countertransference readiness fit the patient's characteristic way of interacting), it is clear that most of his reaction was evoked by the pressure exerted in the transference. Sometimes this reaction took on intense, even "murderous" dimensions.

As a metaphor, it is therefore useful to think of this aspect of the relationship as involving the patient's request for the therapist to "hold" the destructive affect. As we will see, such negative affect was equated with horrors that the patient experienced as literally too terrifying to even imagine. In this regard, Limentani's (1981) thesis concerning disintegration of the ego following the development of integrative capacities is relevant. For this patient, fragmentation was often a preferred state over and above the capacity to think and to make judgements.

This was especially true, when the patient was avoiding the implications of her envy and rivalrous feelings.

Introduction and Background

The patient is a married, professionally successful middle aged woman with two children. She entered the current treatment right after another therapy had ended. The prior therapy left the patient feeling depressed, furious, and abandoned. The ending constituted, according to the therapist, "a narcissistic injury." In part, the injury represented a mixture of intense shame and rage occasioned by being rejected in her wish to remain friends with the previous therapist. In addition to this presenting problem, the patient related a general sense of malaise with marked anxiety in her day to day life as mother, wife and career woman.

Early Trauma and False Self Development. The patient suffered from a a crippling childhood disease, a condition which necessitated a great deal of care. Throughout her childhood, the patient was seen by numerous doctors. She was hospitalized frequently and had surgery performed on a number of occasions. The therapist remarked:

> When you consider the environment, that is, the impairment of her body from birth, of her focus on her body, how she developed ways of engaging, both the real body - the reality of this body - and the fantasies that help her defend against the pain of deformity, and the pain of the surgery ... the aspects of negotiation around her body ... these are certainly things that ...

> happened early on and represent for me the core ... [of] her pathology.

Though the actual trauma can not be minimized, it is the extent to which the patient felt forced to present herself as strong and resilient which is most striking. Throughout the interview, the therapist made references to how no one in the family (not mother, not father, not even the favorite grandmother) could allow the patient "to reveal the extent of her dysphoric state." The patient, in Winnicott's terms, developed an entrenched false self. No one:

> ever contended with the chronic pain and unhappiness that she was going through as a kid. Nobody talked with her about it, nobody was willing to acknowledge that that was so. All the adults tended to see her as a strong, special child who overcame physical adversity ... she was a doll, she was a poster child.

The family's characteristic denial of unpleasant events is also evident in the way they shunned attending to instances of incestuous relations. Without going into details, it is safe to presume that the patient's parents went to great lengths in creating an atmosphere of enforced silence even when faced with undeniable evidence of impropriety in the family.

It is also worth noting that the family took a similar stance of denial regarding an important relative's death. That the patient herself painted a distorted picture of this relative's death for her kids, further suggests the intense

shame, characteristic of, yet undoubtedly motivating, this family's way of dealing with painful events.

In speaking to the patient's false self development, the therapist stated, "So the history presents essentially a kid who has a lot to think about and" who "is feeling a great deal" of sadness. "And the only thing" the parents "want to hear is how great things are going in her life." The father "would tell her, very, very emotionally, and with a great deal of anxiety himself, that he can not stand to see her cry. Please don't cry! And she says that over the years she learned not to show any of this."[6]

Confluence of Oedipal and Preoedipal Pathology. I want to move into a more specific discussion of the patient's relationship to her mother, father, and siblings. Again, characteristic of so many of the patients described in this study, we can begin to appreciate the complexity of both pre-oedipal and oedipal issues in the development of an individual vulnerable to forming an NTR. The issues to be highlighted include the dysfunctional aspects of the maternal-infant dyad, the prevalence of envy as a characterological trait, and oedipal victory, with the resultant emergence of unconscious guilt.

The patient's mother is described as an "ungiving, mean and angry woman." The relationship was always filled with contempt. Mother would "constantly accuse" and "blame" the patient for the ongoing conflicts that occurred between the patient and her siblings. Ostensibly this was because the

patient was the eldest, "and therefore should have known better."

The therapist remarked that he thought of the patient's relationship to mother as heavily tinged with preoedipal difficulties. Regarding the mother he states that "her mistake was essentially that she missed an opportunity to have an experience with her daughter that allowed the daughter to reveal the extent of her dysphoric state." As a result, the patient had to "split" off her rage at being the victim of her misfortune early on in her development. Such split off rage was typically associated with her relationship to the preoedipal mother.

Conversely, the patient's relationship with father was very close. In fact, "she experienced herself as her father's favorite." The therapist remarked that "from her descriptions, he was a very giving and warm man toward her." Unfortunately, this closeness came at a price, in that it was largely within the context of the mother's rejection of the father. The patient's recollection was that father's attempts to engage the mother were always refused. As a result:

> The father often turned to this daughter and did many things with her. And she felt victorious, although she doesn't hold, she is not aware of the intense rivalry that she was experiencing around the mother and the father. She doesn't see herself as in any way stealing something that rightfully belonged to the mother. The way I think she gets around that is to maintain this ongoing rage against the mother, and thus avoids feeling any guilt over the victory.

This brief history establishes a framework to begin to understand the confluence of oedipal and preoedipal issues in the patient's struggles throughout her later life. One cannot simply opt for an oedipally based or preoedipally based analysis of the patient's problems. Indeed, from this material we see how the guilt over the oedipal triumph is defended against by invoking a preoedipally constituted rage. Yet this is not merely an instance of regression as a defense. The guilt is real, yet so is the rage an undistorted vestige of earlier experience.[7]

Finally, in terms of the patient's history, the therapist spoke at length about how the patient's envy of her siblings dominated many of her interactions in the family. In fact, the patient's envy, as it informed the constant feuding in the family, is what appears most likely to have provoked the mother to blame the patient for causing so much strife in the family. Be that as it may, to the therapist, the envy was of pathological proportions, "and is still as sharp today as it must have been then."

The patient's envy is depicted as central to her character. We can appreciate the reasons for this when we consider her childhood trauma in conjunction with the extent to which the trauma was denied by others. Thus the patient was envious of her siblings "because they seemed to have access to all the things that weren't available to her." In addition to other qualities, "she envied their mobility,

their ability to socialize" and "their ability to get involved" in adolescent romances.

According to the therapist, the patient has continued to be afflicted by her envy of others, though she cannot acknowledge the depth and continual presence of it. He stated:

> What she has a great deal of trouble thinking about and conceptualizing is the role of envy in her life, and the powerful impact of her envious feelings and retributive fantasies. She is a woman who really wants revenge, and she cannot acknowledge the intensity of that desire.

The Therapeutic Relationship

When the therapy began, the therapist was struck by how quickly he felt negatively toward the patient. He recalled that these feelings were focused primarily in two ways. The first had to do with the split off affect that accompanied her "difficulty in the whole associative process." The patient could give "very little in the way of history." During the many silences in the beginning of the treatment, "often the patient would just stare" at the therapist "with a helpless, infantile demeanor" which the therapist found "annoying." The second focus was related to the first. This amounted to the patient's "absence of recollection." It was clear to the therapist that the patient did not suffer from an organically based cognitive impairment. The therapist thus regarded the patient's inability to recall more than just superficial aspects of important events and

relationships as psychologically motivated. That is, he considered her absence of historical recollection as resistance. From early on he felt that the resistance was subtlely yet profoundly tinged with deflance and oppositionallsm.

The therapist conceived of his task as trying to create a space in the therapy where the patient could notice, without fear of reprisal, under what circumstances this resistance became manifest. Indeed, I think it is safe to say that a major theme of this therapy regarded the tenacious way this therapist worked at creating a nonjudgemental accepting atmosphere. I want to suggest, however, that while the therapist was largely successful in this endeavor, the entrenched characterological traits of this patient eventually defeated these efforts. The therapist, in part because of noticing how he would get angry at the patient for the way she presented herself, became aware of how the patient externalized and projected onto him a persecuting attitude. Despite his efforts to contain these projections, eventually the patient did experience one of his reactions as pernicious and mean spirited. The point is not whether this can be considered solely as a transference distortion. Rather, the point of this matter, underscored by the therapist's own remarks, is that he did react in a way that from the patient's viewpoint was aggressive and hurtful.

Early Dependency and Idealization. Initially, the patient became "quite attached" to the therapist. A prominent relational theme in the beginning revolves around the patient's dependent fantasies and regressive wishes toward the therapist. She would often dream about the therapist, wherein the content typically portrayed the therapist as a large, powerful figure. Though these dreams contained latent images of menacing qualities, it was too early in the relationship for the patient to entertain any direct fears of the therapist.

The patient impressed the therapist as being "very serious" about the treatment. He saw her as working hard to find a way to be with him comfortably, where she would not have to metaphorically introduce a third person into the relationship. He, sensing a great deal of repressed sadness in this woman, worked at providing her with the necessary environment that would allow her sadness to be expressed. Overall, a sense of comfort did evolve. The therapist stated, "In the early sessions she would essentially cry during the whole hour, and feel in a sense comforted by the capacity of the environment to tolerate it, and not to interrupt it, not to force her to do something else with it." Part and parcel to these experiences, the patient developed an idealizing transference toward the therapist.

Sensing the brittle nature of the idealization, the therapist engaged the patient around how the feelings were

similar to how she spoke of her father. The therapist remarked:

> What I began to learn was that as much as she seemed dependent and soft in many ways - you know, unformed - she had an iron will and could easily oppose any idea or notion or direction we might want to introduce, if it caused her to have to face the possibility that these idealizations that she had created in her family were more complicated than that.

As the therapy continued, both the idealization and the use of denial become increasingly evident. In large part, these defenses manifested themselves in the complaints the patient voiced about her children and her husband. In these stories, the patient shows herself to be unfairly cruel, especially to her children. This way of portraying herself exerts a great deal of interactional pressure on the therapist. He finds himself "feeling quite angry at her." The anger, however, is not so much predicated on the cruel way she acts toward members of her family, but on the implicit request that the therapist collude with her assessments. He stated:

> The anger doesn't have to do so much with her tactics, with her behavior toward them. The anger has to do with her insistence on, well, basically the use of denial, so that there's no space for us to talk about the impact of the family dynamics and the family relationships. At those times, what she wants to do, essentially, is tell me what it is, that is, get me to agree with her.

Dissolution of the Dependency and Idealization. The therapist understood the patient's use of denial as

predicated on her envy and competition which "seem so central to this woman's organization." In denying her envious and rivalrous feelings, she would "not consider that she has anything but the most maternal, parental concerns for her kids." She insisted on "leaving out elements of aggression, of agency ... that she is reactive of what is done to her, but that she does not initiate action."

When the therapist began to explore this aspect of passive agency, the "tone of the therapy began to change." The change in tone occurred on several levels. On one level, she was "less in an idealizing mode and more disappointed in me." On another level, the patient presented as "increasingly anxious" and "aggressively dependent" during the therapy hours. Though "by her report, she was doing quite well professionally ... she would, in a way that I experienced as aggressive, inform me about how terribly she was doing."

In response to a story about her son's adolescent relationship to a girl at school, the therapist "introduced the idea of envy." He framed the comment in terms of "the notion that something had been stirred up by witnessing this intimacy, that was very reminiscent of her early experiences in her own family." The patient would have none of this interpretation: "She was really angry about that. She would often come in ... and present her anger and her opposition to those ideas."

At this point, the patient saw the therapist "as someone to be feared." The patient's dream material displayed this clearly. The patient also began to express fears of losing control which arose out of her feelings of persecution. It was, as the therapist remarked, "a period of richness" not so much in terms of the content, but in terms of "her affective awareness" of the therapist's presence. But it was during this period when the patient "began to withdraw and to appear increasingly anxious, increasingly angry, increasingly entrenched in an oppositional sense, that marked for me the beginning of the development of the NTR."

The NTR Situation

The period which the therapist demarcated as the NTR lasted for several months. The patient reported signs of increasing depression - an inability to sleep, eating problems and crying jags. During this period, someone the patient had known very well died, bringing to the fore once again her conflicted feelings related to her father. Part of what informed her feelings of conflict, the therapist reported, concerned the fact that the father had passed away many years prior. The therapist stated that the patient had not grieved the father's death, preferring to remember him as healthy, happy and vital. Though she denied thinking more about the father, the therapist thought that what this other man's death represented, intensified her depression.

Also during this period, there were a couple of phone calls from the patient. The phone calls were not emergencies, per se. Rather, they seemed to be motivated by the patient's wanting "to communicate ... something she thought I wasn't getting in the hours."

Destroying the Attachment. From the therapist's perspective, most of what went on during these sessions was an attempt "to organize a way of looking at what was going on between us." This was met by "active silence" on the patient's part. She did not "seem to recognize anything of importance in what I said." The therapist continued:

> I thought what she was doing ... was making it clear that she'd rather hold onto the experience of the illness than to her attachment with the therapist. [She was] holding onto her right to feel badly about herself, insisting on that right. ... She made clear in a very hostile way, beginning each hour, how miserable she was feeling, that she wasn't feeling any better [coming to therapy.] I experienced that as an attack, *but also an effort to maintain a clear separateness.* We weren't in something together. She was clearly going to let me know that I had no impact on her, that there was no way that I could communicate with her that made a difference. (Italics added)

Before moving on, I find it interesting to note, how in distinction to the first case presented in this chapter, this patient's NTR is characterized by wanting to maintain separateness. In the first case, the NTR was characterized by the patient's tenacious way of holding onto the fantasy

of fusion with the therapist. Once again, we are witness to the variety of ways that NTRs can be motivated.

Working Through the NTR. There are two aspects of the therapist's response to the patient which sheds light on considering the NTR as a process variable, rather than as an immutable deterrent to treatment. One aspect pertains to how the therapist used his countertransference reaction to understand the object relations dynamics being recreated in the transference. The other aspect suggests how he was able to convey his understanding of what the patient was resisting, in a manner that she could hear as empathic and free of danger.

Regarding the patient's holding onto her right to be ill, the therapist noticed that he "experienced it as being back with the mother." He stated, "there was something about the nature of her impasse with me that was so similar to her descriptions of her relationship with her mother." Though never rich in content, her avoidant descriptions of mother "really does emphasize the intensity of her affect."

This therapist noted throughout the interview how he was able to fill out her history by attending to what he himself experienced during the times when her denial was most evident. The therapist related how he would often find her "to be someone I had to protect myself from." Such recognition allowed the therapist to acknowledge and accept the feelings without finding it necessary to act upon them. That is, overall, he was able to accept her projections onto

him without being compelled to counter-attack. As a result, he "always felt that the richness of this woman's history [was] in part developed by my willingness to imagine what she alludes to, but what she herself cannot say yet." This underscores the therapist's ability to use his countertransference toward a greater appreciation of what the patient was experiencing in the transference, namely, the sense of being attacked.

With the above formulation serving as the context, the therapist hypothesized that something had occurred in the relationship that had injured the patient. He then "wondered" aloud "if she had any thoughts about what that might have been. And she immediately said she did." The patient elaborated on two areas. One concerned his "insistence" on focusing on the issue of envy toward her children. The other, "was more important in her mind. That was my response to her on the phone." The therapist stated that she had correctly felt him to be disinterested in talking to her on the phone. This "disrupted ... the fantasy she had about how this relationship ought to work." The disruption "was humiliating to her and she felt very angry about that."

The therapist was ultimately successful in finding a way to discuss with the patient the impact on her of his response on the phone. He stated, "It was after that hour that we discussed the content of her injury, that things began to change." His willingness to expose the disruption

that had occurred brought the patient much relief. In fact, the patient wanted "to stay with that for a while." That is, "she wanted to be angry at me ... and wanted me to feel the anger without denying ... or recreating the scenario between the mother and the daughter." During this interchange, she "listened very carefully" to his remark that he experienced her way of being in the therapy relationship much like the relationship she had with her mother. At the end of that hour the therapist felt that the impasse "was going to be resolved." His reasoning for this was based on feeling "more connected to her again ... I could feel her presence in a more familiar way."

That the NTR did indeed give way is demonstrated by the patient's ability to talk openly about her unwillingness to give up her oppositional position. The therapist stated that in the following hours:

> She came in reluctantly reporting to me that she was feeling less depressed. And she emphasized the reluctance, because she feels as though she is giving something up that is very important. And indeed, I think she is. What I experience essentially is the giving up of the symptom for the relationship. She can't have both, because the depression is essentially, has always been her effort to protect herself from disappointment in relationship to her mother. That is her own. The depression is her own. She can nurture it. She can have total control over it. She can only have access to it.

