

Another Look at Contraindications to Psychoanalysis:

Are there Persons We Should Not Take into Psychoanalysis?

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Introduction

We are not many years beyond the time when psychoanalysis was widely held to be a panacea, the infallible cure for all ills of the spirit. It was not only considered to be the best treatment, it was the only treatment. If we suggested to a patient that a less expensive and less arduous treatment might do, we also would have to reassure him that we intended no implication that he was either too sick, not smart enough, or not worthy enough to be analyzed: We are no longer so single-mindedly ambitious about psychoanalysis, but regard it as a powerful treatment with a limited range of application in its native form. It has given rise, however, to a wide range of dynamically inspired therapeutic approaches that extend its reach enormously. Still, when an analyst comes across a prospective patient who presents the attractive picture of a bright and articulate person who has enjoyed reasonable success at a career and bears the outward signs of a fair social adjustment, but who is dissatisfied with his life, our first thought is likely to be, “why not analysis?” I will propose that some people who look analyzable and who ask for analysis nevertheless should not be taken into analysis without careful consideration of the likely hazards.

The Usual Contraindications

Some analysts now believe that perhaps there are only a few prospective patients who seem analyzable but for whom psychoanalysis might not be the best treatment:¹ In general, these are persons whose life circumstances permit little change, and for whom the “neurosis” might be the best compromise, or best adaptive solution open to them.

¹ In our earliest days, persons with schizophrenia were thought to be unanalyzable because they could not form transferences. Recall too, old age once was considered a contraindication; at one time persons over 40 were considered too inflexible to be analyzed.

They are viewed as having little capacity for independent living, or have other severely limiting factors including severe physical defects that would preclude a more gratifying life even if analysis could relieve them of their neurosis.

Some have raised ethical objections even to this minimal degree of exclusionary thinking, "Do we not play God when we decide what another's future must be? Should we arrogate to ourselves the power to dismiss another's capacity for growth, change and development? Is it not wrong to underestimate anyone's capacity to find new adaptive solutions and to change what may until then have seemed to be unalterable aspects of reality? After all, is it not the spirit of analysis to challenge the assumption of a recalcitrant "reality" and to regard it as a construct until proven otherwise? Of course, we will want to balance this libertarian stance by the humane concern to avoid raising "false hopes."

In recent years, even these minimal contraindications have been seen as less than absolute. Under the banner of the "widening scope," we have used psychoanalysis either in native form or suitably modified with reasonable success for many groups of patients formerly considered unreachable. Life no longer stops at 40 and we now accept patients from early childhood to the quite elderly and with a wide range of psychopathology. Still, I believe there remains a group of patients for whom we should recommend psychoanalysis with great caution and if we accept them, proceed with respect for the hazards. I do not need to caution you about the persons with fragile defenses who might regress beyond the point of safety. Most analysts are familiar enough with the danger that patients may decompensate in analysis. After all, any treatment that is psycho-effective, under some circumstances, may also be psycho-noxious. Neither do I warn against taking into analysis patients whose defensive structures seem inalterably rigid. Ironically, my concern is not with the patients who are "unanalyzable," but rather those for whom the result of a "successful" analysis may be socially disastrous.

The Problematic Patient

To highlight the common elements among members of this class of patients, and out of concern for privacy, the clinical material I present is a composite of several patients. For convenience, I will use the male pronoun throughout and I will state specifically if I intend to refer to one rather than the other sex. The class of persons I refer to are those whose "core" character structure is basically "narcissistic," in ways that I will describe and who also have chronic symptoms of neurotic conflict that are organized into what amounts, as it were, to a "superimposed" neurosis, one that typically is mild and usually obsessive-compulsive in form. In the initial interviews, the analyst will find the prospective patient attractive, even charming. He is not necessarily seductive, though that possibility will occur to the analyst. He is a bit aloof, not readily forthcoming, perhaps intriguingly mysterious, but answers questions fully. There is nothing alarming in his background as he tells about it, no obvious psychopathic tendencies, and no cruelty to animals. He has been successful in life to this point, is likely to be in a profession or an entrepreneur and able to afford a private fee. If he is in an appropriate profession and applies to an institute, he may seem acceptable as a candidate; if subjected to no more searching evaluation, he may seem ideally suited for analysis and to join the field.

In his analysis, which may go quite smoothly at first, he may complain of a frank neurotic symptom, perhaps about the obsessive thoughts that occasionally crowd out of his mind things he would rather think about. More likely, he will be uncertain if he even has a focal complaint, his "symptoms" tend to come and go. He is concerned mainly about a vague sense of being inhibited, "held back." Although to outward appearance he is successful, his life feels unfulfilling. He has a capacity for hard and productive work when he feels like it; he generally gets what he strives for and is appropriately proud of his real accomplishments. Still, it often turns out that what results from his efforts turns out not to be what he wants, but he is not sure what it is that he wants. Whatever it is, it feels always to be just out of reach.