The patient then spoke about feeling more vulnerable because she anticipated that the therapist would require her to think about the nature of what they discuss. I inquired

whether that was due to her feeling she would have to submit to the therapist. His response was quite instructive. He said that he did not see it that way. Instead, he pointed out that what he asks her is "to break an agreement with her family." This agreement is one in which she would "keep things to herself, especially intense negative affect." The patient, then, is asking that we appreciate the depths of the betrayal she experiences, when she goes against the family's longstanding rule that negative things "simply will not be talked about." From this vantage point we can begin to understand why "this is a woman whose enemy is the light" who needs to avoid what is entailed in thinking and knowing.

The NTR as a Process Variable

In closing on this interview, I want to present this therapist's ideas on the NTR as being an impasse that evolves out of the mutual effect of patient on therapist and therapist on patient. In this regard, the NTR can be thought of as a predictable event if the therapist is tracking the ever shifting transference enactments and his reactions to these enactments.

The NTR can be understood as a therapeutic error in tracking who the therapist represents in the transference. Yet, here the term "transference" does not mean solely what the patient brings in, unaffected by the therapist's presence. Indeed, as this therapist pointed out, the therapist and the patient act upon each other in ways that

influence the transference reaction. Regarding the present case, the therapist's lack of interest in talking to the patient on the phone brought about a return, in the transference, to the disturbing relationship with the mother.

Noting a shift in the transference, such as this, is the therapist's responsibility. It is also his responsibility, according to this therapist, to "be the one to find a way to make it possible for the patient to identify what gets in the way." From this perspective, NTRs can be as frequent as when "the therapist doesn't anticipate the impact of his or her ways [and] statements on the patient." Thus, "the regression to a state related to the preoedipal mother is not necessarily the same as an impasse, if when that occurs, you understand what provoked it." In this way, the NTR is also an opportunity for the therapist to learn something about himself:

> When you find yourself engaged in an impasse, you move into something that has been out of your awareness. Not to say that you didn't anticipate it, but in a sense, you've enacted something with the patient. And the only mode of resolution is for the therapist to find a way in which the patient has been taken in by [the therapist's] unconscious scenario. [This can be called] a countertransference reaction.

Fundamentally, the NTR is a destruction of the relationship. It is not accurate, however to characterize it solely in terms of the patient's move to disengage the therapist, "because the therapist is also at a loss as to

how to engage the patient." The therapist, therefore, needs to re-acquaint himself with what he has said or done that has prompted the patient to destroy the relationship. When the therapist can locate the meaning of his presence on the patient's motives to dissolve the attachment, then the NTR can be reversed. Such a reversal can be powerful:

> What so many patients believe is that once [the relationship] has been destroyed, it can never be repaired. And to learn that you can come up against these moments, and not get around them, but can get through them. To me, its an incredibly therapeutic moment.

The NTR as an Entrenched Sadomasochistic Reenactment

The following NTR was described by an analyst who served as the supervisor[8] to the case. I found this interview to be among the richest I conducted; because I am intrigued by the last therapist's comment that NTRs are predictable "especially from the supervisor's position," I will present this NTR next.

From this vantage point of predictability, it is interesting to see how the next patient's characteristic style of relating to others sets the stage for the NTR to emerge. This is yet another way of saying, in Gorney's (1975) terms, that this is a patient who is vulnerable to forming a NTR. Thinking in terms of identificatory processes and the development of internalized objects, we can view this next NTR drama in terms of transference enactments and repetition compulsions. Obviously such

hindsight analyses can be circumspect. I offer this one here, however, motivated toward dispelling the commonly held notion that NTRs are unexpected events outside of therapeutic understanding and application.

After presenting the relevant background and history, the aspects of this NTR upon which I will focus regard the role played by the patient's sadomasochistic character in the transference and countertransference scenarios which develop. Further, using this case, I will demonstrate how closely intertwined the NTR--seen as a recreation of the patient's main conflicts--and the therapist's own neurotic tendencies, can become. I will then present four aspects of this case that are similarly highlighted in many of the other NTR descriptions collected in this study as well. These aspects will be discussed in terms of the patient's characteristic tendencies and also in terms of the therapeutic relationship. Briefly, these four aspects involve: 1) the role of the patient's projections in compelling the therapist to interpret aggressively, and 2) the way the patient's defensive tendencies creates for himself an experience of pleasure when confronted by the therapist's aggression, 3) the emergence in the patient of dystonically experienced homosexual urges, and 4) the constant rage at the father which dominates the transference enactment in a manner that serves to cover the disintegrating split off rage at the mother.

History and Background

The patient is a single, "lower middle management type," 50 year old man who presented on the inpatient unit "in a suicidal panic." Never before in psychiatric treatment, the patient portrayed his life as free of any problems until just prior to admission. Then the patient began to "feel increasingly guilty and apprehensive about his tax situation." Soon these feelings escalated and the patient sought treatment.

The patient had been brought up in a strict household. Father, who had been a judge, was "a severe man, a very stern taskmaster whose manner of relating to his son was all bound up in one injunction or another." In his younger years, the patient is described as "a very compliant individual" who had "gotten fairly far along in life by being mild mannered, diffident, and deferential."

The patient's mother was described as a superficial and flamboyant woman, "who reveled in the social life she enjoyed." She was "very proud of her station" being of upper class origins, and "held this over the father" whenever the couple would fight. When the patient spoke about his mother[9], "there was a kind of warding off of how exciting their relationship was, that he was holding in how stimulating he found her." The therapist imagined that the relationship with mother was so powerfully dominating, that the patient never married "as a way of clinging to the mother" and also "maintained distant relationships with

women as a way of warding off the prospect of becoming excited."

The therapist was struck most by the patient's denial of aggressive feelings. The therapist reasoned as follows. First there was the patient's presentation of himself as compliant and passive, a "false self" employed to ward off other's (especially paternal figures') aggression. On a deeper level the therapist thought that the compliance served to ward off "his own rising tension, and anger, and wish to retaliate, which was overwhelming." The therapist conceived of this deeper level as a response to mother's overexcitation of the patient. Withholding, then, "was a key relational issue for the patient." He withheld "so as not to be punished." But more importantly, he withheld as a way of warding off "disintegrating" aggression.

The Initial Phase of Treatment

From the outset, the patient took the position "that he would not be suicidal if he could get himself to pay." The patient "clearly invited a narrow focus" which the therapist experienced as "a set-up." The therapist thought that the meaning of this communication betrayed the patient's "need to withhold." The therapist thought "that his withholding had some value, that it was ... tied up in all sorts of characterological issues.[10]"

With this formulation guiding him, the supervisor described how the therapist gingerly tried to approach the

topic that the patient might feel some motivation not to comply. Paraphrasing the therapist's interpretation, the supervisor stated, "y'know, maybe next to the wish to be so pleasing, might be another kind of wish to be nothing of the sort, to stand your ground and tell someone to back off and get away." But, "the patient would have none of that. He utterly denied the possibility that he could have anything like an angry feeling toward anybody." The therapist then thought that the only "shot at anything that would have any vividness would be if it found its way into the transference." The therapist therefore started commenting on the inconsistency between the patient's high regard for the therapist and the fact that he was still miserable, that nothing had changed in the situation causing, presumably, the suicidal ideation. The result of such interpretations: "The patient just avoided all that."

The NTR Situation

After a couple of weeks the patient grew impatient with the therapist's comments and began again to press the issue around the filing. Countless times the patient would introduce the question, "What am I going to do," followed by exclamations of suicidality. In response, the therapist tried to create a space in the therapy where the patient's rage and anger, the "patient's true, acknowledged perspective" could emerge freely. The therapist "belabored" his remarks to the patient that it was safe to express such

angry feelings. The patient, in turn, became more entrenched in resisting these remarks; he seemed to ignore them and responded with subtle devaluing comments to the therapist. The supervisor's understanding of these interactions was that primarily, the therapist's remarks were experienced as an attack, that the "therapist attacked ... by trying to induce in the patient the possibility of negative feeling."

Having worked to establish the psychological reasons behind the patient's inability to file his tax returns, during the NTR period, the therapist "gave up his hope that anything would find its way into the transference." From the supervisor's viewpoint, the therapist "just assumed they were leaving all that other neat psychodynamic stuff off to one side." What transpired from then on, was a continual transaction in which the therapist and the patient "tried to induce a sense of urgency in the other." These transactions, the supervisor believed, were based on "the need to be rid of the despair" each was experiencing and attributing to the other.

In response to whether the therapist's experience of despair was induced by the patient, the supervisor stated, "from the patient's side, I would say 'yes'." The supervisor then went on to elaborate that it is not simply a matter of what we might call projective identification, but just as much a matter of the therapist's own neurotic leanings. That is, the therapist's tendency to get caught

up in such a neurotic entanglement prepared him to get caught up in the sadomasochistic scenario. The supervisor remarked, "To say that it was induced, is to say that there was plenty there to be called up in the therapist."

The patient and the therapist stepped up their efforts to compel some type of activity in the other. The patient increasingly withdrew, showed up late for appointments, while continuing to communicate an increase in his suicidality. The therapist, for his part, stuck to making interpretations, which were infused with his aggression, hopelessness and impatience. The supervisor stated, "The resident was just fit to be tied. He began using interpretations as his weapon." The supervisor commented that "the patient was torturing the therapist and that the therapist was torturing the patient." They were both "trading on the same dynamic." The transference-countertransference scenario was one of shifting victim-victimizer enactments. This continued until the patient was transferred to another, longer term unit, with the therapist "finally giving up in defeat."

The NTR Designation: Accurate or Inaccurate?

Clearly, the therapist's countertransference reaction exacerbated the NTR. Indeed, the countertransference is so pronounced that we should pause and question whether this NTR should be more accurately thought of as an iatrogenic

failure. The following excerpt allows us to examine this question from a broader perspective:

> I thought that the underpinning of the case had less to do with the countertransference bind that the therapist got into, as one would normally conceive of it, and more to do with the core resilience of the sadomasochistic position which brought the transference and countertransference about. This was a man who took an important kind of pleasure in designing the very position that he found himself in, and hiding every bit of his activity in it. And on one superficial layer it had to do with withholding as a way of retaliating in a vengeful manner, toward someone who was being domineering like father. But on a deeper level it had to do with warding off the activity of being excited."

The supervisor's reasoning is clear. From his perspective, the therapist's countertransference contribution certainly had a worsening effect on the treatment relationship. Yet he believed that the emergence of the therapist's countertransference was a function of the NTR, rather than vice versa.

Other Common NTR Themes

Three other themes reported on in this case prominently figured into a number of the other NTR descriptions I collected. As I will be referring back to these themes later in this section, I briefly present them now. These themes consist of 1) transforming aggressive impulses into passively received experiences of pleasure, 2) the emergence of homosexual feelings, and 3) avoiding preoedipally based conflicts through a process of oedipally based passivity.

Transforming Aggression into Passive Pleasure. The supervisor, in response to a question about what the patient did with the therapist's interpretations, offered a very interesting assessment: Rather than, as one might expect, disregarding the attacking remarks, the patient "took them in" because they afforded an experience of pleasure. The supervisor stated, "In fact he did take in everything, but assigned it a niche, because it served his defensive purpose with respect to his own excitement. In other words, "the idea of being attacked was absolutely crucial to warding off his pleasure in attacking." To the supervisor, then, the sadomasochistic quality of the relationship pivoted around the issue of pleasure. He stated that for the patient "there really was a wish to invite an attack to project out the activity of attacking and stimulating and being excited. And to experience that as a victim might, rather than acknowledge the disavowed wish to touch and to attack, to stimulate and to arouse."

The Emergence of Homosexual Feelings. In connection to these dynamics, the supervisor spoke of the patient's "homosexual undercurrent" that could be glimpsed in the transference. This undercurrent, the supervisor implied, was etiologically based on what Freud called the process of inversion: The patient " could not get in touch with his wishes" to seek out his mother, "to fondle her, to arouse her. He could only experience the sexuality as a childlike victim of an overwhelming presence." Yet, such memories of

mother remained split off from awareness. As such, recollections of her being the stimulating one were transformed into memories of father, where the experience of arousal and stimulation became fused with punishment. In this way, the patient's active sexual aims to conquer the mother became transformed into passive homosexual aims.

Avoiding Preoedipal Aggression Through Oedipal Passivity. One of the ways this patient's deeper preoedipal conflicts were avoided is suggested by the patient's numerous complaints about the father (with their transference recreations in the therapy) and the exclusion of any felt conflict with mother. The supervisor said of the patient, "He left his mother out of his history, out of his psychology." Such a process in therapy speaks to how patients may unconsciously invoke oedipally based conflicts as a way of defending against more unsettling conflicts from the preoedipal period. This, as discussed in Gorney's article, is typical of patients vulnerable to forming NTRs. The salience of such an observation is premised on the assessment that many of the patient's difficulties coping in life stemmed from preoedipally based problematic experiences. In this case, this assessment appears to capture what was stifling the patient's capacity to form mature loving relations throughout the whole of his adult life.

The NTR as Resistance to Taking In

One of the most enjoyable aspects of conducting this research has been my being witness to the enthusiasm many therapists bring to their work. Nowhere was this more apparent than with the therapist whose NTR description I will be presenting next. This therapist responded to my request to discuss a NTR with unabashed exuberance. Clearly, this therapist had taken the time to review the therapy he was reporting on; he came prepared, and was very thoughtful. Yet most remarkable was the way the therapist brought the therapy alive in his account.

History and Background

The patient is a single man in his late 30's who presented for therapy due to depression. The patient related his depression to his discouragement at his job. Often the patient was unable to get himself to go to work, instead spending the day in bed. The therapist also believed that a precipitant to the patient's entering treatment "at a most unconscious level" had to do with his father's chronic and life threatening illness.

At the time of the interview, the patient had been in therapy for over two years and was still in treatment. Little is known about the patient's early relationships. In fact, the therapist noted that he knew less about the patient's parents than practically any other patient he had worked with. The therapist stated that at times he would

inquire about the parents, with little information disclosed. In addition, information about the parents "certainly doesn't come up spontaneously." The therapist implied that this was a manifestation of the patient's resistance to exploring the family dynamics. The "little that is known" is that the father owned a store prior to becoming ill and that the mother's career had been in social services.

More had been established about the relationship between the patient and his twin brother, and the impact on the patient being a twin. Though the patient was born first, the brother was the bigger and stronger baby. The therapist made it clear that the patient was greatly effected by the fact that the brother received the father's name.

The relationship between the brothers was described as always being very close. They played together as kids and as adolescents they were nearly inseparable. Though they spent their school terms apart at different prep schools, they always made it a point to be together during their vacations. Every summer they served as counselors together at camp.

Despite their intimacy, the patient "perceived a difference between them almost from the beginning." The patient was more introverted and intellectually inclined. His childhood interests were in the realm of science and boyhood research. The brother, on the other hand, was more

athletic, outgoing and social. To the patient, the brother was clearly the parents' favorite. As such, the parents often encouraged the patient to be more like his brother. For example, when remarking on the brother's superior athletic prowess, the therapist recalled the patient talking about how the father would "drag him out to practice playing catch." The patient found this "extremely humiliating" and would wonder "why couldn't they appreciate what I was doing?"

The patient, an honor student, matriculated to one of the most prestigious colleges in the country. The first two years went without incident. Then in the summer prior to his junior year, "something went wrong" at the camp the patient and his brother were working at. What went wrong is not clear. However, both brothers were displeased with the management of the camp and therefore decided never to return. To the patient, this was the end of an era, and constituted, according to the therapist, "a very significant turning point" in the patient's life. For the therapist, it was clear that the meaning of this event concerned the patient's feeling that the closeness with the brother was undergoing an irreversible change.

After that summer "his life really began to fall apart." Twice the patient got thrown out of school for not completing his coursework. Numerous failed attempts at finishing college ensued. His work history also became sporadic. Though the patient is "very intelligent, very

bright and very creative ... he gets into certain kinds of authoritarian conflicts when he's in a work situation." The patient simply "can not stand to be told what to do." Even when the patient would take direction, he "would subvert it." Most often, the patient's obstinacy concerning work was expressed passively. Typically he would "unexpectedly not show up for work and stay in bed that day."

The Initial Phase of Treatment

The therapist remarked that "very quickly into the therapy" the patient began to talk about "intimate aspects of his life." The patient talked about how he hid his "darker side" from others by maintaining a social facade of cheerfulness, wittiness, and liveliness. The patient also talked about how "he hides the fact that his depression - if you want to call it that[11] - is so disabling to him."

Also very early on, the patient "confessed ... three or four sexual secrets." These secrets were all told under the auspices of the patient's fear of being gay. Two of these secrets related to an adolescent experience with his brother, and a later encounter with a close friend that involved mutual masturbatory activity. The "most important" secret concerned a series of experiences that occurred when the patient was one of several managers on one of the high school athletic teams. On three or four separate occasions a group of the managers, "as a kind of taunting, cruel exercise, grabbed him, held his arms behind his back, forced

him to his knees, and shoved their penises in his face, taunting him to suck them off, which he resisted with clenched teeth." A couple of these episodes occurred in front of the patient's friends, and once in front of his brother.