He has never found satisfaction in intimate relationships, tending to turn off when, for the moment, he has had enough. He has to force himself to remember that his partner too has needs and, if he does remember, makes allowance for them with little grace. He has an easy way with women. They find him interesting, even intriguing, but after successful courtship, he soon finds them boring and moves on. He also is bored, if not resentful, at the restrictions placed on his "freedom" by the rules and regulations that most of us abide as a matter of course as the price of living in an orderly society. He has a fussy distaste for irksome restrictions and may even feel they are directed personally at him, just to be annoying. If he is a candidate, he soon is regarded as a nuisance by the administrative staff of the institute as he requires more than the ordinary prodding to get his reports in and to meet other requirements. He claims to have friends, but has none of long duration, and no "best friend." The people he refers to as friends, that is, the people he tends to spend time with, mostly are younger than he and look up to him as an authority; indeed, he speaks on almost every topic with authority. They tend to call him; he rarely initiates social contacts

As the analysis continues, the analyst comes to see that elements of neurosis the patient complains of, his mild obsessive symptoms, are not so much troublesome in their own right as that they restrict his "will," they inhibit him from doing what he wants when he wants to. The analyst gets the impression that the neurotic elements are not grounded in his character; that is, as it were, they do not seem to be of his essence, but rather seem to be superimposed on his personality. They seem to be a confining "veneer" rather than an expression of his narcissistic character structure.

As we know, neurotic symptoms yield more quickly to analysis than do malformations of character and patients tend to experience relief from pain long before they have had a chance to tackle, or before they feel any need to face, the tougher issues that are imbedded in character, that is, in who they are. Let us consider the situation of the typical patient we accept into analysis. We expect of any "suitable" patient that the patient's initial motivation to be rid of pain soon becomes replaced by more intrinsic

motives including curiosity about how the mind works, a regressive dependency based in transference, and a valued, trusting relationship with the analyst. As the constraints of the neurosis loosen, the patient naturally feels better, even “well,” and his life expands. When analyzing has freed him, more or less, of the complaints that brought him to analysis in the first place, he does not rise from the couch and walk away pleased with his “cure.” He has found that psychoanalysis has not only helped him to reach some long held goals, but also to discover goals he previously could not have considered. In the course of becoming relieved of his presenting complaints, the patient discovers a new way of relating to himself and new reasons to be less than satisfied with how he deals with himself, with others and with the world. We might put it that, now that the patient has come to see himself and his situation more clearly, he no longer is willing to remain as he was; he can now envision himself in a new stance and wants to be there. Another way of looking at it is that the patient discovers new possibilities of being, new postures in relation to himself and to the world. I have also sketched here, of course, the history of the attitude of our field toward “cure,” or at least toward the goals of treatment, and the shift from rapid relief of hysterical symptoms to analysis of the ego and character, from relief of pain to personality change.

How is it with our more problematic patients? In contrast, after only a period of analysis sufficient to free them substantially from inhibitions, they see little more need to remain in analysis. Even if they can be prevailed upon to stay on, the motivation for change, of which in retrospect there was little enough to begin with, is now so diminished that little more seems to happen. When a patient expects little good to come of more analyzing, attending sessions becomes a burden. He no longer complains about neurotic flaws and now is now impatient to leave. He would reject the implication of smugness in the suggestion that he feels pleased with himself, and he would resent any implication that he is happy with his state of affairs. His mood is something closer to “grimly satisfied,” a mood that does not carry the implication that he now has found whatever it was he was after, only that he is now freer to search for it and believes he is not likely to find it by

searching “inside.” He is only sure that he wants more of something “out there” to make him feel complete and he is increasingly restless to get at it.

He grows more impatient as he becomes convinced that the analyst is holding him back. If he is a candidate, he may feel that his cases bore him; he regards himself already an analyst and does not need to rely on the opinions of supervisors any longer. Supervisors have found him puzzling. The first patient assigned to him left after a few weeks complaining that he was “cold.” Somewhat taken aback by this rejection, he turned on more charm and three of the next four patients remained with him. A couple of his patients seem to be doing all right clinically. He is smart, can listen to his patients when he wants to and can say the right things. He shows little compassion for patient’s pain; mostly he seems to feel they just ought to get on with it. He does not seem to want anything from his supervisors but recognizes that he has to put in his time with them, and does so none too gracefully. Mostly just listens to their suggestions with barely concealed condescension. None feel any positive response, let alone gratitude, from him.

As he waits impatiently to be released from his analysis, he even rejects the idea that it has helped him to make any gains, let alone that the analyst might have had anything to do with them. Although he feels he has nothing to be grateful for, he hopes, pro forma, that his saying so hasn’t hurt the analyst’s feelings or offended him. Yet, as he reflects on his last remark, maybe the analysis has helped him to be more honest; he notices that he now can tell people what he thinks of them without pulling punches. The analyst wonders silently but glumly, “So why doesn’t he just quit? The institute is ‘non-reporting,’ there would be no record made of how he ended his analysis, only that he ended it. What keeps him?” The analyst is concerned that if he would raise the issue in just those terms, the patient might take it as a dare and quit. Thus, the issue that he stays on unwillingly remains in the air. He seems to want something from the analyst, though he does not name it. The analyst finally deduces that he is waiting, and none too patiently, for the analyst to acknowledge him and to accept him on his own terms. He would prefer to leave with the blessing of the analyst, but, after allowing some time for