The therapist commented that "no one, including him, ever spoke about this." The patient never discussed these events with his friends nor with his brother. Further, in the interim between episodes, the patient described that he would return to his work as a manager "as though nothing had happened." The therapist, in presenting this story then exclaimed, "Why this bizarre silence?" The therapist then proceeded to recount his understanding of the meaning of these events.

The therapist spoke about how the patient had been aware of his attraction to and sexual interest in men. The patient disclosed that in choosing him "in some way meant they knew about his interest in other men." Yet further exploration suggested that "there was no manifest or overt way they could have known." He had been sexually active with his brother prior to these assaultive episodes, but the patient was convinced that the brother never let this on to anybody, that it was their secret.

The patient "felt intensely humiliated and ashamed," not so much for what happened, but because of the "implication that they knew that this interest in him showed in some way." For the patient to tell anyone meant he would

be the greater victim of humiliation, "because he would become known and because it would confirm that he was homosexually inclined." The patient was convinced that he, rather than the perpetrators, would be chastised.

In relating how complicated these issues are for the patient, the therapist then went on to discuss how he and the patient have drawn similarities between the patient's experiences of being forced to submit and women who have been victims of rape. With a tone bordering on incredulity, the therapist stated:

> He and I have discussed this [similarity] ... and to show you how important this is to him, he has said, "It is really ridiculous that a woman feels she brought it on. I can see that that's ridiculous, that that must come from the experience." But he absolutely denies that that applies to him ... he cannot apply the same line of thought to himself.

The therapist, tending "to think that we keep views of ourselves that we need" described the patient's view of himself as "quite harsh and condemnatory." The patient, according to the therapist, has "a masochistic view of himself as the victim." The therapist then pointed out that in his interactions with the patient, he had offered to the patient "a form of expiation" which the patient strongly resisted. Though the therapist "doesn't fully claim to understand all about this," further data from the therapy suggested to him that the patient "much prefers to be the victim than to be the aggressor." The therapist followed this comment by saying:

> The notion of unconscious diffuse rage in this man is quite important. And this mechanism we're discussing is extremely important to him in managing that. And that, I think, may be the roots of what is so unconscious and so unknown here."

The Emergence of the NTR

After revealing his "secrets" the patient "very much expected" that his depressive symptoms would go away. And though the patient did experience "a kind of transient absolution ... the problems raised their ugly heads again." At this point, "the NTR begins to be visible." The patient began to voice "striking disappointments" with the therapist and the therapy. The patient had expected from the therapist "a quite magical and omnipotent solution to his problems."

Confronted by his disappointment, the patient began to struggle with whether to leave treatment. He talked about taking long trips, moving to an island he had visited previously, and volunteering to be part of various expeditions around the world. The therapist, for his part "would raise cautionary questions" about the patient's plans. In response, the patient "would just dismiss me and say he was going anyway." A number of times the patient announced that he would be gone for a week and then he would call to say that he would be gone another week. He would return from these therapy respites and state that he was "fine" while away, that he "had no troubles." Then, according to the therapist, the patient would remark "how

ridiculous" it was that he was continuing in therapy, that his troubles only emerged when he met with the therapist. The therapist also stated that during a period when the patient was "feeling so enraged at me, that this was so worthless," the patient "on the sly" consulted with another psychiatrist. The patient returned to this therapist and informed him that the other treater was "worse than you are."

Coincident with this period of the patient's ambivalence about staying in treatment, the patient's work situation deteriorated further. Increasingly, the patient failed in meeting his responsibilities and was more truant than otherwise. This type of behavior, though having a history of its own, also appeared to the therapist to be an "acting out" aspect of the NTR.

The therapist summarized the "elements" of the reaction by stating:

> Whenever I make a connection about something from his past or even something about us, he retreats to his bed and can't get up, and [he] stops working. And he has no recognition of what it is about at all. [Then he] will come back in and speak of the futility of our work - what good is it, what difference does it make, we're not getting anywhere. And once he gets on this tack, its like a downward spiral, and he grinds[12] away in the hour. You can tell when he begins that he's going to become more and more depressed and hopeless and futile.

The therapist remarked that during these periods he has often found the patient so convincing in his recitation of how futile he is, that he has wondered what indeed prevents

the patient from committing suicide. In time, the therapist realized that these downward spirals are designed "very much to torture me." The therapist then posited three reasons for the recitations: one, to show the therapist that he "can't possibly help" the patient; two, to demonstrate that the patient is unhelpable, "and parenthetically, unlovable;" and, three, to suggest that if the patient decided to kill himself, the therapist "would be absolutely powerless to stop him, which of course is true."

The above captures so well a number of the most prominent features of the NTRs described in this study. One feature consists of the patient's belief that he is beyond any type of help and that, therefore, he is destined to suffer. This is invariably communicated in a most caustic manner. Another prominent feature is the patient's profound belief that at bottom, he is unlovable, that he is, as another patient exclaimed, "just a pile of dog shit." A third feature consists of the patient's inability to feel a sense of control, except when it comes to what Camus thought was the only legitimate question a person can ask: Suicide or existence? This is typically communicated with derision, which can often be seen as barely covering the patient's insecurities and terror.

Elements of the NTR

As the therapy continued one of the foci of discussion revolved around the patient's experience at work, and more

specifically, the patient's response to authority figures. The therapist noted that during these discussions "his unconscious rage becomes more apparent." The therapist also stated that the patient took on "a paranoid position" such that he "developed rageful fantasies" toward his bosses. Feeling "they're out to do him in" the patient began to disclose these long involved fantasies.

Splitting and the Revenge Motif. The prominent theme of the patient's fantasies consisted of "his exacting revenge on someone in such a way that sometimes they wouldn't even know the revenge had been taken." These fantasies, however, would be presented from the vantage point of some other fictional character; in this way the patient was maintaining his dissociation from the characters whose words he was using. Thus, the patient could talk "about the Count of Montecristo, but he can't see that the rage applies to him." Describing both the drawn out quality of these fantasies and the lack of agency involved, the therapist underlined the "carefully controlled manner" in which the patient's unconscious rage remains hidden from himself.

As he was describing this, the therapist then looked for a card the patient had brought in one day. Though he couldn't find the card he described it as being "a cartoon in the Gary Larson ilk." The title of the cartoon was "The angriest dog in the world." It depicted a dog "tied to a stake." Successive panels of the cartoon showed the dog in

this position through day, night, and day again. The last panel shows the dog untied. The wording on the card was paraphrased by the therapist: "This dog is so angry and so filled with intense emotional rage that his jaws are clenched shut. He is so filled with rage in every molecule of his body that he is completely paralyzed."

The therapist thought the meaning was clear. First there is the allusion to "clenched teeth," an image that stood out in the "secret" stories previously, and which was to emerge again later. More to the point, was what the patient was communicating about the overwhelming nature of his rage: it is so intense, it destroys his capacity to take in what he needs to survive, namely food and nourishment.

The therapist recalled that when the patient brought the card to him, the patient snickered and said, "I thought you'd like this, this seemed relevant to what we were talking about last week." I then inquired what the snicker suggested. The therapist then paraphrased the intent from the patient's point of view. He stated, "we know how to think about this over here. We two can talk about this angry dog, but of course, you and I aren't angry, that doesn't happen here." The therapist then alluded to how its been very important for him to sit and notice the patient's denial without challenging the patient's need to keep himself psychologically removed from what he discusses.

The therapist mentioned that one of the ways he's come to understand the patient is in terms of the "internal

saboteur.[13]" This is a phrase Fairbairn (1952) used in his theorizing about the structure of the personality. Briefly, the internal saboteur is the part of the ego that becomes the repository for hatred and destruction. In Fairbairn's object relations theory the internal saboteur is attached to and identified with the rejecting, depriving and withholding object. As such, it disdains all hope, particularly of hope for anything meaningful with other people, and rages at any individual experienced as offering the possibility of relatedness.

After mentioning the internal saboteur, I then asked if Limentani's thesis concerning the disintegration of the ego after the ego has developed integrative capacities fit for the patient he was describing. The therapist responded affirmatively and then continued:

> That fits with a great deal because this is a man who cannot be "successful," because I think that means that he's on his own. I think he's so enraged for so many things going way back - that there was a twin, that he was entitled to the title but he didn't get it, that his brother is the way he wanted to be. He wanted to be the heterosexual, married with kids. And so in a strange sort of way, any effort to integrate and have some hope for a partner, or to be loved, or [to have] a career, means he has to give up his grievances and he's unwilling to do it.

<u>Spoiling and the Envy Motif.</u> The therapist related three short examples that connect the themes of split off rage, orality, spoiling and denial. The first occurred at a point when the patient was vociferously relating how

"annoyed" he was with the therapist. The patient brought to the session two cups of coffee. After pausing for dramatic effect, the patient said, "I brought you one, not to be nice, but because I thought it would be rude not to." Another time the patient again brought in coffee. On this occasion the patient said, "Well, let's see, I think this one is yours. That's the one I spit in." The third example occurred prior to a holiday in which the dyad would be apart briefly. The patient, an accomplished cook, had baked "this wonderful loaf of bread" which he brought with him to the session. At the end of the hour the patient gave the bread to the therapist and said, "I guess you'll have to trust me that its not poisoned." The patient considered all of these "just jokes."

Later in the interview, when discussing the patient's transference dynamics the therapist stated, "Envy has played an enormous role in this therapy[14]." He added that a major ingredient in the transference from the beginning of the therapy was the patient's "envious rage that I am the Other[15]." The therapist then related what the patient is envious of: "That I'm not a sick, depressed man, that he's the patient and I'm the doctor. And he cannot stand that and wants to destroy it." The envious spoiling, moreover, is a "pattern" that "occurs again and again." Regarding the loaf of bread mentioned above, the therapist explained, "You see, even the bread - he does a nice thing - but the idea that he could give and repair and love, it fills him with

such .... I mean, he so quickly becomes on his knees (alluding to the incidents with the other team managers), that he has to destroy it, and spoil it, and mess it up." The therapist stated that he understood many of these interactions in terms of "a lot of giving and taking into one another's mouths."

Later, the therapist discussed the patient's "typically characterological" response to medication. Early in the treatment, the therapist prescribed an anti-depressant. He noted that the effect of the medication appeared to take the edge off the severest lows the patient was experiencing. The patient, however, "could only stand that for a while," that is, the patient felt lost without his depressive affect. As such, he quit the medication, "deprecating this nasty stuff" in the process. Remarking that "there again is the NTR" the therapist followed, "I think there is no other way to understand this than as a kind of putting something in his mouth, and at times, his spitting it back at me."

Countertransference

I want to highlight some of the reactions the therapist mentioned having in his work with this patient. As suggested, an important aspect of this patient's NTR was the communicative nature of his behavior. For instance, when the therapist was speaking to the way the patient "grinds away," he stated that he had come to see this behavior as motivated by the patient's wish to "torture" him.

A number of times the therapist talked about the "distance that has evolved" in his capacity to contain the rage or "worry" or "frenzy" that the patient has evoked at various times. He stated that early in the therapy "there was a time when I was sucked into the futility of it all." Questioning whether he should hospitalize the patient, the therapist was struck by the paralysis he was feeling. In time, noting this experience helped him to realize that "there is some real value for [the patient] in abstinence." That is, the therapist realized that the patient was wanting to communicate his futility and suicidal hopelessness but not wanting the therapist to take it at face value.

Even so, as the therapist pointed out, there are limits to such abstinence. For example, the therapist related a story that occurred about a year after the treatment began. The patient had been suicidal and then missed the following session without calling to cancel. Concerned, the therapist called the patient and had to leave a message on an answering machine. The therapist paraphrased the message he left: "Given what we've been talking about I'm obviously concerned, so call me. If I don't hear from you by a certain point this afternoon, I'm going to attempt to reach some of your friends and make sure you're okay." The patient did not return the therapist's call; therefore, the therapist phoned some of the patient's friends.

Though acting out of concern, the therapist also noted the "element of revenge" in his actions. At one and the

same time the therapist's calling the patient's friends was "an egregious breach of his confidence, but necessary, I thought." The therapist's following remarks were instructive. He could not disclaim the act of revenge: "Oh, you're going to do this to me, well I'm going to tell your friend that you're in therapy." But not to act would have been at least as harmful, if not moreso. That is, not to have called - given the fears the therapist was having - would have been akin to being "paralyzed by one's guilt ... into doing nothing." Not acting, the therapist added, would have indicated a counteridentification with the patient, in which the therapist, like the patient, would have been "hiding out." Thus, while the therapist acknowledged his revenge, it was more important not to stifle himself from calling. He remarked, "It is the inability to metabolize the rage you feel that keeps you from acting in a reparative and loving way."

Final Thoughts

The therapist's portrayal of the treatment left me with a sense of the movement that had occurred over the two years. As stated, the therapy was still in progress at the time of the interview. As such, questions related to whether the patient was able to work through the NTR seem irrelevant. However, each time I read over the interview I am left with much optimism, despite the patient's

overwhelming obstinacy. The following vignette underscores some of my optimism.

The therapist mentioned that "recently" the patient was talking in a way that is indicative of his "downward spiral." The therapist "let him go on for a while" before saying: "You know, when you talk this way, which is by now quite familiar to us both, do you ever listen to yourself, do you ever listen to how this sounds and what you are saying?" The patient paused for a few moments and then responded, "Nonsense, its all nonsense. I know its all nonsense, its totally absurd. But I believe it anyway, and I'm going to believe it." The therapist chuckled at this point and said, "and he went right back into it."

Case Summaries

In this section I will summarize all the NTR descriptions collected in this study. In order to show the way I am organizing and synthesizing the data, I will first summarize the five cases already presented. This will be followed by summaries of the other ten NTRs.

As can be seen, some of these summaries are heavily laden with theory, while others use terminology that are more descriptive than explanatory. This is because I have tried to remain as close as possible to what the therapists themselves emphasized in their interview responses, while also maintaining a concern for coherence.

The first NTR (see pages 89-96) was characterized by the patient's resistance to acknowledging her separateness from the therapist. The resistance, according to the therapist, was marked by the patient's use of splitting, omnipotence, and denial. Thus, when the patient's resistance was confronted (if not by the therapist's words, then by the real limits of the relationship), the patient characteristically reacted with blinding rage toward the therapist. The rage, however, was not integrated with the patient's transference experience of the therapist as her symbiotic partner. Rather, the rage remained split off from her awareness. As a result, the patient was able to maintain her omnipotent fantasies of fusion and merger with the therapist. The therapist understood this interactional process as a reenactment of the patient's preoedipal fixation to her mother.

The therapist had to terminate the treatment because of his relocating to a distant city. Therefore, many questions remained unanswered concerning what the patient would have needed in order to work through her NTR. The therapist wondered whether the patient might have needed the safety provided by an inpatient setting in order to experience her rage more directly. The patient's proneness to transient psychotic episodes and her tendency to become suicidal underscored the therapist's concerns.

The second NTR presented (see pages 96-102) revolved around issues more typical of Oedipal dynamics. In this

description, the patient maintained a lifelong unconscious sense of guilt occasioned by his never having relinquished his wishes to defeat the father and claim the mother as his rightful lover and sexual partner. Unlike most of the other NTRs described, this patient did not attack or devalue the therapist. Rather, this patient's NTR was characterized by hysterical conversion symptoms which turned out to be a manifestation of the patient's identification with the mother. Because the mother chose the father over the patient, the patient fantasized about harming the mother in various ways, such as by stabbing her with a knife. This evoked a great deal of guilt which the patient attempted to stifle by turning the attacks upon himself. The meaning of the NTR was recognized when the source of the patient's guilt was unraveled. In essence, the patient had deemed himself unworthy of the therapist's help. The patient believed that his continued suffering was necessary punishment for having such horrible thoughts about his mother.

The third NTR was presented (see pages 102-121) at greater length. The essence of this NTR had to do with the patient's opting to remain symptomatic, as a resistance to maintaining the relationship with the therapist. In the context of the transference, the therapist understood the reaction in terms of the patient's choice not to be related to the pre-oedipal mother. Being in relation to the pre-oedipal mother meant, for the patient, having to give up her

"true" self in the most fundamental of ways. It meant having to relinquish her unresolved feelings of sorrow at having been victim to physical trauma at birth. It also meant having to disown the shame she experienced as a result of being unable to engage in typical activities (re: playing with friends, dating, etc.) of childhood and adolescence. At foundation, it meant having to abide by her mother's envy laced perceptions of the patient's character. Such perceptions involved being ungrateful, selfish and unconcerned with the needs of others.