the analyst to come around, he concludes regretfully that this affirmation is not essential. It becomes clearer that, while he “believes in analysis” for others, he regards it as a bothersome requirement for himself. He thought he always had functioned at a level above most people and would not settle for being merely “normal.” Though he is happy enough to be rid of the “few inhibitions” he mentioned at the outset of his analysis, and feels good about having mastered them, as he looks back on it, they were not all that troubling. He does not quite say that he did it alone, but seems ready to challenge the analyst if he claimed that he had some part in it. Unlike the ordinary patient who is inclined to give the analyst too much credit for his progress, so much so that the analyst is tempted to say, “But I couldn’t have done it without you,” our problematic patient is averse to owing anything to anyone. I must hedge this last statement; it is not entirely accurate. It is rather that he prefers not to be in the debt of any extant person.

This patient always was an omnivorous and searching reader. Now, the analyst suspects that he was searching for authorities he could respect but who also were sufficiently defunct as to be in no position to challenge him, as his teachers and supervisors do when his pompous declarations cry out for confrontation. He may anoint himself as a disciple or the intellectual heir, it may not be clear which, of a fairly obscure theorist of a generation back. He quotes this authority liberally with the effect of putting an end to discussions since no one else is familiar with what that authority said or why they should genuflect to him.

Another disclaimer: I should note that some of these problematic patients do not press for immediate release from the analysis once their symptoms are relieved. Their main motive for staying on, however, is less to discover more about themselves than to gain the unqualified approval of the analyst. They want endorsement, not analysis. My impression is that this pattern, which also involves sufficient (transference based) wanting something from the analyst, is more amenable to analysis than the dismissiveness reflected in the pattern of demanding release, even though that too involves transference.

To return to the situation of one of the more difficult of the problematic patients, only after the inhibitions imposed by the neurosis had been relieved did it become clear to the analyst that the symptomatic relief the patient experienced also had some undesirable side effects. The analyst could see now that "the neurosis" had served several socially valuable functions. First, it served to "dampen" the expansionist, even omnivorous, proclivities of the patient's core narcissistic character. The patient had complied resentfully with the inhibitions that kept him from reaching out and grabbing whatever seemed attractive and worth having at any moment. Additionally, his obsessive uncertainty, "Is that really what I want?" held him back. Second, the neurosis, through its connections to objects in fantasy, seemed also to provide indirect connection to objects in reality. To be sure, as these connections were based on fleeting, unstable transferences, they made for distorted, disappointing and short-lived connections. Nonetheless, these temporary connections were "real" and they involved him with the hurt feelings, disappointments and anger of others whom he mistreated; thus they served to remind the patient painfully of his own humanity. They forced on him some awareness that all of us share a common fate and, fitfully, they permitted (or forced) a degree of empathy with others. These painful reminders were not welcome and he resisted learning anything about himself from them. Rather, feeling wounded by the recriminations, he resolved for instance, not to get involved with "one of that type" again. As he generally was able to blame the failure of a relationship on some shortcoming of the other, he could hide from himself his own part in the difficulties.

Once freed to some extent from the restraints of neurosis, he felt even less need for relationship; his fantasy of self-sufficiency both diminished the possibility of making empathic contact with others, and left him an even more isolated and self-centered person. Perhaps in compensation, he enlarged his self image by awarding himself the cachet of "one who has been analyzed. Now he is even more entitled to the privileges that go with being an "exception." He is exempt from ordinary life demands because not only is he who he is, but also because he has suffered and has been "cleansed," that is

dipped in analysis. The analyst thought that the way the patient viewed himself might be analogous to the experience of being “born again.” Unlike them, the patient felt under no moral obligation to evangelize; he was not about to bring the “word” to others. The self-righteousness and entitlement that had always lurked just out of sight now became more obvious. Before analysis, the inhibitions imposed by his neurosis, and the doubting and sense of uncertainty that his obsessionalism inflicted, kept his social behavior within bounds so that he appeared superficially to be a “good person.” Now, no longer trammled by doubt, the patient’s self-assurance is unbounded and his behavior heedless.

The Problematic Patient as Candidate

When such persons apply for training at an analytic institute, the admissions committee may find their presentation troubling. As applicants, some of them openly declare that they are seeking the “best” training in the “best” institute in order to become the “best” analyst possible. This laudable objective, one every member of the analytic faculty could subscribe to, may also conceal a malignant need for narcissistic perfection (Rothstein, 1980), one fueled by a hidden uncertain sense of worth. The applicant seems driven by the not wholly unconscious formula, “If I achieve it (perfection) then I can no longer be denied the adulation I crave and deserve.” These candidates are not lazy and they tend to be bright. They work hard and acquire cognitive mastery with relative ease. With less ease, they may even learn to simulate modesty and diffidence. But they are not satisfied with the intellectual pleasure that comes with understanding, or the pleasure that comes with helping another to achieve mastery or to resume growth; their goal is extrinsic to learning and helping. They expect “payoff” in the form of constant reassurance of their greatness and appreciation of their every deed. Interestingly, many such applicants do not seem to be greedy in the everyday sense of driven to seek wealth. When they do seek wealth, it seems to serve more as reassurance of self-worth than as an opening to a better life.