Like the one above, the fourth NTR description (see pages 121-130) demonstrated the complicated overlap between the patient's transference reenactments in the therapeutic relationship and the therapist's own countertransference experiences. In the above NTR, the therapist was mainly able to use his countertransference reactions in a facilitative way to further his understanding of the patient's difficulties accepting his help and attention. In this fourth NTR description, the therapist ultimately got stuck with the patient due to his being unable to extricate himself from his own difficulties. As a result, the patient's passive-aggressive avoidant posture was met with the therapist's own avoidant counterattacks. These counterattacks were precipitated by the therapist's unease with and inability to contain the despair engendered in him in his relationship to the patient. Unlike the third NTR, which had a positive outcome, this NTR ended in failure.

The fifth and last NTR description presented above (see pages 131-147) focused on the patient's turmoil at taking in and metaphorically digesting the therapist's offerings, as the basis for understanding the meaning of the reaction. Unable to fundamentally trust the therapist's motives, the patient was described as either retreating from the relationship through withdrawal or, when not retreating, attacking the therapist, typically in envious vengeful ways.

While there are many common themes between the third, fourth and fifth NTR descriptions (re: countertransference difficulties, envy, shame, diffuse rage, devaluation of the therapist and grandiosity), there are also important differences. For example, while the third NTR was worked through and the fourth NTR ended in a complete breakdown of the treatment, the fifth NTR resided somewhere in the middle of such a continuum. That is, the NTR was still dominating the treatment at the time of the interview. This NTR can also be thought of as synonymous with the treatment as a whole, whereas in the third and fourth descriptions, the NTR concerned a portion of each respective therapy.

As can be seen, there are many different ways we can address the question of commonalities and differences between descriptions. One way would be to focus on the dominating transference reenactments and the subsequent countertransference responses during the NTR. Another way would be to focus on the descriptive and explanatory terms, such as envy, rage, etc., used to portray the patient's

behavior toward the therapist. I believe that both of these ways can be meaningful when focusing on each case individually.

When looking at the NTR descriptions thus far not presented, however, there is a different level of description and explanation which I find more useful as an organizing schema for half of the cases. This has to do with understanding the NTR generically as the patient's need to hold onto some experience of the self in relation to important others that takes precedence over and above any other event in the therapy. Often "what" is held onto can be thought of as a sustained wish embedded in the patient's relationship history (i.e., the wish to remain fused with the caretaker, the wish to be punished, etc.). This schema works well for five of the other NTRs described in the interviews. These cases will now be presented.

The Wish for Revenge

One analyst described a NTR that occurred with a man he started seeing twice a week after the patient had been discharged from a hospital. When the patient had been admitted to the hospital, mostly on the father's insistence, the therapist was the admitting physician. The patient remained in the hospital for over a year. This served as the salient context for what emerged as the NTR.

The patient was described as being very angry at the father. The patient believed that the father wanted to

totally control his life. As a result, the therapist stated that the only way the patient could exercise some control was via his being a psychiatric patient. That is, being delusional, or being "schizophrenic" was the patient's way of rebelling against being a narcissistic extension of the hated father.

As the patient was getting ready to be discharged from the hospital he asked the therapist if he would take him into private treatment. Money was not an issue, as the patient's father was wealthy and would "happily" pay the fee. Though the therapist admitted not liking such an arrangement (he stated that therapy was most effective when the patient was responsible for the fee), he agreed to the patient's request.

For the first six months, the therapist thought that the therapy was "going reasonably well." Then the patient "stopped working in the treatment." At the same time that he ceased showing any interest in the work of the therapy, the patient's concern about his appearance waned, his schoolwork suffered from a complete lack of attention, and he began to engage in potentially harmful sexual liaisons. This continued for many months until, according to the therapist, the patient announced his plans for termination. The patient said it was time to terminate because he finally realized what had been motivating his lack of concern about his detrimental behavior. This centered on his wish to exact revenge on the therapist. The patient explained that

from the day the therapist agreed to admit him to the hospital (some three years prior), the patient harbored vengeful fantasies which only recently had become conscious. Though the therapist saw this as a transference enactment regarding the father, the therapist felt there was no leverage with which this understanding could be gainfully used. The patient's NTR served to provide the patient with an experience of success: He got revenge on the father by not getting better in treatment (and by costing the father a large sum of money), and he got revenge on the therapist by defeating all the latter's efforts to make sense of the patient's behavior in a way that would have reversed the acting out behavior. While it is useful to think of the patient's narcissistic pathology, his shame at being "mentally ill," and his rage at his caretakers as informing the NTR, the point I am getting at here has to do with the patient's holding onto the wish to exact revenge as being of more importance to the patient than, as the therapist put it, "getting on with his life."

The Wish to See Others as Hateful

Another patient entered treatment with his therapist as part of a larger research project on depression. Some of the patients in this study were put on anti-depressants, others were put on an anti-anxiety agent. All were assigned to psychotherapy. Within a week, the patient had what the therapist considered "a very dramatic response to the study-

drug.". The patient "was brighter, more congenial, much more engaged and open in the therapy." Toward the completion of the research protocol, the therapist offered to continue seeing the patient in his private practice, which the patient "was very interested in doing."

A week or two before the transition, the therapist noticed that the patient "began to look more depressed again" in addition to appearing "paranoid." The therapy then continued for another four months, until the patient stopped treatment without notifying the therapist. The therapist stated, "the way I understood what happened was through the concept of the NTR."

The therapist noted that the patient had stopped taking the medication on his own initiative, but did not tell the therapist for many weeks. Then, some two months after stopping the medication, the patient requested something else. The therapist "was dumbfounded." He stated: "He looked so much worse off the med than on. Why would he stop a med that was so clearly helping?"

The therapist also addressed a similarity in the patient's reaction to the therapy itself. Throughout the initial period of treatment, there was a sense of deepening rapport and alliance building. Then the therapist "started getting spooked by him." Further clarification of this remark revealed that the patient began to appear increasingly paranoid and rageful in a "barely controlled manner." This sense of suspiciousness and potential

violence continued until the patient terminated the treatment.

The therapist, in hindsight, understood this reaction as due to the patient's need to see others as he saw himself: "rotten to the core." The therapist "understood this in Kleinian terms," by which the therapist meant that the patient "had incorporated the bad breast." Consistent with the theory, the therapist sensed the patient's envy "very strongly," especially in regards to the therapist's ability to love and capacity to be "tenaciously caring." By stopping the medication (which was helping) and ultimately by stopping the therapy, the patient was able to win back his depression and maintain his experience of caretakers as "having failed him."

Before moving on to the next NTR, it is worth mentioning how this therapist pointed to his own analysis as a way of understanding NTRs. In describing this, the therapist spoke of feeling "very grateful to my analyst for being very helpful to me." The therapist then went on to say that while feeling grateful, he also "hated the fact" that his own analyst had helped him. The therapist "resented" that his analyst "had this kind of power." The therapist spoke of it as "a challenge" to his view of himself as self-sufficient.

The therapist then said that he thought the patient had a similar, though more exaggerated, experience of detesting the feeling of gratitude. Ultimately, the therapist

believed, the patient could not tolerate feeling grateful, because then the patient would have to give up his wish to see everyone else as hateful like himself.

The Wish to be Seen as Flawed

One therapist described a case in which the patient was attached to seeing himself as very ill. Throughout the treatment, which lasted seven years, the patient continually related his frustration at the therapist for not viewing him as more disturbed. His characteristic remark was, "I'm worse than you think." The patient typically attributed his sense of the discrepancy to the therapist's inability to fully understand him. Thus, while the therapist felt that the treatment was a beneficial one, he stated that he believed this more than the patient did.

The main way that the therapist came to understand the patient's need to be seen as sicker was in the context of the patient's overlapping preoedipal and oedipal difficulties. The therapist noted that at the time of the patient's birth, his mother was depressed. The father was away at war, so the mother turned to the young boy for much of the comfort and support she would have enlisted her husband to provide. The patient remembered an intense involvement with his mother during his earliest years. It was a closeness, however, that was "filled with shame." According to the therapist, the patient (who was a "voracious[16] reader" of psychoanalytic literature) believed

his problems were "dominated" by his preoedipal difficulties.

When father returned home, the patient "had to give up mother in an unrepressed way." The therapist remarked that the patient did not have the opportunity to develop and slowly work through the Oedipal scenario. Rather, he had to relinquish his mother in a way that felt sudden and unexpected. Complicating matters was the father's own ambivalence concerning sexuality. According to the therapist, the father had an unacknowledged homosexual orientation which he projected onto his son. Via the projection, the father would appear "terrified" that his son "would become homosexual."

When he entered treatment, the patient was afraid that he was gay, that he was in some way defective as a man. This sense of himself was maintained by the patient despite many stories which demonstrated his heterosexual prowess. In time, the therapy dyad came to understand the meaning of the patient's fears as being related to the guilt and betrayal he felt in relation to his father. Father was a marginally compensated alcoholic who barely maintained the longstanding family business. It was expected that the patient would also enter and eventually run the business. But instead, the patient opted to take an independent path. In making this autonomous move, the patient's guilt toward father for being his mother's favorite was redoubled. In essence, the therapist came to see the patient's fears about

his manhood as covering the more profound pain occasioned by his sense of guilt and betrayal.

The Wish to Keep the Experiential Separate

Another patient was described as forming a NTR when interpretations were offered that attempted to bridge the patient's cognitive understanding and her internal experience. In a manner resembling Limentani's thesis, the therapist reported that the patient showed a massive difficulty applying her understanding to her experience. While demonstrating a respect for this difficulty, the therapist stated that the treatment could not have been beneficial if he did not begin to address this difficulty. He found, however, that upon addressing this "split," the patient began to withdraw from the treatment.

In part, the withdrawal was due to the patient's experience of the therapist as an aggressor. Though the therapist was clarifying that "in reality" the patient was putting herself in some dangerous situations (related to drug abuse and sexual contact), she felt his words as abusive accusations. The therapist understood this as a projection onto him of the patient's own harsh judgmental attitudes.

The therapist also understood this interaction as a transference enactment having to do with the patient's relationship to her father. Like the patient, the patient's father had been a drug abuser. The therapist felt that the

patient had established a strong identification with the father. When the patient verbally attacked the therapist, shouting that he had "no right" to tell her how to live, the therapist understood this as the patient's wish to kill off the father "inside of her."

During this period of the therapy, the patient decreased the number of sessions from three times a week to twice a week. She also cancelled a number of other sessions. The therapist did not confront this withdrawal. Rather, he maintained his availability, including leaving open the third hour which the patient had said she did not need. After a week of cancellations, the therapist called the patient and asked her if she was all right and whether she wanted to re-schedule. The patient then stated to the therapist, "It's very good that you called, I need you." In response the therapist set up another meeting time.

The therapist then explained in the interview that he felt that he had to "take on" the patient's aggression. He presented his reasoning in the following way: The patient began by talking about having had "a rage attack on her boss" after the boss had fired a co-worker for using drugs. After the patient discussed this, the therapist connected the patient's reaction to her father. The patient then said that she understood the connection, but added "It doesn't calm me down." The therapist noted this as an ambivalent comment and stated to the patient that "unlike previous

times". her reaction may have more to do with himself than the father.

The patient then "became very frightened" realizing that her rage at the boss was because he was "uncaring." This thought then led her to directly experience the therapist as uncaring. She sobbed "and showered" the therapist with tissues, "picking at" the therapist for the remainder of the session. She left the session remarking that "this is all very confusing."

In subsequent hours, the patient began again to "dissociate" her experience of the confusion from her understanding of it. That is, "she re-invoked the split." At that point the therapist felt it was necessary to address this response. He framed it as a didactic exercise in which he talked to the adult about the child inside the patient. The therapist said to the patient, "I need to teach you something about the NTR." He then said that the adult and the child parts of herself understood together that something was wrong in the way they perceived reality, and that therefore, something ought to change. "But," the therapist continued in his remarks to the patient, "if there will be a change, it will be a terrible situation."

The therapist then stated that the adult and child had agreed to accept the alternative that it was not reality that was confusing, but that the therapy was the problem. The two decided to accept the alternative so that the patient could get on with her life. But, the therapist went

on, still paraphrasing his understanding to the patient of what was going on inside of her, "to do that would be to abandon" the child. "And, the child," he added, "right now may be panicked inside." The patient then burst out crying, and felt "to her bones" having been "abandoned by her father." After this dramatic moment, the therapist stated that the patient "cuddled up" like a little child. Despite the turmoil she had experienced, she finally felt understood and soothed.

The Wish to Take Rather Than to Give

In describing his patient's characteristic way of being in relationships, another therapist stated that the patient viewed others as "either those who give or those who take." The therapist felt he was put in the role of those who give. Thus his attempts to explore the various difficulties his patient was having during the treatment (for example, problems with authority figures at work, or his envy infused lack of concern for his new born son) was met with passive withdrawal. The withdrawal occurred, according to the therapist, because it made the patient feel as though he had to give something of himself.

Like many of the other NTR descriptions, the process of this therapy included an initial period of alliance building followed by a seeming break in the trust established between the dyad. Regarding this case, the therapist was not sure of the meaning of this shift in the relationship, except to

say that "this kind of move away from involvement was characteristic of the patient's whole life."

The therapist spent most of his time relating the patient's history. The most dramatic situations included: 1) the patient's inability to remember his biological mother (the parents were divorced when the patient was an infant), 2) the father's having remarried a woman, described as a "stereotypical bad step-mother" who was "psychologically abusive," and 3) the patient's "withdrawal and depression" at age 13, due to the abuse by step-mother and the lack of safety provided by the father.

The patient was described as "marginally coping" from adolescence onward. He "barely" graduated high school. He developed "social phobias" and became a recluse. He moved from job to job, usually getting into trouble with the authorities before resigning or getting fired.

On a more positive note, the therapist also spoke at length about the patient's relationship to the paternal grandmother, a woman portrayed as "nurturant and benevolent." The grandmother "was a giver, not a taker." She encouraged the patient to pursue a college education and helped him financially.

Despite having fairly detailed and vivid information about the patient's past relationships, this therapist spoke very little about how his patient experienced their relationship, other than to point to the giver-taker dichotomy. In fact, on a number of occasions when I asked

specifically about the relationship, the therapist would respond with more information about the patient's life outside of the therapy. Invariably I felt this as a resistance on the therapist's part, and I wondered if some kind of parallel processing was in effect. That is, I felt the therapist was retreating from my questions (in which I was asking him to reflect on and then give me certain kinds of information), but in a way in which he did not seem to notice. Because I am uneasy about interpreting why the therapist did not respond to my queries, and because all I can do is conjecture about the relevant transference-countertransference scenarios (It would be different if the therapist himself had spoken to this topic), I leave this case with many questions unanswered concerning the form, texture, and meaning of this NTR.

Other Cases

The other five NTR cases will be summarized here. Unlike the five cases above, there is no discernible grouping that arises from the data. This is not to suggest that these last five cases to be presented do not overlap in certain ways. However, the ways they overlap seem peripherally related to the meanings of the interactions as portrayed by each therapist. With this in mind, I will briefly present what I consider to be the essence of each case.

One therapist talked about a divorced patient who was in her late twenties at the time of the treatment. She had been referred by a physician who had been prescribing a sedative for her chronic bouts of anxiety. The therapist stated that the patient presented as an overwhelmed drug abusing woman who was having difficulty managing her kids and her finances. The patient also complained of a pattern getting involved with abusive men.

Initially the therapist was struck by the patient's lack of insight into her problems. Two other aspects that the therapist emphasized were the patient's disinterest in exploring her relationships to significant others and the intensity of the patient's "diffuse rage."

Regarding their interactions, the therapist spoke of "trying to have a relationship" with the patient, "but to no avail." The therapist emphasized that whenever she tried to draw the patient's focus to "what was going on between us," the patient would respond with "a fit of rage." Clearly, the therapist remarked, an impasse had developed.

After a few months the patient began to cancel sessions on a regular basis. On a number of these occasions, the patient would call the therapist asking if they could have the session over the phone. The patient reported being unable to get to the session (she had to take a bus from a town nearby). Each time the therapist denied the request, considering it a form of acting out. The therapist reasoned that to capitulate to the request (which in time evolved

into a "demand") would have been akin to colluding with the patient in a manner detrimental to the patient's well-being.

The patient considered the denial as insensitive on the therapist's part. The cancellations increased; when the patient did show for the hour she would verbally abuse and blame the therapist for making her life so miserable. The therapist spoke of having tried to talk to the patient about what feelings were evoked by her "standing firm" on the matter of not doing phone therapy. Typically, the therapist said, the patient reacted with rage and "would not talk about their relationship." This continued for a few more months before the patient quit the therapy.