Detecting the Problematic Patient

How may we detect such applicants or prospective patients? Here are some signs that an initial interviewer can observe and evaluate:

1. The person's desire for training (or for psychoanalytic treatment) is motivated more by what the person wants to be or become rather than what he wants to do, e.g., "I want to have been analyzed" or "I want to be designated officially as an analyst."
2. The person shows relatively little curiosity about himself, how his mind works, or why he behaved in a rather odd way during an incident he described in telling about his life. If he is not obsessional, he may display little doubt about himself or what he might make of his life.
3. He wants an analyst who is a "big man" in the field, one whose "greatness" might be absorbed by association.
4. If his desire for psychoanalysis is motivated by pain, the pain tends to be less a consequence of conflict, than a sense of undeserved imperfection.
5. As he tells of his relationships, they include many transitory ones, broken off after disappointment; he describes few, if any, reciprocal, non-exploitative relationships. He may have difficulty in describing a "best friend," if indeed he admits to having one, and his account of a relationship significant to him fails to impress the interviewer that he is coming to know a whole person, with "warts and all," one not idealized. The interviewer will feel either that he is being kept out of the object world of the applicant or that the applicant's object world indeed is as thinly populated as he all too accurately conveys. The applicant cannot convince the interviewer that he knows any other person intimately because he doesn't. As might be expected, the applicant's stories mostly convey a low sense of trust in others. His sexuality, narrowly defined, may be technically

unimpaired, but he uses sex primarily to conquer, to achieve an end rather than to enhance intimacy with a valued other. Of course, when some degree of neurosis is also present, as in the persons I described above, symptoms and inhibitions may impair sexual performance as they ordinarily do.

6. I believe this advice is sound for the evaluation of prospective analytic patients whether for training or not. I must admit, however, if you follow the advice, you still may not identify all such problematic patients in advance. In particular, this approach is not proof against conscious deception and I will offer a spectacular example of such a failure.

I return to the problems such an applicant may make for the institute. When the applicant, now candidate, advances in training, the progression committee hears feedback from courses, and particularly from supervisors, about the candidate's competitive attitude toward peers and patients. He seems to have difficulty, of which he seems unaware, in making empathic contact with his patients and tends to show an absence of "heart." He has no difficulty in the realm of ideas. He puzzles his supervisors by performing inconsistently. If not unduly frustrated, as by a patient who requires more interest and empathy than the candidate can muster; he seems to do reasonably well. He has learned to say the right words at about the right time, but the supervisor cannot figure where the words come from; they seem to be learned responses rather than emerging spontaneously from the candidate's empathic engagement with the patient. But when frustrated either by a patient's persisting resistance or by a sensitive patient's accurate sense that the candidate is not fully "there," the candidate tends to punish the patient by withdrawing into aloof silence that he then rationalizes as abstemious technique. This sort of feedback from patients and supervisors could be of inestimable value to the candidate if he would take it seriously, but he tends to ignore it. His usual response is that he is misunderstood and insufficiently appreciated. Although one would expect he would bring these confrontations to his analysis, by that time either he has withdrawn from his analysis or does not view it as a source of support and insight.

As we know, institutes, like other schools, are reluctant to revisit their admission decisions in search of possible error. Instead, unless a candidate of dubious merit commits egregious errors in his work, manifests obvious breaches of professional conduct or is socially unbearable, the institute will pass him along. Institutes commonly play for time as they ponder what do about the insufficiently talented or psychologically unprepared candidate; they opt for hoping that more supervision or more analysis will cure “the problem.” When the candidate merely is a slow learner, this conservative treatment often works. The relatively untalented candidate puts up with being held back, accustomed by now to being convoyed as long as he is polite and plugs along persistently and uncomplainingly.

It is not so with our problematic candidate. By this time, neurotic inhibition no longer retards him. As part of his newfound freedom, he does not put up with faculty members who fail to endorse his specialness. He may even hint at becoming litigious if he feels held back unjustly. By this time, of course, the faculty will have accumulated grave doubts about him. However, they realize that their academic records are inadequate to make a winnable case for dismissal. They quail at the prospect of counseling him to drop out and may finally consider that they have no choice but to follow the prudent course of graduating him with the hope that then he will go away. It is perhaps fortunate that the problematic candidate may feel so disgusted by the faculty’s “dithering” about his status and their failure to honor him that he may express his disdain by resigning.

Of course, nowadays only a few psychiatrists, psychologists or social workers aspire to become analysts. I believe it a salutary effect of our loss of prestige that becoming a psychoanalyst no longer is the only conceivable course of advancement for an ambitious professional. People who enter the field now generally have more intrinsic interest in learning how the mind works. They apply because the teachers and supervisors from whom they have learned the most were analysts and they have seen how their teaching benefits patients. Probably, they have profited also from personal therapy or analysis.

However, problematic persons still show up in our consulting rooms hoping to escape the constraints of neurosis but with no complaints about their character. A colleague, to whom I mentioned I was preparing this talk, said that one of his early cases fit my description precisely. He became deeply concerned when effective analyzing relaxed the patient's inhibitions enough to reveal the previously unseen possibilities that lurked in the former patient's personality. The patient dropped out soon thereafter and the analyst followed his subsequent career in the newspapers with horrified fascination. When he heard that the former patient had died, his first thought was, "Was it by drug or by bullet?"

Problems for analytic education

Over the years, I observed that when they graduate, the former problematic candidates tended to be less interested in analyzing than in exploiting the status that becoming an analyst confers. Of course, since becoming an analyst no longer guarantees status, it is less likely to attract the status seeker, but some still may come for that reason. If that person does remain in the field and seeks to rise within the usual career paths an institute provides, the institute probably will allow him to teach. He is, after all, bright and knowledgeable, especially about theory. Ironically, he may become more like the teachers he once reviled as holding him back than like the revolutionary he once held himself to be. As a teacher, he does not age gracefully; he neither welcomes the coming generations nor sees that his immortality actually lies in helping them to become all they can be. Rather he becomes increasingly bitter as he realizes that his time is passing and that, on this mistaken path of helping others, he may never achieve the personal greatness he deserves. He may try to deny to these others what he was unable to grasp for himself and so uses his power to hold back the revolution that the coming on of the next generation signifies to him.

If this dire picture fits at all with your experience, you certainly will want to remind me that not all such problematic graduates turn out that way. Some seem to relish remaining as outliers in order to devil the establishment. They use their brilliance selectively, often picking on a flaw in conventional practice or theory that they write about and speak about

at every opportunity. What they have to say may amount to a contribution to the field, even an important one. However, as in their student days, they offer their trenchant comments not so much to enhance our body of knowledge and experience as to promote themselves as anti-establishment prophets. Since they still belong to the establishment, we try to listen to them respectfully even as we try to ignore their misbehavior. They exploit the status they earn through their intellectual prowess; their public standing becomes such that the institute can neither ignore nor exclude them, even though their antics, both intellectual and social are scandalous and yield the headlines that make the rest of us cringe with embarrassment. Unlike those I described first who tend to become stern upholders of revealed truth as embodied in “standards,” not only do they not age gracefully, they may not age at all; they are likely to burn out, figuratively or literally. Their antics, intellectual or social, become so extreme that, eventually, institute, society or nature imposes the appropriate sanction. While their careers are spectacular, they generally spread themselves on the larger field so that they do not remain merely a local problem for the institute.

Indeed, once graduated, both sorts of problematic candidate may find that the institute is too small a container for their ambitions. Each of them may consider achieving professional advancement by seeking office in a national or international organization. As that path may seem to require too much kowtowing in the local institute and society, he may find it easier and more attractive to start his own shop and recruit students and followers. He may advertise that his institute, unlike the others, is based on sound educational principles and he guarantees that he will not stifle the genius of brilliant students as do the conformity-worshipping, hidebound “traditional” institutes. You will understand that I am speaking in terms of tendencies and generalities and intend no reference to any local situation, current or past

Problems for terminating analysis

My major interest just now is in the termination of psychoanalysis and psychotherapy. I view termination not as a fancy and proprietary synonym for ending treatment but as only

one of the ways in which a treatment may end, though by far the best way. I distinguish termination as the process through which an analysis “all comes together.” Its special feature is to work-through the patient’s fantasy that in order to keep the gains he has made he must remain with the analyst rather than analyze that dependency. Too frequently, as we know to our sorrow, and with these problematic cases in particular, it does not all come together at the end. That is one of the reasons why the process of termination requires special attention in analytic education, not just with problematic patients.

For all patients, termination is too important a matter to leave until the end of the analysis. Indeed, I believe the analyst should have the idea of termination in mind throughout the entire course of the analysis and especially when evaluating the patient for analysis. Estimating whether or not the treatment will end electively and by mutual agreement is as important an issue at the beginning of treatment as whether or not the patient is analyzable, and yet it is an issue often ignored by beginners. To borrow an aphorism from surgery, getting in is easy; getting out can be a problem.

The problematic persons make for particular problems when it comes to ending their analysis. As I described, some of them do not regard analysis as a collaborative project and they take matters into their own hands when they feel they have had enough. Even so, while the analyst might prefer that the patient invest in more analyzing, it may be possible, given a willing patient, to help him to *terminate this episode of analysis*. The devil is in that unruly detail, “the willing patient.” I have not experienced a patient of this sort who, once relieved of pain, was willing to remain in analysis long enough to deal with the issues embedded in his (narcissistic) character structure. It is doubly difficult to work on termination, if we conceive of termination as helping the patient separate the gains he has made from fantasies that the gains rest on the transference, if the patient resists even recognizing some aspects of transference. In some of the persons I described, the patient tends to credit himself with any gains and, at most thanks the analyst for renting him the couch on which he treated himself.