Another therapist described a treatment with "a borderline woman" that lasted six years. He portrayed the therapy as a constant process of NTRs. That is, this therapist stated that the concept of the NTR was meaningful to him in terms of understanding the patient's "acting out" (re: suicidal gestures, having repeated affairs and one night stands, frequent car accidents, etc) as a negative reaction to their relationship as it developed.

Unfortunately, this therapist spoke in cliches and generalities. As such I was not able to get a sense of what inspired either the therapist or the patient to respond to each other as they did. For example, throughout the interview the therapist talked about the patient's behavior as "typically borderline." When I asked the therapist to describe what he meant, he replied with comments like,

"y'know, what Kernberg writes about" and "well, she wanted to be involved with me, yet couldn't be involved, in the way borderlines are." This therapist also mentioned on a number of occasions that he had "no head" for details. I felt that this therapist was clearly telling me that I should not ask for a more descriptive account of what he was talking about. Yet, he did not convey this in an angry or put off way. In fact, the therapist seemed quite pleased with being interviewed, and stated so a number of times. At the end of the interview the therapist thanked me for giving him the opportunity to review a case that had been very important to him.

Similar to the one above, another therapist described the whole therapy as a series of NTRs. As the interview proceeded, this therapist developed the idea of thinking about the NTR not as a discrete event but as a way of capturing the essence of the patient's ongoing fear of getting close to the therapist. At foundation, the therapist said, the fear had to do with the patient's shame about his "darker side." The phrase "darker side" was the patient's way of describing his resistance. In time, the dyad came to understand that this term connoted the patient's anger and aggression, which the patient experienced as overwhelming and uncontainable. The therapist felt that the patient had been brought up to believe that all aggressive feelings were bad, and therefore, had to be disavowed and repudiated.

Typical of most of the cases described, this therapist emphasized the split off nature of the patient's affective experience. In discussing this aspect of how he understood the patient's behavior, the therapist talked about an "uncanny" process that occurred on a couple of occasions. This process involved the therapist having certain images in which he "could see and hear" the patient interacting with his parents. The therapist noted that these images were invariably unrelated to the content of what the patient was addressing. Struck by how "vivid" these images were, the therapist would present the image to the patient and ask if it had any relevance.

Each time such a process occurred, the patient was "moved" by the therapist's image. Tears would well up in his eyes and the patient's typical "intellectual" facade would dissipate. The dyad then would talk about the relevance of the image (the patient confirmed its validity). The therapist said that the outcome always produced a sense of increased intimacy and relatedness.

The last two cases to summarize were purposely left for the end of this section. This is because the two therapists interviewed left me with a very vivid image of the interaction each described. My hope is that I can pass on the vividness to the reader.

The first one concerns a NTR that the therapist described as the outcome of the first session with the patient. He stated that the patient came into the room and

proceeded to tell him of the panic she was experiencing generally in her life. The therapist then spoke about how the patient portrayed herself in a "very reasonable" way. Despite "the mess she was in" the patient appeared to respond favorably to the therapist's comments. He noted that she seemed to feel supported by how the session went.

A few minutes after the session ended, the therapist left his office and found the patient "huddled on the stairs, sobbing uncontrollably." Perplexed by the discrepancy, the therapist stated to the patient that if it was too difficult for her to get to and from the sessions without it "being so dreadful" then maybe they should talk about another arrangement. The patient quickly dried her tears and said "I'll be okay, I'll be okay." The therapist moved on, but noted that the patient ran out of the building. He could hear her car "laying patches" as she drove off. The therapist then said to me, "In that drama was our whole relationship."

In the ensuing sessions, the patient "maintained her facade of capability" and "only brought in the reasonable parts of herself." In hindsight, the therapist "was only too happy to go along." The therapist described that the patient would bring in very graphic dreams. Many of the dreams consisted of the patient's "swallowing dangerous objects." Other dreams conveyed themes of abuse and humiliation perpetrated by the therapist. One dream consisted of the patient being on stage and the therapist

lifting her skirt. The therapist added, "and she has to pretend that nothing is happening to her."

During this period of the treatment, the therapist noted that in the room he had a number of striking fantasies in which he would be stabbing himself in the arm, or mutilating himself in some other manner. He also stated that he found himself humming a popular song in which part of the lyrics include, "I know you've been hurt before, but I won't do that to you."

The therapist sought consultation for this case. He said that a number of theories were proposed to him. One theory had to do with his "trying to let her in." Another focused on his wish to help her "by giving her my own blood." A third focused on "taking on her masochism." I then asked what he believed. He stated, "I felt so guilty about her anguish that I was warding off my own suffering."

Clearly the dyad was involved in a sadomasochistic entanglement. And the entanglement continued to intensify. For "a long time" the patient described that she felt "nothing happened in-between the sessions." The therapist stated, "It was like she blacked out between sessions. She'd leave and the next thing she knew she was coming for the next session. Nothing existed for her outside of the sessions." Unable to figure out how to extricate themselves from this problematic scenario, the therapist exclaimed, "It was bizarre. It was a bizarre relationship."

Further underlining the intensity of their relationship, the therapist spoke of a number of occasions in which the patient "refused to leave" when the hour was over. Frustrated by his attempts to invoke a more "reasonable" response form the patient, he finally threatened her with calling the police if she did not leave. The patient also had a few "psychotic episodes" during this period. These episodes consisted of the patient accusing the therapist of having changed the room in some manner, such as putting in new furniture or painting the walls a different color.

Some time later the patient filed charges with the police accusing the therapist of sexual impropriety. I raise this not to point to the patient's "craziness," but in fact, to point to the perplexing nature of the interaction. The therapist himself stated that one of the "bizarre" aspects of her charges was that she accused him of saying things which he remembered as actually having said. This included comments such as, "I hope in time you will feel comfortable sharing with me the parts of yourself you keep hidden." Though the charges were later dropped, the therapy ended in a way that left the therapist feeling that these interactions were never worked through. The therapist said, in remarking about the first session, "I wish I had been more tuned in to who that was at the bottom of the stairs."

The last case to be presented concerns a woman patient who presented for treatment "in a panic." She stated that

she was suffering from a severe work inhibition and considered herself "an imposter." She expressed that she felt she was "losing control" of her life, and by this meant that she was afraid she might hurt her young child.

The patient worked in social services. As such, she had seen the therapist do a few consultations at her agency. Furthermore, the type of work she did had a lot in common with both the therapist and the therapist's wife.

The therapist framed the first four sessions as an assessment in which the patient's task was to describe her life history. The therapist noted that the patient told her history in a very intense manner. He used terms such as "spilling" and "torrential" to describe her process. During these first sessions, the patient alluded to having been raped as an adolescent. She also vaguely talked about "something terrible" which happened to her in her childhood, but was unclear what that consisted of.

At the end of the assessment, the therapist said to the patient "next week we can start going through what you've talked about." After leaving the session, the patient had what the therapist thought was a NTR. She went into a "disorganized panic" that lasted for two months. A number of times she called the therapist in a rage and verbally assaulted him. She ended these conversations by angrily telling him that she was quitting the therapy. She would then call him back a week or two later and ask if she could resume the treatment. Throughout these two months, her work

suffered tremendously, as she became paralyzed in her attempts to perform her tasks.

This period was marked by "a shared despair." The therapist thought the patient was telling him to "look at how crazy I am." He stated, "I felt like we had opened Pandora's Box, and she had literally come undone." Surmising that the initial four sessions had been fairly structured, and that his comment at the end about "getting into all this next time" left the patient to face her "gaping emptiness," the therapist tried what he called a "paradoxical intervention." He called the patient and told her that he was setting a termination date in six months. He also told her that she was to see him twice rather than once a week. The therapist said that he could hear her tone change on the phone. From being "hysterical," the patient quickly became more reasonable. She thought about what he said and calmly agreed to the arrangement.

The therapist then discussed how he arrived at this intervention. First he noted the issue of structure. He stated that this woman seemed to be experiencing herself as very close to falling into a void. Establishing an end date was a way of providing her with some structure that allowed her to distance herself from this experience.

Then the therapist mentioned his intent to give her a complicated message. That is, while he was saying that their relationship was not going to last long, he was also saying that he wanted to spend more time with her each week.

The therapist also stated that he was purposely enacting her harsh superego. He said that he consciously presented his intervention in an authoritative voice, which he termed "sadistic." This he felt would gratify her masochistic needs.

Finally, the therapist spoke of having hypothesized a particular Oedipal scenario to have been re-invoked by the patient's coming specifically to him for treatment. Though their's was a talking therapy, the patient knew that the therapist often enjoined other expressive modes in the work he did. Specifically, the therapist was well acquainted with dance therapy techniques. As such he thought there was a strong possibility that the patient chose him (someone she already knew) with the unconscious wish that "we would roll around the room together." He added, "I think she hoped I would be someone who was physical with her."

Regarding this last hypothesis, the therapist reported feeling that the patient had been victim to some type of physical assault perpetrated by the father. His feeling had to do both with her vague allusion to being victim to something terrible in her childhood, and his ever constant sense during the tumultuous two months prior to his intervention that he was "raping her" in some way. He figured that the patient had developed a transference "that brought back to life being victimized."

During the six months of treatment, the therapist reported that his hypotheses were largely validated.

Memories of abuse at the hands of her father surfaced clearly and vividly. He also reported that she remembered having vomited when she was raped. The therapist considered this to be in line with the way she "spilled and vomited out" her history in the first four sessions.

The therapist also noted that these same issues resurfaced as the termination date drew near. The patient in an increasingly agitated manner, sought to extend the termination date. The therapist, fearing to reenact "the seduction" held firm and denied her direct and indirect requests to continue the treatment. The patient, in turn, began to verbally assault the therapist with renewed vigor. But, the therapist related, the "attempts at spoiling" the work accomplished had a less severe quality than her attempts to spoil his image six months prior. He described this aspect of the patient's presentation at the end of the treatment as "a mild vomit, more like a belch."

Prominent Themes and Images

The following topics, each in their own way, capture a significant part of the interview data. They represent themes that wove their way through many of the descriptions, especially at times when the therapist was emphasizing a point about himself and the patient.

Serving Meat to Hungry Vegetarians

On a number of occasions the image of serving meat to a vegetarian came to mind while listening to the accounts described in this study. The therapist, for everything else that he might be, is a server and a provider. His task is to provide "something" (e.g. a corrective emotional experience, a containing function, an empathic ear, an analytic instrument, etc.) for the patient to take from him. This is an aspect of the paradox of the NTR: The patient needs something to ease his suffering, yet defies accepting whatever may be offered as potentially soothing. I think that it is generally useful to view this dynamic in oral terms, since it has to do with the very basic aspect of living as eating, and the associated acts of sucking, biting, chewing (re: "grinding"), digestion, and the like.

Eating is at foundation, a relational event. Though as children and adults we may be able to prepare our own food, the infant is not. Eating emerges out of an object relational context which includes the provider of food.

As we saw, this metaphor of eating applies to the cases presented above: there was the patient who had difficulty swallowing, and the other patient who had clenched teeth. Here, I am stating that the related descriptions that cohere around this metaphor of eating were mentioned by many of the other therapists I interviewed. In a sense, I feel like I have been re-discovering the wheel. For example, did not Freud and those who followed him constantly invoke the oral

sphere of dominance, especially when discussing their most disturbed patients?

In the NTR situation, this sphere of dominance can itself be said to dominate the therapeutic relationship. Yet, it dominates in a peculiar way. The patient is hungry, no doubt. But he will not digest what we offer. The patient is like the vegetarian of many years who knows his system can not tolerate meat anymore without disastrous side effects; he will spit it back up if he's lucky, or worse, he will become ill.

Perhaps the most overt way this dynamic emerges in NTR situations pertains to medication compliance. Four therapists noted that their patients stopped taking their medications before letting it be known. In each case, the therapist was surprised because they believed they had seen the medications having a positive effect. That is, the medications were working in the manner they were intended - to decrease depressive symptomatology and ease the subjective state of unhappiness.

"A Touch, A Touch, I Do Confess"

Hamlet was not only being honest when he told the assembled court that Laertes had nicked him in their duel. He was also letting the audience know that his demise was imminent. We knew that Laertes had plotted with Claudius to poison the tip of his rapier. Of course, he was only nicked.

I think we are being most honest when we accept that all loving and caring behaviors have an aggressive component. Euphemistically, we can think of loving someone to death, killing with kindness, or drowning someone in our love. Now, I don't know if there is a death instinct. But I do think that if we are to accept ourselves honestly, then we need to accept the aggressive parts of ourselves, even when these parts may be overshadowed by our capacity to love and feel concern.

The patients described in this study seem to have experienced their therapists' caring as something to be avoided at all costs. Frequently, this was portrayed around the metaphor of touch. A number of therapists (some, somewhat abashedly) spoke of how their comments were experienced by the patient as being physically touched. And with mixed results. On the one hand, these touching comments invariably elicited in the patient a sense of being understood, and a discernible feeling of relief. On the other hand, such understanding was terrifying, and led the patient to obliterate the experience from his mind.

Typically, these patients had been abused during childhood. For them, as one therapist put it, "being touched meant being violated." Another therapist remarked how the patient "hated to be touched by my interpretations." This was the third time that week I had heard a phrase such as this one. The therapist noted my quizzical look and stated that the patient seemed to experience his words as

being "penetrated and violated." He then described the physical abuse that had taken place in the patient's childhood.

A closely associated finding was that NTR patients experience intimacy or closeness as life threatening. One therapist stated that his patient left treatment because the patient "had become too close to me." Another therapist also talked about how the patient's "sense that we were developing a close relationship, whatever that means" was followed by missed appointments whenever that 'sense' developed. A third therapist spoke of how he restructured the therapy - he invoked a termination date, and established what could and could not be worked on in the time remaining to them - because the patient was "merging" with him so fully that she could not concentrate at her job and was calling him at home at all hours of the night.

"...But Words Will Never Hurt Me"

The patient's experience of the therapist's interpretations seen in the context of the therapeutic relationship often combine these metaphors of orality and touch. The description of one patient's response to interpretations brought to my mind the character of Bartleby in the Melville story about the scrivener. This short story has a distinctive existential feel to it; faced with his withering physical and spiritual condition, Bartleby stereotypically replies "I prefer not to" whenever given an

opportunity to redress his deteriorating condition. Juxtaposing the image of Bartleby with Camus' Rebel ("I rebel, therefore I am") captured my developing image of this patient. The patient's therapist talked about the patient's typical response to interpretations as seeming "passively resistant." The therapist then went on to state that underneath the passivity was a "rigid" proclamation, "I will not submit." Taking in the interpretation, according to the therapist, was tantamount to being forced to accept physical abuse. The patient's lack of emotion - "He would calmly say, 'I don't agree with that comment'" - betrayed, according to this therapist "the Sturm and Drang" latently communicated.

Most of the therapists interviewed made it a point to talk about their patients' avoidant responses to their interpretations. The responses ran the gamut of expressed emotion from "passive disinterest" to "hostile rage." Impressively, these therapists invariably followed up their disclosures by noting how they attempted to find something wrong with the interpretation: "I constantly wondered if I had missed something important in what [the patient] was communicating" and "For a long time I thought it had to do with my own issues with my father that I was defending against hearing [in the patient's] response to me" are two examples. Both of these therapists ultimately decided that it was not their inabilities that were causing the defiant

reaction, but something more central in the patient's transference experience.

We have already seen one example where the therapist was using his interpretations as arsenal to attack the patient. These attacks, the supervisor of the case believed, were motivated by the therapist's feelings of despair and hopelessness. Yet, a number of times, other therapists expressed that the patient seemed to feel attacked by their interpretations, even when the therapist could find no motivation in himself to account for the patient's reaction. Some of these therapists further noted that they felt the patient was "pressuring" them to be aggressive and punitive, but believed that they had resisted acting upon the pressure. Whatever the actual reasons underlying these exchanges, these NTR patients had a proclivity to experience their therapists' words as sticks and stones.

"I'm Not Capitulating"

Berenger's last line in Ionesco's Rhinoceros, stated with overblown bravado, reveals the pathos of his condition: if his defiance is strong enough, he will succeed in remaining a man, but at the cost of eternal alienation. He will remain true to his condition, that of homo sapien, in a world populated by rhinoceri.

Most of the NTR patients described in this study provoked a similar image of conflict. From their

perspective, to depend on the therapist is synonymous with losing their identity. There is an element of control, certainly. Yet the element of control, and the related elements of power and authority, while supplying some of the structure, do not fully capture the essence of the image.