Is this just a long-winded way to say that the job is impossible? Hardly, the task is difficult enough in fact, but I do not consider it impossible in principle. If the analyst fully evaluates the risks and the possibilities of working with a particular patient, he will be in a position to estimate whether or not to offer the patient a chance at analyzing. If he thinks him analyzable but too difficult, perhaps he will refer him to another analyst better suited to the task. In any event, the analyst should recognize that it is important to address the relationship of the neurotic elements in the patient to the narcissistic character from the outset. The analyst should not leave that central issue unaddressed until the patient threatens to leave.

How can one estimate if this treatment one is about to undertake seems terminable? I shall assume that we are considering the evaluation of a prospective analytic patient by a candidate who has a knowledgeable supervisor to consult. There generally are many clues in both the patient's presentation and in his history. The stigmata of the patient's narcissistic orientation will be more or less apparent but the candidate may tend to overlook or minimize their significance because of the understandable attraction of working with a bright and articulate person who says he feels impeded by something, something that keeps him from becoming all he can be. Perhaps attributing his distress to "*some thing*" might be a clue, implying that he attributes cause to a force, that is not quite an aspect of himself. That way of putting it, thinks the analyst, however, is too common to serve as a marker without further supporting evidence. "Anyway, thinks the candidate, "He looks like a natural for psychoanalysis. After all, everyone has a "narcissistic core" of some degree. Is there not such a thing as healthy narcissism?" I have put these questions the way an eager beginner might put them if afraid his supervisor is about to take an attractive case away from him. In any event, the supervisor is likely to tell him that the answer to all of these questions is "Yes, the attractive patient's neurotic symptoms would make him a 'natural,' if they were in a less problematic character setting. Still, it might be reasonable to go ahead provided you are aware of the likely difficulties that lie ahead. To estimate the possible difficulties in

terminating, you would do well to look further into the patient's history of relationships with an eye to predicting the kind of investment or commitment he is likely to make to the analysis and to you, and when and how he is likely to want to separate." I agree with this thoughtful supervisor and shall not repeat the suggestions I made earlier about what to look for in the history of relationships.

Assuming the supervisor's impression from the initial study of the patient is somewhere between reasonably encouraging and not altogether disqualifying, there is still the matter of how to keep the issue of terminability in mind throughout the analysis. A full treatment of this issue would take a talk at least as lengthy as this one has been. I would have to discuss how to maintain a focus on the patient's character as well as on his symptoms and especially on how symptoms and character interact with each other, particularly on the way the symptoms and inhibitions function to keep the patient's narcissism in check and also hidden from the patient. In short, character analysis must proceed in pace with symptom analysis if we are to anticipate the problems of termination one would prefer not to discover when the patient decides to take his leave of us.

Perhaps you are thinking that such obvious psychopathology could not be masked so completely by neurotic inhibition that a competent interviewer would see no signs of it while evaluating the patient for suitability. However, in the cases I summarized in my composite patient, the potential problems were not at all obvious to the evaluating analysts. Possibly they were not looking in the right place; possibly they did not follow up a line of inquiry that had been opened or possibly, perhaps, because they had found so many attractive features to these patients, they lowered the index of suspicion. We might consider that, as I attributed to our candidate a moment ago, they might not have wanted to discover disqualifying features that might keep them from working with an otherwise suitable case. My best guess includes all of the above, and with hindsight, I believe that paying more attention to the degree of the patient's investment in relationships and the quality of these relationships would have given some inkling about future developments

in the analysis. Common to these patients was lack of empathy for others or outright indifference to the feelings of others whenever maintaining a relationship conflicted with the patient's ambitions.

Another Variety of the Problematic Patient

As I promised earlier, I will present some findings that throw doubt on my suggestions.

Although all of the patients who contributed to the composite example I discussed were male and were mainly obsessive in orientation, occasionally one comes across one, in this instance female, who has a convincing hysterical overlay to her narcissistic core. This patient was recently divorced from a husband she claimed she no longer respected. She felt she had failed to convert a passable boy friend into a proper husband. She said she despaired that he ever would be an adequate parent; nevertheless, she said she felt guilty about depriving her small children of their father. In addition to her wish to be free of a variety of anxieties that she tended to master through submissiveness and by being "goody-goody," she hoped to gain from analysis the ability to choose a better man. The patient was professionally trained as an organizational consultant and was employed by a large firm. She was bright, interested and reflective, though emotionally volatile.

Early on, the analyst caught some faint signals that there might be trouble ahead. One signal was that, during the diagnostic evaluation, the patient matter of factly announced her intention to marry a man she had known for some time, but who was unsuitable on several counts. She did not voice spontaneously that this plan might conflict with one of her stated goals, to understand why she seemed unable to attract a suitable man. When the analyst merely aired the contradiction, the patient dismissed the unsuitable suitor. The analyst felt that further inquiry off the couch would not settle the remaining matters. Not wanting to prolong the evaluation unduly, he asked a colleague, an experienced clinician, to administer a

full battery of psychological tests. The testing, however, revealed no evidence of significant psychopathology but merely confirmed the hysterical structure and narcissistic tendencies already noted by the analyst. While it still seemed to the analyst that there was something vaguely “off” in the patient’s presentation of herself, it was so ephemeral that he thought it would become clear only in analysis.