In Berenger's last soliloquy, he exclaims, "To talk to them I'd have to learn their language. Or they'd have to learn mine. But what language do I speak? What is my language? Am I talking French? Yes, it must be French. But what is French? I can call it French if I want, and nobody can say it isn't - I'm the only one who speaks it"

A significant feature of the NTR patient's language, from the commonly shared perspective of our culture, is that they profoundly confuse pain and pleasure. For example, one patient became enraged at the therapist because he was accusing her of participating in perverse forms of pleasurable activity. In one sense, she had reason to protest: No one can tell others how to live. The facts are, however, that she was defending her right to ingest a drug that is known to be unpredictable and sometimes lethal, and was sleeping with a man who himself "slept around indiscriminately." Whatever position we take on a person's right to engage in masochistic activity, I don't think that we would disagree that certain behaviors - child and spousal abuse, drug abuse, indiscriminate sexual activity, etc. - warrant some kind of action on the therapist's part.

But the confusion between pain and pleasure is more complicated and borders on ontological issues rarely invoked in psychoanalytic discourse. Here, I think Valenstein's thesis that some NTR patients enter relationships in order to exact a singular quality of pain which makes these people feel alive, is relevant. One therapist spoke of his patient's reasons for cutting on herself. Paraphrasing, she related that the cutting was not to hurt herself (though it did), nor was it to defy her caretakers (which it did). It was in order to feel something, anything, to give her a sense that her being had some integrity, some form, some shape. Otherwise, there was deadness, an experience of life as a constant confrontation with the abyss.

This is not to romanticize these patients' conditions. Rather, it is to take them at their word, even if their word is so idiosyncratic that it is fair to say that the language is a language of one.

In line with this idea, one therapist's response to my question concerning his current interests is instructive. This therapist talked about the "notion of suicide" as an ally, indeed, "the only ally" some people have in their experience in the world. Thinking in an object relations context, this therapist talked about how he was exploring the notion that some people develop in such a way, that this "ally" is the only internalized object that has the potential for solace and soothing.

NOTES

1. In a footnote regarding his presentation of three varieties, Asch stated, "Although further clinical material might reveal additional varieties, I am limiting this report to those configurations I have studied in depth and can support with clinical data."

2. In more than fifteen years of practicing psychotherapy and psychoanalysis, the therapist stated that only one other time had he contacted a patient while on vacation.

3. This therapist did not comment on whether the patient had been effected by the mother's incapacity at birth. Thus my comment here is more speculative than otherwise. The literature, however, is replete with references to birth trauma as forming the foundation for these pre-oedipal crimes. Given what we know about this woman's prominent object-relations, it seems reasonable that she carried with her a sense of culpability regarding her mother's longstanding incapacitation which began just prior to the patient's birth.

4. Unlike the last case, I was unable (due to time limitations) to collect data specifically about this man's developmental history. As such, the reader is not afforded a viewing of this NTR in the context of historical information.

5. The reader may notice the similarity between this description and that of The Wolfman. I inquired about this and the therapist remarked that he thought of The Wolfman as "not neurotic, he was much sicker" than the patient being described here.

6. In this, and other remarks to follow, the therapist sometimes switches between past and present tenses. In that these shifts are often for the purpose of emphasis, I will not change the usage of tense employed by the therapist. This also allows the reader a closer look at the interview experience.

7. It is worth mentioning here, that during the interviews, I often heard the opinion that thinking in terms of this oedipal/preoedipal dichotomy can only lead to superficial conclusions. The arguments in the literature which advocate one position or the other, then, seem fairly simplistic when contrasted with the interview data.

8. In addition to supervising, the analyst was the Ward Chief on the unit that the patient was admitted to. As such, the supervisor also had many occasions to meet and

witness the patient. The supervisor also explained that he would meet with the therapist after each therapy session.

9. Throughout this case, in order to increase readability, I will be using remarks such as "the therapist stated ..." when in fact the more accurate reference would be "according to the supervisor, the therapist stated ..."

10. The supervisor ventured that the patient had a "mixed character disorder with very prominent sadomasochistic features." He then stated that he "didn't know if there's anything like a sadomasochistic personality disorder." Given this remark, it is interesting to note that the newest revision of DSM-III includes the provisional diagnosis of "Self-Defeating Personality Disorder." The substance of the criteria for this diagnosis bear a remarkable resemblance to the patients reported on in this study.

11. Like many of the therapists I interviewed, this therapist at first playfully downplayed my request for a diagnosis. First he told a funny vignette: "I once listened to Merton Gill give a discussion of a colleagues' patient, and someone asked him about the diagnosis. Gill said, 'He's very sick.'" This therapist then stated, "I think this is a severe personality disturbance with a whole variety of features. Certainly narcissistic, even some schizoid, and at times, some borderline. There are even some flourishes of obsessional and hysterical elements. But the kind of preoedipal, narcissistic and borderline elements - those are at the heart of the matter."

12. When I asked what he meant by the term "grind" the therapist stated that it derived from his image of the poem "Jack and the Beanstalk." He then recited, "... fee, fie, foe, fum, I'll grind the bones of an Englishman."

13. The therapist quipped, "When I read the paper [on the internal saboteur], it was so dense and difficult to follow, I thought, who in the world would sit there in an office listening to a patient and come up with this. BUT, lo and behold, here is the internal saboteur."

14. When I first spoke to this therapist and explained what I was working on, he inquired about what had led me to the topic of the NTR. I then mentioned that I had been interested in the notion of envy and that researching envy eventually led me to the NTR. After he introduced the notion of envy in the above excerpt, this therapist then stated, "I know we talked about this briefly before. Let me assure you this is something that came up quite explicitly before I ever met you. So its not that you are tilting me in that direction."

15. I am capitalizing the word "Other" because I think the therapist was using Lacan's terminology.

16. Initially the therapist used the word "avaricious." He then paused for a moment and said, "I mean voracious." Later, the therapist commented that the "slip" had something to do with the "greedy and envious" nature of the patient's presentation.

CHAPTER V

DISCUSSION

Introduction

The results of this study suggest that the NTR situation is frequently comprised of many dramatic intrapsychic and interpersonal processes. From an intrapsychic perspective, the NTR patient often suffers from excessive masochistic tendencies, guilt, and envy. Interpersonally, destructive interaction patterns dominate the therapeutic relationship; typically the patient's transference informed fears and resentments serve to block the possibility of trust and intimacy developing between the therapeutic dyad. Confronted by the pressure of the patient's sadistic attacks, his seemingly intractable obstinacy, and his withdrawal from the therapeutic work, the therapist finds him- or herself in a particularly vulnerable position. This position is typically fraught with despair, feelings of inadequacy and the urge to harm the patient.

Yet despite such difficult circumstances, we have seen a number of case examples in which the therapeutic dyad was able to withstand and eventually overcome the destructive enactments that occur during the NTR situation. As such, I would venture that the field has progressed in significant ways since Freud first addressed the NTR event. This progress is marked by a greater understanding of the ways early developmental pathology becomes reenacted in the

transference, a fuller appreciation for the ways severely disturbed patients communicate (especially in the domain of unconscious communication) their suffering to their therapists, and more encompassing considerations of the interactional context in which the NTR becomes manifest. Thus I believe there are sound reasons to be optimistic about the potential of psychoanalytic psychotherapy to help patients who form NTRs in treatment.

Yet, in drawing this optimistic inference, we must also consider the limitations inherent in the case study format. Therefore, I will turn our attention to what I consider the major limitations of this kind of study. As groundwork, I will first say a few words about the methodology used in this study. This will lead me into a critical examination concerning how the field typically organizes and presents its findings. I will relate this to both the way the therapists interviewed presented their cases to me and how I have presented the cases for the reader. In this discussion I will raise some concerns about the tradition embodied in the psychoanalytic case study method. This will then lead me to consider the role of theory in psychoanalytic psychotherapy. In these sections to follow, I will also be drawing on my own experience in conducting this research and upon some of the data collected. After these discussions are presented, I will then address implications for further research.

Thus far I have said relatively little about the methodological considerations that have gone into this work. In the main, this was intentional: I conceived of the interview data as narrative accounts, each one unique in its own way. I saw my task as mainly organizational, motivated by concerns of inclusiveness and coherence. Thus, I consciously attempted to minimize imposing what Bruner (1984) calls paradigmatic interpretations. Such interpretations serve to anchor a set of data around certain specific concepts, thereby minimizing the report of any material that does not cohere around the chosen concept. Further, paradigmatic accounts purposely attempt to leave no room for alternative hypotheses. Since this study was an exploratory venture, imparting my own paradigmatic interpretations before or during the report of the data, would have been an act of bad faith. The procedure that I chose, therefore, was one which illustrated my method, highlighting the process and tabling (for the time being) an explication of my reasons. Basically, my intention was to present the results in a manner where they could stand on their own. I believe that the extent to which this project is a contribution to our understanding of the NTR situation is largely dependent on the ability of the results to be evocative and compelling, in and of themselves.

The Implications of Narrative Smoothing

In order to address this conclusion, and further, in order to anticipate what I consider to be future research goals, I now turn our attention to some issues regarding how psychoanalytic knowledge is derived and passed on. I will rely on the evolution of my own thought during the conduct of this research as a starting point.

As mentioned earlier, I underwent a radical shift in my approach to the topic of the NTR while conducting this research. When I began this project I embraced a hypothetical-deductive approach to the NTR situation. Within this approach, I considered the theory of envy as the most fruitful way of understanding why NTRs develop. Indeed, I was quite excited about the potential of a theory founded in envy to explain many of the documented behaviors evidenced by NTR patients.

As I pursued the study of envy I began to connect it to notions related to narcissistic development, character pathology, and certain types of countertransference problems. I then reasoned that patients who formed NTRs seemed to react in this negativistic (re: envious) manner when perceiving the therapist to be someone who was potentially capable of offering help. Furthermore, my sense was that it was precisely at those moments when the therapist's potency was acutely acknowledged that the patient responded in ways designed to render the therapist ineffective. I figured, then, that in understanding the

experience of envy, the paradoxical NTR situation could be decoded and even demystified.

Yet, as I became more concerned with how we arrive at experientially derived understandings of the NTR syndrome, I realized I was working at cross purposes to myself. I concluded that I was highlighting theoretical concerns in a way that was going to diminish my ability to ascertain how each therapist arrived at the meaning of the patient's reaction. Thus I adjusted my approach, and in so doing, became less interested in evoking therapist responses which related to the interpretations I had developed about the influence of envy. That is, I realized that taking these theoretical constructs into the interviews and holding them in the foreground of the interaction could only retard the potential richness of the data and delimit the possibility that I would be surprised by what I heard.

Now I want to broaden the implications of these realizations, within one view of the historical context of the development of psychoanalytic understanding. I start with Freud the master story teller.

That Freud captured his audience because he presented compelling narrative accounts has been noted elsewhere (see, for example, Hertz, 1983 and Brooks, 1984). Indeed, that Freud was often primarily motivated by holding his audience's attention was stated by him on many occasions. For example, when presenting the case of Dora, Freud explicitly noted his concern with keeping the reader's

interest. He wrote that he wanted to provide the reader with a story which was "intelligible, consistent and unbroken" (Freud, 1905, p. 18). His goal was to maximize the mystery and suspense surrounding the intricate connections between the patient's many symptoms, in addition to deducing why these symptoms developed in the particular manner they did. In prescribing this as his task, he relegated technical considerations to a secondary position of importance.

The esteemed position of Freud's cases, such as Dora, established a particular type of clinical report that dominates the field today. This type of report consists mainly of maximizing narrative coherence at the expense of reporting the details of what actually took place in the therapy process. Let us first examine an excerpt from the Dora case which is representative of the points being developed here:

> There is another kind of incompleteness which I myself have introduced. I have as a rule not reproduced the process of interpretation to which the patient's associations and communications had to be subjected, but only the results of that process. Apart from the dreams, therefore, the technique of the analytic work has been revealed in only a very few places. My object in this case history was to demonstrate the intimate structure of a neurotic disorder and the determination of its symptoms; and it would have led to nothing but hopeless confusion if I had tried to complete the other task at the same time. (1905, p. 27)

Like Freud, many of the therapists I interviewed omitted accounts of how they arrived at their

interpretations, except by way of invoking theoretical considerations. Often, when these omissions caught my attention, I attempted to find out the details of what the therapist had experienced--his thoughts, feelings, associations, etc.--that led him to choose the particular theory invoked. Typically, the responses I received were similar to this one: "I don't think at the time I was consciously aware of what went into my interpretation to the patient." Many other therapists responded with terms such as "uncanny" or "ineffable" when I tried to ascertain the flavor of the therapeutic data that led them to posit certain interpretations.

Such responses left me feeling that the therapists were essentially shortchanging themselves. That is, I felt that most of the interviewees knew more than they could articulate. This led me, then, to wonder why these therapists would find it difficult to capture in more personal terms, what went into the formation of a particular interpretation. I will say more on this topic when I address the role of theory in the practice of psychotherapy.

Getting back to the Dora excerpt above, we can speculate further as to why Freud declined to account for how he arrived at his interpretations. Perhaps full disclosure would have revealed interpretations that produced no insight, or worse, introduced some temporary obstacle in the search for paradigmatic support. While this speculation seems probable, given the uneven way most therapies proceed,

there is another reason which is more compelling for me. This has to do with Freud's concern with maintaining the flow of the narrative; reporting the details of the give and take between therapist and patient undoubtedly would have interfered with the story's readability and suspense.

In a critique of the case report method, Spence (1986) points out that the lack of attention to how the therapist arrives at his interpretations has plagued analytic writing since Freud. He calls this a process of "Level II" narrative smoothing in which the source of analytic knowledge in the consulting room is ambiguous and untraceable. Central to this "smoothing" process is the attempt to bring the clinical account into conformity with some kind of public standard or stereotype.

Spence argues that since Freud published the great case histories of Dora, the Wolf Man, and the Rat Man, this type of narrative smoothing has dominated the case study literature. As such, these case studies typically attempt to "tell a coherent story by selecting certain facts (and ignoring others), which allows interpretation to masquerade as explanation, and which effectively prevents the reader from making contact with the full account and thereby prevents the reader (if he so chooses) from coming up with an alternative explanation" (p. 212-213).

Indeed, Spence further argues that since Freud, this type of narrative smoothing has significantly increased. Spence backs up this conclusion by noting that the narrative

structure of the average clinical case in a current journal is supported by only a few anecdotes. Thus, the reader is presented with clinical impressions that must be accepted on faith. The reader is also presented with observations "so heavily mixed with theory that it is impossible to form a second opinion" (p. 213). Such a process of reporting can only be sustained if clinical examples are kept to a minimum.

Clearly, the NTR literature is representative of Spence's argument: the observations presented are so theory-laden that the reader never has a chance to view what actually happened in the interchange between patient and therapist, before or during the time of the NTR. In what I now view as an insidious process, I took for a time the observations reported in the literature as illustrative of what transpired in the therapeutic process. Indeed, because I was so heavily motivated to find logical coherence for why NTRs develop when I reviewed the literature, I was not even concerned with raising alternative hypotheses until the very end. At that point, all I could argue was that the different theoretical principles proposed all seemed equally plausible. That these articles contain very little clinical data structured this conclusion.

In the interviews I attempted to find out how the therapists arrived at their conclusions, what they were hearing from their patients that motivated them to interpret what they did, and how they used certain concepts in

arriving at, with the patient, the meaning of the clinical material. Overall, I was moderately successful. Some therapists were able to recollect telling examples of these processes; most, however, were not. This is not to discredit these latter therapists. What I was asking for often amounted to a radical change in context for the therapist. Certainly there was an interactional component. On my part, I often did not convey clearly enough what it was I wanted to get at. On the therapist's part, there was often a look of puzzlement. This look typically seemed to be saying: I thought you wanted to hear my conclusions, but now you are asking me to describe how I arrived at these conclusions, which is an entirely different matter.

Still, my sense was that many therapists were reluctant to make public the intimate process by which they had arrived at their narrative accounts. Placing these therapists in the context of the psychoanalytic tradition offers us some explanation. As noted, this tradition values coherence at the expense of detailed description. It is as if the time honored notions of privacy and confidentiality in the therapy setting have been extended and applied to the therapist's own experience and processing of the material.

There is something gained in maintaining this stance in which relatively less attention is paid to how ideas and conclusions in the psychoanalytic setting are arrived at by the therapist. Primarily it reduces tension and promotes a kind of clarity. By not acknowledging the existence of

material that does not fit with the prevailing formulation, the therapist has that much more room to expound on and further study the implications of his formulation. But such a process excludes the possibility of entertaining rival hypotheses; ultimately progress in refining theory grinds to a halt.