He was all too right. After about a year of analysis, the hysterical basis of the patient’s anxieties had been understood and worked through sufficiently that the patient no longer required medication. The other portion of her initial complaints, inability to find a suitable man was replaced by an erotized transference with narcissistic features that bordered on the delusional. She flew into a rage, for example, on seeing in the analyst’s waiting room a magazine about saving the environment and screamed, “You shouldn’t care about other people, only about me!” With perfect sincerity, she proposed repeatedly that they should stop the analysis and start a new life together as lovers. Once analyzing had relieved the hysterical anxieties and her obligatory submissiveness and eagerness to please, the malignant triad of severe narcissism (narcissistic, paranoid and antisocial features) stood out in bold relief. Her violent shifts from expressing passionate love to hatred and vengefulness, her loss of capacity to modulate affect and lack of a stable sense of identity all fit the diagnostic category of a personality disorder with narcissistic features. More history emerged which, if known during the evaluation, might have led the analyst not to proceed with analysis. An example: the patient disclosed that she had become so fed up with a boyfriend who would not comply with her demands that she took karate lessons so as to be able to kill him undetectably.

The treatment ended badly. The analyst had to suspend practice to have surgery that he had been putting off, in part because it would require several months of convalescence. Though the analyst tried for several weeks to work

with the patient about the impending absence and had arranged for a colleague to back up, the patient said she could not tolerate the separation. In a rage, she repeatedly tried to visit the analyst in his hospital room at all hours, and when she succeeded in getting in, berated the analyst for abandoning her. When the analyst could no longer take what amounted to being stalked, he obtained both professional and legal counseling and with this help, informed the patient that he could no longer work with her. The patient's fury mounted and the harassing continued. In the course of her condemnations, the patient let slip the information that she was also in treatment with another therapist and that she had begun this second treatment even before the analyst went for surgery. Eventually she sued the analyst for the fees she had paid for this worthless treatment. Her suit did not succeed.

What are we to make of these findings and suggestions? Certainly we should add to the usual contraindications to analysis persons who lack essential honesty, if the analyst can discover it during the evaluation. Unmodified psychoanalysis is a fine tool for helping patients to deal with self-deception but it is poorly equipped to deal with persons who intend consciously to deceive others. I should have added this exclusion to my short list in the first place.

Analyzing the Narcissistic Patient

Is the lesson to be extracted from this disastrous case that we should avoid taking into analysis patients whose complaints reflect a neurotic condition that serves to keep a severe narcissistic orientation in check? That conclusion would overreach the data. Consider, these persons are likely to get treatment for what troubles them one place or another and with even less likelihood that the relationship of complaints to the underlying narcissistic orientation will be understood and with results likely no better than those I described. Consider too, working with narcissistic conditions is challenging under the most favorable conditions and is even more so if the analyst is not sufficiently alert to its presence and the way it interacts with the presenting neurosis. But if the analyst is

prepared, as he must always be, to work both with the patient's complaints and with the underlying character, I think the patient will have the best chance of emerging from analysis both relatively free of symptoms and as a reasonably responsible persons. At least, I know of no better way to treat these problematic patients and I can think of no honorable way of evading the challenge.

A full discussion of this issue would take a talk at least as lengthy as this one has been. To anticipate that talk, I shall just mention that it would touch on the necessity to maintain a focus on the patient's character as well as on his symptoms and on how symptoms and character interact with each other. In particular, the analyst will want to focus on the way the patient's symptoms and inhibitions have functioned to keep the patient's narcissism in check. I refer here to attending to the "microprocess," and the necessity that the analyst recognize what is going on and stays ready to intervene. It is a technical issue, not just a theoretical one and I shall illustrate it shortly.

Technical Implications

Let us consider the moment analysts all long for, the moment when following an interpretation, the patient feels a bit of release from the bonds of symptom or inhibition. With the ordinary patient one might prefer to desist from intervening at that moment in order to observe whether the patient relishes the experience of freedom with its overtones of anxiety or feels forced instantly to control the anxiety by attempting to restore the neurotic defenses (Schlesinger, 1995). This too is the moment when the analyst of the problematic patient must be ready to address the somewhat different experience we presume the patient is having. I expect that the problematic patient also will be surprised at suddenly feeling relaxed and free and also will feel anxious.

Let us see what is likely to happen if the analyst does not intervene: The problematic patient will *not* allow himself to linger in the new experience of freedom, but will deal with the bit of anxiety by trying to restore his narcissistic defenses. The evidence for that restoration will be an influx of feeling exultant, triumphant, empowered and superior. In

short, instead of relief, the patient will experience a flush of enhanced narcissism. In moments, if the analyst does not interrupt, the patient's experience will develop toward an enhanced sense of exceptionalism. The previous pain forgotten, the patient will turn his attention away from the occasion of release. He is not curious about it but takes it for granted.

As with the ordinary neurotic patient who opts for defense at that moment, the analyst of the problematic patient must be ready to intervene in order to slow down the process of repairing defenses, to allow the patient time to appreciate what just happened and to see what he next selected to attend to and what he preferred to ignore. It is a delicate process that calls upon the analyst's skill at formulating brief, laconic and appreciative non-critical statements – a higher degree of what all of us aspire to when analyzing – but more so because at such moments our interventions are particularly unwelcome. The analyst should expect that it is inevitable at such moments that his efforts will not be appreciated; he will be regarded as critical, as a spoiler. Nevertheless we want to avoid unnecessarily providing evidence to support the patient's accusations. I add, perhaps unnecessarily, that no guarantee of success comes with this advice and that a kind of "faith based" persistence is called upon.

Before illustrating how the analyst might go about intervening to slow down the patient's effort to restore his narcissistic defenses, I would like to comment on how our way of referring to these matters gets in the way of understanding. I spoke of "the patient's efforts to restore his narcissistic defenses," as if you and I would know what that means. It is part of our usual way of constructing professional jargon to turn our verbs into nouns, just as we speak of a patient's "reality testing" when we mean how the patient "tests reality." Rather than saying that the problematic patient is restoring his "narcissistic defenses," it would be clearer if we would say that he is trying to defend his narcissism, or to put it even more plainly, he is trying to defend or restore his sense of self that was threatened by the analyst's intervention. We can then add that we assume too that his feeling threatened obscured the momentary sense of relief that also might

have been present. By deconstructing the patient's reaction in this way, we are led to ask *why* the patient felt threatened by the analyst's intended helpful comment. Here is an example:

Imagine that a patient of this kind, who has been having a difficult time accepting his dependency, finally is able to look at the issue less defensively when the analyst figures out how to put the matter to him in more palatable terms. The analyst guesses that if he couches the matter of the patient's rejected dependency in terms the patient feels more comfortable with, his sense of entitlement, the patient might permit himself to hear the sub-text that dependency need not feel threatening. An opportunity arose following the patient's by now usual denunciation of his undependable younger brother. As the denunciation wound down, the analyst thought he heard a slightly different tone of voice, a kind of weariness of exhausted patience, as the patient finished his peroration. He took a chance at framing an intervention to pick up that sense of newness by saying, "You sound almost ready to believe, after all you have put into his education, that you are entitled to rely on your brother now and then." The patient did not turn on the analyst as he often did when he felt the analyst was taking his brother's side. Instead, after a brief and seemingly thoughtful pause, he said, "Yes, I should be able to depend on him -- in fact, I just recalled that last week he came through when I needed him to get those documents to me in time for the meeting. It felt good, but I forgot to mention it." Again, the patient fell silent. The analyst noticed that the patient's fists were now clenched and believed he could hear the wheels turning in the patient's mind. On the basis of his experience with the patient he ventured, "I think for a moment you also felt good when you recalled how it felt when you could depend on your brother for once, but you immediately went on to fantasy how you would 'take charge' and insist on better performance from now on, and to show him who's boss." After a moment, the patient sheepishly admitted that indeed he had fantasized along that line and filled in the rest of the "take charge" fantasy. As he did so, his mood changed toward

truculence and he turned on the analyst, “Why shouldn’t I be able to expect more of him?” (and so on, but this tirade was briefer). The analyst then commented softly to the effect that there was no reason he shouldn’t be able to expect more of his brother, but that he might notice that he didn’t allow himself to stay even for a moment with the simple sense that he felt good about something, he couldn’t let himself notice that his horizon of possibilities had expanded a bit and for the moment he felt freer. Instead he instantly had to put that sense of freedom to work, as it were, to restore his status that somehow was threatened when he felt good following what the analyst had said. From here on the analyst tried to help the patient focus on the sense of threat, that oddly, simply allowing himself to feel good might open him to the possibility of narcissistic injury. And feeling it necessary to protect himself spoiled a legitimate experience of pleasure that he had earned.

I offer this example not so much for the content, which after all concerns a particular patient at a particular time, but rather to illustrate how one can intervene to interrupt the patient’s effort to restore an automatic defensive operation to protect the patient’s precarious sense of self (i.e., as we conventionally would say, “his narcissism”) that was threatened by the “natural” response of feeling liberated by an interpretation. Notice that the analyst followed up first by addressing the presumed narcissistic response and only addressed the transference when the patient moved into a secondary position of feeling attacked by the analyst.

The analyst’s technical purpose, as always when interpreting, is to slow down the patient’s automatic efforts to restore the status quo ante. Whenever the analyst can slow down an automatic defensive response to interpretation, a response that amounts to what I have called “damage control,” he increases the chances that the bit of change that just occurred may eventually become structuralized (Schlesinger, 1995; 2003). This principle of technique applies to the treatment of these problematic patients as well as to those with less complicated personalities and disorders. But because the patient is likely to be less

firmly attached to the analyst than the ordinary patient, more attention has to be paid to helping the patient to remain in analysis.

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