And there is more to this matter. "Level II" narrative smoothing proceeds after the therapeutic event. In this type of smoothing, data that do not conform to the presentation of the formulation is simply dismissed as irrelevant. But these data are there, they do exist. Yet, there are ways that we as therapists may not even notice these data in the first place, or may not even know that these data are potentially manifest. Such a situation can be understood in terms of what Spence calls "Level I" narrative smoothing.

This type of narrative smoothing takes place prior to the reporting of a case. It occurs during the therapeutic interaction itself. It "begins with leading suggestions," and "continues in more subtle form, in a variety of guises - pressing certain interpretations more than others, supporting the patient in certain kinds of explanations, or 'hearing' one meaning in a tone of voice as opposed to others, to name only a few" (p. 213). From a broad perspective, such "smoothing" signifies that the therapist has an agenda which he is imposing on the relationship.

Just as the reader can only speculate whether a case report in the literature was influenced by this type of "smoothing," I can only speculate about the existence of it in the descriptions I heard. But one can look at the material in certain ways to estimate its influence. For example, I could, in going over a transcript, look for evidence of a therapist's insisting on a certain interpretation. Or, conversely, I could look for evidence of the therapist having entertained more than one meaning for a particular utterance by the patient.

The way I attempted to diminish the influence of "Level I" narrative smoothing was by choosing three cases (the last three cases presented in section two of the results chapter) that I thought most exemplified the interviewee's awareness of this type of smoothing. The criteria I used, in conjunction with the above, in choosing these cases were: 1) noting the element of surprise on the interviewee's part in his portrayal of the NTR situation; 2) noting the interviewee's sensitivity to when and how the patient might have been unintentionally influenced by the therapist, especially in regards to the patient's tendency to be compliant; and 3) noting the interviewee's capacity to sit with doubt and uncertainty, without feeling compelled to provide explanations for why the NTR occurred.

Regarding this last point, I presented the three cases which most left me with the feeling that whatever explanations were to be derived were essentially left for me

to decide. I then saw as my task to pass on this sense of uncertainty (as to why these NTRs developed) so that the reader would be imposed on as minimally as possible.

The Role of Theory in Psychoanalytic Psychotherapy

Before addressing the implications for further research, I think it is necessary to explicate what the role of theory is in the conduct of psychoanalytic psychotherapy. I think such a pursuit is essential given that therapists typically use the same language and ideas for both descriptive and explanatory purposes. Indeed, we have seen that often a single statement is used for both purposes at one and the same time. For example, terms like "narcissistic," "masochistic," and "transferential" simultaneously describe and explain certain phenomena. Does the use of these terms merely imply sloppy thinking, or is the matter more complicated? Addressing a question like this one seems of utmost importance for the clinical researcher who is trying to locate an unbiased way of addressing the phenomena under discussion.

We know that perception, and therefore, the manner of listening, is not theory free. Perception is goal directed; it is an active process, not a passive one. Such a realization then begs the question of how we are to minimize the influence of "Level I" smoothing in the way we listen clinically, if we know that a pure form of unaffected attention is a myth.

Patients tell us their stories. As such, trying to understand the meaning of what the patient is telling us is similar to understanding a text. When we meet with a patient, be it the initial session or the hundredth session, we approach the interaction as an unfamiliar one, one that is beyond memory and desire. Thus, we meet the patient prepared to be told something new.

Gadamer's (1984) thoughts about how to approach an unfamiliar text are relevant here. This author suggests that the reader must be sensitive to the text's quality of newness. But this kind of sensitivity, Gadamer writes:

> involves neither "neutrality" in the matter of the object nor the extinction of one's self, but the conscious assimilation of one's own fore-meanings and prejudices. The important thing is to be aware of one's own bias, so that the text may present itself in all its newness and thus be able to assert its own truth against one's own fore-meanings. (p. 238)

Prejudice, in this context, does not necessarily mean unfounded judgement. More broadly, it refers to the witting and unwitting assumptions that we bring to any new experience.

Relating this idea to case study research leads me to the thought that the psychoanalytic clinician has developed two distinctly different sets of values in his approach to the work and in his way of reporting the work. In his approach to the work he has been greatly influenced not to accept what on the surface seems sensible. He looks below the surface of what the patient utters to find which voice

the patient is using. In this way the therapist-as-listener maintains a healthy suspicion that what appears to be is not always what really is. The possibility of discovering what is fresh and new is enhanced. Put another way, the therapist maximizes his capacity to read between the lines.

Yet, paradoxically, we have seen that the therapist-as-reporter tends to delimit the value of listening between the lines. Thus, most clinical reports attempt to be as transparent as possible. The closer the report gets to providing a story that encourages the reader to derive the exact conclusions that the writer did, the more successful the report. I think this has to do mainly with some erroneous ideas about the place of theory in the psychoanalytic interchange.

Duncan (1981) writes that what is "most unique and inimitable about psychoanalytic theories is that they are inextricably involved in the core-function of psychoanalysis" (p. 344). He considers this to be an essential aspect of intersubjective knowing. intersubjective knowing is the cognitive set appropriate for understanding human motivation. Thus, we can say with Duncan that intersubjective knowing is experiential motive-knowing.

Such a cognitive set provides the therapist with a position very different from that prescribed by social convention. That is, common sense is pushed aside so that the therapist can maintain neutrality. Whereas common sense

would dictate, for example, that an angry response would be appropriate in response to what a patient may say or do to us, we as therapeutic agents would typically not react with anger. Instead, we see our task as involving an attempt to extend motivational awareness. Thus, we try not to collude with or actualize the patient's reenactments. Rather, we extend our intersubjective knowing and then present the findings of this specialized form of knowing, usually by way of an interpretation. This is the therapist's position, unique to the therapeutic encounter.

As a result of maintaining this position, as Duncan points out, we put ourselves outside "the pale of social consensus" (p. 346). Thus, the way we react to the patient, what we say and do, from the standpoint of common knowledge, is, in a sense, "crazy," or at least, crazy-making. The vulnerability of the position we take registers as anxiety - we are cut off from the security of social approval and the backing of social authority.

Since Freud, those who have followed in the analytic tradition have been accommodated fairly well. We have developed a role that has been fairly well sanctioned by society. We are allowed to say "crazy" things. But the anxiety experienced when maintaining the analytic position has not completely given way.

In chapter three of this paper, I alluded to an ongoing source of anxiety in the therapist in the position he takes when meeting the patient. This source, as I mentioned,

pertains to the leaving go of causal knowing, with all the familiarity and certainty that such knowing affords. Fleshing out this notion further, I cite Duncan:

> The fulcrum of the analytic act is a focusing of intersubjective knowing to the momentary obliteration of objective or causal knowing. In this metaphorical moment the analyst loses all the ontological security of causal knowing, the familiar physical world with its cause and effect certainties. They are sacrificed to gain an extended motivational glimpse. Thus, as an existentialist would put it, the analyst must abide in loneliness and dread. (p. 346)

Yet, as the existentialist would also point out, at most we can only embrace such loneliness and dread briefly. Thus, the question becomes, how does the therapist sooth himself, so that he can maintain his inner stance? Some might point to Freud and conclude that it is moral courage that sustains us. But here, we would be romanticizing the figure of Freud beyond realistic considerations. Freud was courageous, no doubt about it. But he did not remain isolated in his endeavors. Rather, he sought out others, most notably Fleiss, to assuage his fears and to garner the necessary support which allowed him to continue in his ground breaking achievements.

I think therapists do something similar. That is, we invoke--consciously and unconsciously--our internalized representations of our teachers, our supervisors, and our own therapists, to sooth and sustain us. These are our authorities. They have become internalized and provide us with the fulcrum by which we counter the inner persecutory

attacks that "threatens us with subjective disintegration," as Duncan puts it.

Similarly, we put "to an altogether equivalent use *the theories*" (p. 346, italics in original). The theories become, like our analytic identifications, internalized. Indeed, to speak of the theories and the therapists who authored them as separate is somewhat misleading. Typically, we prefer the theories used by the teachers and supervisors whom we most identify ourselves with. Yet, there are certain qualities of the theories which set them apart from their author in the way they are internalized and used to anchor us in working intersubjectively. Duncan writes that the theories "embody social authority, and have a quality of objectiveness which links them in our imagination with a sphere of causal reality" (p. 346).

By internalizing our theories, their secondary process use gives way to their use as symbol. If the intersubjective knowing is extended by means of the symbol, then we gain motivational insight. It is natural, then, that this will be structured and given conscious form in line with the theories we are using.

Harkening back to my ill-fated requests to find out from the interviewees' what led them to posit their interpretations, I now have a context in which to understand the difficulties I was having. I was hearing the theory-laden responses as deriving from something "out there," external to the therapist. Thus, when I heard something

like, "it was a matter of projective identification," I took this to be an abridged response denoting that the therapist had an experience which he then applied some construct to. I thought I was hearing only the tacked on construct. More accurately, I think the therapist was actually saying "this is how I experienced what went into the interpretation." In essence, the therapist and I were talking around each other because we were defining the role of theory differently. That is, I was overlooking the aspect of internalization which, Duncan argues, is unique to the psychoanalytic process.

Duncan's analysis dispels the notion of a simple linear relationship between our theories and our clinical insights, since this notion by-passes the dimension of internalization. Thus, the therapist uses theory in two ways. One way pertains to what is common in all scientific disciplines. This involves the observational and logical integrity of a given theory. The other way is that the theory becomes internalized and used by the unconscious as symbol. Further, the two ways mutually influence each other in a manner that cannot be mapped out, since such a mapping procedure ignores the timeless and seamless nature of unconscious processing. Thus, Duncan stresses the "inextricability" of the two modes by which theory is used in therapy. He writes:

> When an analyst has found his way to a theoretical construct which speaks for him the inner experience of his sessions, and when a theory has symbolically entered that

> experience, it has a meaningfulness and instrumentality which is not conveyed in the face-value theoretical statement. (p. 347)

Here, I think it is useful to excerpt from the interview data in order to clarify how some therapists internalize a theory. This concerns projective identification. I think that the theory of projective identification is apropos of Duncan's remarks.

Going into the interviews I had envisioned asking about the influence of projective identification during the NTR situation. First of all, this is a concept that I have found meaningful in my own clinical work. Secondly, I came across a number of writers (e.g. Rosenfeld, 1975 and Finnell, 1987) who have hypothesized that projective identification is an indispensable aspect of the NTR situation. But then, as a result of my move away from the hypothesis testing approach, I modified the question, asking instead whether the notion of projective identification had relevance to the therapist in his search with the patient to locate the meaning of their interactions.

The responses I received varied considerably. Some therapists stated that it was "indispensable" in how they came to understand their patients. One therapist went so far as to say that he couldn't effectively treat character disordered patients until he fully integrated what the term connotes into his understanding of interactional dynamics. On the other hand, a couple of therapists stated that they

avoided "thinking this way" because the term "is so much in dispute today." One of these therapists then stated, "I think its best to try and be as simplistic as possible. We shouldn't introduce terms that add so much confusion." Another therapist ventured that he didn't "need" the term. He stated that the field has other terms (he mentioned "empathy" and "mature caring") which accurately capture what projective identification "is said to connote." All of these comments suggest a consensus of opinion concerning how therapists and patients communicate: We do "get to" each other. These therapists differ, however, in describing which constructs best capture how this "getting to" occurs.

This is not to imply that the results of this study suggest that all theories are relative. In fact, while theories do become internalized, and as such, aid in the intersubjective act of knowing, they still require that we question how they influence what we perceive. All theories are not equal. The results here in fact suggest that the therapist requires a theory that meaningfully addresses the projective-introjective dimension of relating that is characteristic of being in relation to a NTR patient. Whether we construct this theory around "projective identification," "empathy," or some other concept will determine to some degree what we hear and what we dismiss when meeting with our patients.

General Implications for Further Research

Given the foregoing, the question raised for me concerns which theories aid in the furthering of intersubjective knowing that is the hallmark of the psychoanalytic process. It seems to me that one way we can start to address this question is by presenting detailed clinical material and as much of what we can about the way we have arrived at our interpretations. We need to discuss whether a given theoretical postulate was consciously being applied to any given set of data and we must comb our own unconscious tendencies in the effort to make them more consciously accessible. The relationship between our conscious use and our unconscious use of theory must be broached if we are to extend and refine our theories.

There are no "mechanistic" methods to rely on in undertaking this task. But this need not deter us. We have developed, since Freud, an understanding of some of the many ways that what is unconscious can be made conscious: free association, dreaming, slips of the tongue, etc. Further, we have available to us an avenue of uncovering which Freud did not in his early formative period: We have friends and colleagues who have also trained themselves to listen with the third ear. Lastly, we have internalized an appreciation for how the unconscious works, and have developed individual ways of noting when we are typically avoiding or missing something. Thus, there is also the component of self-analysis which we can bring to this larger dialogue.

Having deferred imposing my own theory-laden conclusions on the results of this study, I will now do so. I have waited to present my conclusions in order to make explicit the context in which my theorizing occurs. I will begin by addressing nosological considerations of patients who are vulnerable to forming NTRs.

Implications for Further Research on Aspects of the NTR

The emphasis on character pathology and personality disorders, so popular in the psychotherapy field today, was borne out in this study on a few levels. On a diagnostic level, all but one patient was described as having an Axis II disorder. On a more descriptive level, where the data concerned the therapist's recollection of the impact of the relationship on the patient, terms such as narcissistic, passive-aggressive, histrionic and borderline consistently dominated the therapists' accounts.

Thus, I think it is worthwhile to think of the NTR as linked to character pathology. It must be added, however, that it is too early in the development of the study of character disorders to further specify or refine how this link manifests itself in a systematic way. A few of the more recent writers on the NTR, such as Gorney (1975) and Brandchaft (1983), believe that it is a manifestation of narcissistic and borderline personalities. Other writers who have written on topics closely related to the NTR, such as Epstein (1975) and Poggi and Ganzarain (1983), also point

to the borderline and narcissistic realms of functioning as the fermenting ground for the development of the vulnerability to respond in treatment in a negatively therapeutic manner. However, the lack of an accepted nosology in psychoanalytic research delimits further specification as to who is most vulnerable, or, more precisely, who is vulnerable in what ways, to forming a NTR in treatment. This is an area of research, albeit a large and complicated one, which deserves further attention.

Another line of study that requires further attention--one that I believe could yield more fruitful insights--regards the primitive ways that NTR patients communicate with their therapists. These primitive ways can be thought of in terms of projective-introjective forms of relatedness. Such forms of relatedness are notable for the sense of permeability that is experienced between the persons of the therapist and the patient. Rather than a sense of experiencing being contained within the psychological boundaries of each individual, there is a sense of oneself and the other as an inseparable entity which cannot be further reduced. From within this latter sense, questions related to what is of me and what is of the other are difficult to address.

The results of this study suggest that NTR patients consistently engage the therapist in such a way that these primitive forms of communication are in the foreground of immediate experiencing. Unlike healthier individuals, these

patients do not seem to have developed the defensive modes of operation that attenuate the potentially overwhelming states of experience related to anxiety, and especially,aggression. Whereas healthier individuals have the capacity to repress their anxiety states and sublimate or isolate their aggressive impulses, NTR patients do not show evidence of these capacities. Rather, NTR patients use projective defenses, usually in conjunction with denial and splitting, in order to mitigate the devastating nature of their experience.

Connected to this primitive level of relating are the particular meanings applied to anger and rage. Almost all of the accounts included some mention of the patient's inability to accept aggressive feelings as a normal aspect of life with others. Typically, the impression conveyed was that these patients had learned that hate, malice and the wish to cause harm to others were in themselves experiences that could not be tolerated. There were various theories presented by the therapists for why their patients had developed this way of experiencing and thinking about aggression. One therapist believed that the patient had learned to equate autonomy with causing irreparable harm to important others. Since, from this therapist's perspective, autonomous strivings always implied aggression, the patient developed a schizoid way of being in the world. By being "schizoid," that is, by excluding the opportunity to be involved with others, the patient excluded the possibility

of causing harm to others. Another therapist stated that his patient's inability to directly experience aggression was due to the expectation that the therapist would then abandon the patient. A third therapist noted that his patient would "psychologically dissolve" in front of him when the patient expressed being angry. This therapist suggested that the patient internally equated angry feelings with actually being annihilated.

Most of these accounts concerning the patient's way of handling aggression were presented in the context of the patient's primitive ways of relating. The question that this raises for me concerns how to approach the meaning the patient applies to his or her aggressive feelings. The analytic researcher has a number of conceptual and experiential tools available to him to carry out further study on the intent and meaning of these primitive forms of communication and defense that are invoked when aggression is experienced. A few of these conceptual tools include the notions of projective identification, the therapist as a containing object and countertransference. More detailed descriptions of the processes that these notions point to are needed. Further, it is necessary that these descriptions be presented in a verbatim format, including as much as the therapist can recollect about all the feelings and thoughts (no matter how fleeting, no matter how seemingly irrelevant), stirred in him. Without such minute detailing, we must rely on prevailing theoretical

assumptions to guide us in our quest to make sense of these interactions. Such reliance, as mentioned, is typically stereotypic in nature, and can only result in tautologies. We need to move beyond relying so heavily on theory which can be accomplished by reporting more detailed descriptions of the clinical interaction.

The results of this study also point to the earliest relational experiences of the infant as a major source of what is reenacted by the NTR patient in his relationship to the therapist. Data that I see supporting this assertion include the following cases: 1) There was the patient whose NTR was portrayed as an opting for illness rather than being in relation to the therapist. This NTR occurred, according to the therapist, at the time that the transference revolved around the preoedipal mother. 2) There was the patient whose NTR was described as an inability to experience separation from the therapist. This therapist also described his having represented the patient's pre-oedipal mother as the context in which the NTR emerged. 3) There was the patient whose NTR was considered as a sadomasochistic entanglement in which the therapist "gave up in despair." This patient was thought of as enacting these sadomasochistic struggles in order to ward off the more threatening excitement experienced in his early relationship with his mother.

Overall, a majority of the accounts focused on the earliest relationships of these NTR patients as involving

some type of pathological interaction which became reenacted during the NTR situation. This finding, I believe fits well with many of the prevailing constructs used to make sense of why certain patients are predisposed to forming an NTR in treatment. That is, I think that many of the main constructs that are used to describe and understand the NTR, such as separation-individuation issues, envy and revenge, and orality, are all getting at similar phenomena related to the infant's initial experiences or glimpses of its emerging sense of self.

We have an abundance of creative and thoughtfully constructed hypotheses (for example, the work of Spitz, 1965; Bowlby, 1969, 1973, 1980; and Stern, 1985) about the nature of the infant's relationship to the primary caretaker to guide us in further researching early development. But again, these hypotheses should be conceptually placed outside of ourselves while in the therapeutic encounter in a manner that maximizes the potential of seeing other possibilities. This could then promote case reports that detail how the patient and therapist confirm or disconfirm the relevance of the patient's earliest memories of childhood. Special attention would need to be paid to the patient's compliance with the therapist's interpretations. Questions related to whether the patient was being led to report early memories, or being led to report particular kinds of early memories would need to be invoked. The

material related to these questions would need to be documented in the fullest possible manner.

Another area of further research that has been peripherally included in this study, but I believe, deserves further attention, regards the capacity of the patient to use the therapist as a transitional object. Above all, transitional object relating provides a soothing function. The patients described in this study appear to have been unable to use the therapist as a source of consolation and solace. They seemed, especially during the NTR period, to be unable to take in the therapist's goodness, nor use the therapist to develop a sense of safety. Rather, they returned to behaviors - such as withdrawal and/or attack - which effectively destroyed the relationship to the therapist, at least during the period of time that the NTR held sway.

A few examples that support a need for us to focus on the patient's capacity and struggle to use the therapist as a transitional object include the following: 1) There was the patient whose NTR was portrayed as a wish for revenge. The revenge was occasioned by the patient's rage at the therapist for admitting him to an in-patient facility. Being admitted confirmed the patient's fear that others saw him as gravely ill. The revenge fantasy and then enactment served to move the focus from the patient's distraught experience of himself to external factors. I think this probably had to do with the patient's inability to feel

consoled that his capacities were stifled by his suffering. Unable to engage the therapist as a source of soothing, the patient set out to destroy the treatment. 2) There was the patient whose NTR was described as a wish to see others as hateful. The therapist emphasized that this patient experienced himself as "rotten to the core." Unable to accept this experience of himself in the face of an other's goodness, this patient ultimately put his energy into maintaining a view of others as similarly disgusting and vicious. Put another way, this patient was unable to experience the therapist as potentially capable of helping him to assuage his self-recriminations. 3) There was the patient who was described as wanting to be seen by the therapist as disturbed and flawed. This patient, in fact, appeared primarily motivated to withstand any potential soothing that the therapist might offer.

The data collected in this study do not allow for more precise statements concerning whether the patient was capable of being soothed, and was avoiding such interactions, or whether the patient did not know how to be soothed. My reading is that individually, both types of situations were present. For example, my sense of the last patient denoted above is that he did have some inner resources that allowed for soothing to be experienced, but was so guilt ridden that he actively avoided feeling any solace. On the other hand, some patients, like the first one mentioned above, probably experience such soothing as

foreign; that is, the soothing cannot be integrated. To complicate matters further, the results suggest that many patients, depending on what is being immediately experienced with the therapist, oscillate between defending against the experience of solace, and experiencing such solace as alien.

The literature (see, for example, Horton, 1984) contains many reports of patients who were apparently able to locate a nonthreatening "space" in the therapeutic relationship such that the patient developed an experience of the therapist as a soothing other. What is lacking in these reports, however, are descriptions of how this soothing actually came about. Again, the literature I've reviewed mainly invokes theory as description. Here, the theory (for example, in Winnicottian terms of impingement, the development of the False Self, etc.) is poetically and aesthetically quite pleasing, which implies much of why it is so heavily relied upon when the writer is reporting the clinical material. It is necessary to note when a theory is so compelling. Usually, a theory that is experienced as compelling, is so experienced because it does provide illumination and clarity about the phenomena it is addressing. But this can be a seductive trap that the researcher falls into if the theory is used at the level of description.

The concept and theory attached to envy structures much of what I consider the flip side of the concept and theory attached to transitional relatedness. Put another way,

where the patient's envy of the therapist is in ascendence, then the patient's capacity to use the therapist as a soothing other is reduced.

The results of this study point to the relevance of the patient's envy of the therapist in the development of the NTR situation. Indeed, envy and the closely related notions pertaining to the patient's insatiable hunger, neediness, spoiling, and greediness all figured prominently in my reading of the data.

For example, there was the patient with "clenched teeth" who brought food and drink to the therapist only to spoil the offerings with comments like, "Don't worry, I didn't poison it this time." This patient seemed to perceive himself as lacking in some fundamental way; underneath his bravado and feigned independence was a sense of extreme neediness that had to be avoided at all costs.

Another example involves the patient who was described as needing to see others as hateful. This NTR was described as occurring when the patient was most aware of the therapist's goodness and "tenacious" ability to care. The therapist remarked that his displeasure at feeling grateful toward his own analyst informed his understanding of what his patient was experiencing and reacting to. This therapist believed that his patient could not tolerate experiencing gratitude toward him. As a result of the anxiety caused by the feelings of gratitude, the patient withdrew from the treatment unannounced.

Overall, nine of the therapists interviewed stated that envy was a prominent feature of their respective patient's character structure. Some of these therapists related that envy was at the foundation of the NTR situation, others saw the patient's envy as an important part of a larger characterological picture that informed the emergence of the NTR.

As a clinician I have increasingly found the notion of envy to be most useful in understanding the patient's resistance to me, and his inability to regard me as a potentially helpful other. This is especially true for those patients, who in hindsight, I would now designate as having formed a NTR in their work with me. Further, my research into the concept of envy has left me ever more convinced of its relevance to not only the NTR event, but also in regards to any intimate relationship that develops between two people, in which one of the people is in the helping or facilitating role. This represents my bias and my leaning in regard to theory.

But, the more important point of the matter has been for me to recognize that this is my bias, that it does not necessarily exist "out there" as much as internally, in terms of what makes sense to me. It is a language that helps me to find meaning with my patients. I like to think that in the most part this is also the patient's language, but I have not studied this rigorously enough to arrive at a valid conclusion.

The results of this study support the contention that envy plays a prominent role in the NTR situation. Still, I think caution is advisable when moving toward a conclusion about envy. I am reminded of the therapist who spoke in terms of separation fears when presenting his example of a NTR. I specifically asked this therapist if the notion of envy illuminated the therapeutic interaction. This therapist said that he essentially could not respond as envy was not part of the language which he and the patient used. What this entails for further research are studies that document the particular language that each of the therapeutic participants finds most meaningful and to document how each participant's language influences the language of the other. Thus, while I have found that thinking in terms of envy is very useful for me in my work as a therapist, and further, that I tend to see NTRs in terms of the dynamics of envy, the theory of envy remains but one of many potentially paradigmatic modes of discourse to be used in the quest for greater understanding of the NTR.

APPENDIX A

Sample Letter

Name
Address

Date

Dear :

I am a graduate student in Clinical Psychology at the University of Massachusetts. Currently, I am working on my dissertation. I am writing you to ask for your help and support in the conduct of this research.

The topic I am studying is the negative therapeutic reaction (NTR). I think this topic has a lot of potential in addressing some of the more basic and human aspects of our work, and therefore, deserves further research. To this end, I've devised an interview that hopefully can shed more light on some of the difficulties patients encounter in trying to accept (and "take in") the help that is offered by the therapist. At the same time, I hope some of the ideas that will emerge from my research will also make this usually vexing topic more understandable to therapists.

The inclusion criteria I am using for the NTR are fairly broad: Basically, I am conceiving of the NTR as an entrenched form of resistance to recovery. Often, it becomes manifest only after some improvement has been made in the therapy. From an intrapsychic perspective, the NTR patient usually has difficulties in the narcissistic realm. Issues related to envy of others, severe guilt, self-punishment, dependency and separation may be evident. Interpersonally, transference and countertransference experiences are very intense. This is in large part due, I believe, to the level of introjective and projective relatedness between patient and therapist.

The way I am studying this topic is by asking therapists to reflect on an experience treating a patient who evidenced a NTR - describing the NTR drama itself and discussing issues related to the therapeutic relationship, countertransference (as a means to understanding what the patient is experiencing but may not be able to put into words), and projective identification.

Specifically, I'm writing to ask if you would be willing to be interviewed. This would entail about an hour of time (at your convenience) to discuss a therapy that you feel went through a period in which the patient was evidencing a NTR. Confidentiality will be scrupulously maintained - all identifying data would be deleted.

I will call you in a few days to discuss this request. If you're not available when I call, please feel free to contact me (call collect). My phone number is (413) 586-0916.

Thank you for taking the time to consider my request. I look forward to speaking with you.

Sincerely,

Charles Field

APPENDIX B

Interview Protocol

I. Setting the stage.

To begin the interview, I would like to ask you certain questions in order to get a sense of who you are as a psychotherapist, such as your training background, what your interests are, and the perspective you bring to your work. I'll start with some questions pertaining to your background.

1. Background information.
   a. Age. Gender. Race.
   b. Academic.
   c. Membership in organizations.
   d. Length of practice.
   e. Types of practice since receiving degree, i.e., inpatient and/or outpatient; psychoanalysis "proper" and/or psychoanalytically oriented psychotherapy; involvement in supervising others.

2. Current information.
   a. Orientation.
   b. Types of patients generally seen in practice.
   c. Primary interests. Types of work environment, patient populations, psychotherapeutic issues, research, etc., that interviewee is most interested in pursuing at present.

II. Description of NTR.

Now I would like to turn our attention to the NTR you have agreed to discuss with me today. As I have mentioned I am particularly interested in talking with you about what both you and your patient were experiencing during the course of the NTR. I am interested in learning what meaning the NTR had for your patient and for you, and your thoughts as to why the NTR emerged as it did. That is, I am interested in understanding more fully what patient, therapist and interactional characteristics were operable when the NTR emerged. Let us begin with a discussion of the NTR itself.

1. Please describe the NTR drama and all that went into it that you think was of importance? Feel free to include as much about the whole therapy as needed.
2. At what point in the therapy did the NTR emerge?
3. What was going on in the therapy that served as the context for the emergence of the NTR?
   a. Was there something your patient was unhappy about in terms of what s/he was wanting from you or from the therapy itself, or did it have more to do with your discomfort with what was occurring in the therapy?

b. Was there a specific event which provoked the NTR or was it a more subtle process that occurred over a length of time?

4. Was the NTR ever resolved?

a. (If not) What is your understanding of what prevented the NTR from being resolved?

b. (If yes) What occurred that prompted and/or allowed for the NTR to be resolved?

III. Patient Information.

Now I would like to turn our attention more specifically to your patient. In addition to the content matter of the questions I am asking, I am also interested in how you came to understand your patient. That is, I would like you to include any pertinent information about how your patient made him/herself known to you. Lastly, in these questions about your patient, I am interested in getting a sense of how your patient regarded you and the comments you made to him/her.

1. Presenting problems and reasons for seeking treatment.

2. Developmental history.

3. Prominent transference reactions.

4. Communicational style.

a. Prominent defenses, including when appropriate, a query about projective identification.

5. How did your patient experience her/himself during the NTR (as fundamentally "bad" or "good", as in need of protecting her/himself or you)?

6. How did your patient experience you (as benevolent or malicious, as flexible or rigid, as giving or depriving, as hopeful or despairing, as easily provoked or impenetrable)?

a. How did your patient respond and react to your interpretations?

7. How would you characterize the role(s) assigned to you by your patient (as victim or victimizer, or as an equal, or as hierarchically arranged with you in authority over and against the patient)?

8. Had your patient been in therapy before, and if so, how did s/he regard the previous treatments?

IV. Therapist Information.

In this next set of questions, I am interested in finding out what it was like for you to be your patient's therapist. That is, I now want to focus our attention on what you thought and felt about yourself, your patient, and providing therapy for this particular patient. I am also interested in hearing about your countertransference reactions and what prompted these reactions.

1. Can you recount some of the salient reactions you had to your patient during the NTR?

2. To what extent did you feel it was necessary to examine your countertransference reactions as clues to understanding your patient's way of engaging you?

a. How were these countertransference reactions elicited in you?

3. Did you seek any consultation from colleagues or supervisors for this case?

a. [if yes] Can you describe the consultation and how it impacted on your work with your patient?

IV. Issues broadly related to narcissistic functioning.

I would like to turn our attention now to some topics that writers typically refer to as indicative of narcissistic functioning.

1. Were there any periods, especially early in the therapy, when your patient idealized you?

a. [if yes] How did the patient seem to experience her/himself at these times?

b. [if yes] What did your patient seem to be wanting in relation to you at these times?

2. Were there any periods when your patient seemed to regard her/himself in a grandiose manner, and/or as being extremely independent, and not in need of your attention and services?

a. [if yes] How did your patient relate to you at these times?

b. [if yes] What do you think was motivating this behavior in your patient?

3. Did your patient ever seem primarily motivated to destroy you and/or what you represented to him/her?

a. [if yes] Could you describe a situation that comes to mind?

4. Could you discuss your understanding of your patient's issues regarding dependency in general, and specifically, how s/he felt about depending on you?

5. Were there any occasions when your patient expressed or seemed to be struggling with envious feelings and reactions toward you?

a. [if yes] Can you describe a relevant example or two?

(1) What was the patient envious of?

(2) How did the patient regard you during these instances when s/he was feeling envious toward you? (For example, did the patient regard you as safe to be with or dangerous, as benign or as intending to do harm, as an enabler or as intending to diminish the patient, etc.)

(3) Did your patient's direct expressions of envy surface during the NTR? [if yes] At what point in the NTR? Could you briefly describe what characterized the therapeutic relationship at this time?

6. Did you ever attempt to interpret to your patient her/his envy of you?

a. [if yes] How did your patient respond?

V. End of Interview.

I am now finished with the formal interview questions. Before we end, however, I want to ask you whether there are any important issues or topics related to the NTR you have described that have not been covered adequately through the course of this interview? Are there any recommendations you have on how I could improve the interview?

Finally I would like to discuss with you your reactions to this interview, and ask you to comment on what the experience has been like for you.

I want to thank you for your time and thoughtful responses to the questions I have asked you today.

APPENDIX C

Informed-Consent Form

I, the undersigned subject, agree to be interviewed by Charles Field about my experience as a therapist with a patient who evidenced a negative therapeutic reaction. I understand that my involvement will entail responding to the questions posed to me during the interview. I also understand that there are no attending discomforts or risks involved in my participation.

I know that I may ask any questions at any time about the procedure of the study. I also know that there is no deception involved in this study.

I understand that the interview will be tape-recorded and that the only person who will listen to the tape is Charles Field. These tapes will remain in Mr. Field's possession at all times. Once the tape has been transcribed by Mr. Field, he will erase the tape. While transcribing the tape, Mr. Field will assign an alias to myself and any other person mentioned by me. All other information which could identify me or anyone else will be changed or deleted to insure confidentiality.

I understand that I am free to withdraw my consent and discontinue my participation in this study at any time.

I have read the above and have received appropriate responses to any questions I might have in order to knowingly partake in this study. My signature below indicates that I am willing to participate as a subject in this study.

_____ _____

(subject) (date)

_____ _____

(witness - Charles Field) (date)

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