UNDERSTANDING FAILURES AND CATASTROPHES IN PSYCHOANALYSIS

by

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ABSTRACT

The conception of analysis based on psychic states (open, neurotic, object-narcissistic, and traumatic) is applied in this paper to systematic clinical failures. These are failures that cannot be attributed to the analyst's lack of experience or expertise in interpreting. A categorization and theory of such failures is proposed. In Category-1, the patient does not progress beyond the presenting state. Clinical gains are limited to beneficial alterations in the patient's neurotic functioning or object-narcissism. This result is likely when the analyst does not use the momentum of effective work to help the patient enter the traumatic state but rather deflects the work away from that goal. In Category-2 failure the patient is helped to enter the traumatic state but the analyst i s unable to manage that state for reconstruction and growth. Such unprotected entry into the traumatic state leads to re-traumatization, manifest by illness, injury, family break-up, or death.

"The illness itself had kept her on the move, and when it died it left in its place total exhaustion. . . . People driven like this to the very boundaries of freewill are forced to turn somewhere for help, to make absolute decisions."

Lawrence Durrell: *Justine*, p. 247.

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INTRODUCTION

The Purpose of this Paper

The failure of a psychoanalysis is a deeply unhappy event. Catastrophe during a psychoanalysis is even more serious. Both topics deserve more study than they receive. In this paper, we will apply our theories to published cases of analytic failure and catastrophe so as to foster the investigation and deepen understanding of such tragedies.

Background of the Present Study

Psychoanalysis assumes the existence of mental mechanisms that protect the individual in an unsatisfactory way. It is accepted that such mechanisms must be understood and their influence be reduced for the therapeutic benefit to occur. It is accepted also that during the analytic process the individual becomes conscious of much that was previously unconscious. Although these statements are analytic truisms, their detailed meanings are not generally agreed upon.

The lack of agreement is evident in the detailed study of protective mental mechanisms. The traditional view is that these mechanisms are based on repression or ego defense (e.g., Brenner, 1976; Fenichel, 1941; A. Freud, 1966; Freud, 1914a, p. 16). Work with narcissistic, borderline, perverse, and psychotic, phenomena has suggested to many analysts that this concept is insufficient (see Cohen & Kinston, 1984 and references contained therein). But even among those who find repression theory lacking, the way to revise it, yet keep with psychoanalytic values and methods, is a source of controversy.

Approaching this problem from many different perspectives, analysts have clarified that there is a mode of protection more fundamental than repression and ego defense. For example, O'Shaughnessy (1981), following Hoffer (1954), contrasted ego defenses with a "defensive organization," "a pathological formation when development arouses irresoluble and almost overwhelming anxiety" (p. 363). Rosenfeld (1971) and other Kleinian analysts refer to a "narcissistic organization". Gedo & Goldberg (1973) have proposed a hierarchy of protective organizations. Within the ego psychological tradition, too, similar language is used. For instance, Schlessinger & Robbins (1983) refer to a "characterological defensive organization …serving as a shield against the transference neurosis" (p.24).

Within the *Program for Psychoanalytic Research*, we have carried out a detailed study of the literature and reviewed our own clinical experience of protective mechanisms (Cohen & Kinston, 1984, 1987; Kinston & Cohen, 1986, 1988). The conclusion that appears inescapable to us is that all protective operations are manifestations of one of two modes of functioning or states of mind—the neurotic and the narcissistic (or object-narcissistic in our terminology). We have suggested that both states of mind develop because of trauma, and that their function for the analysand is to prevent a traumatic state, the emergence of which is potentiated by analytic conditions.

The neurotic and object narcissistic states can be distinguished from one another and from the open state . We have therefore concluded that analysands present in all, four states of mind—open, object-narcissistic, neurotic, and traumatic.

The clinical significance of these findings resides in the fact that each of the four states of mind requires its own particular form of psychoanalytic handling. Each state in effect generates a psychoanalytic method appropriate to it and to no other. Adequate clinical psychoanalysis seems to require that all four states emerge and are worked with extensively.

Although controversial, these conclusions result from our documentation of what analysts actually do, rather than attending overmuch to what they say they do. The conclusion that psychoanalytic technique must be varied substantially to suit the state runs directly counter to standard theory of technique, which is based on a single state of mind (repression) and therefore a single mode of handling (interpretive).

As described in detail by Kinston & Cohen (1988), each state requires a distinctive form of psycho-analytic responsiveness: sympathetic and explanatory in the open state ("working on"), empathic and interpretative in the neurotic state ("working through"), reflective and confronting in the object-narcissistic state ("working off"), and adaptive and reconstructive in the state of primal repression ("working out").

We have found that, given suitable handling, the states of mind unfold in one of a few predictable sequences. The sequence depends on the initial state of mind of the analysand.

When an analysand presents in the neurotic state, insight into that state, conferred by transference interpretation, moves him towards a traumatic state. Before that state emerges, object-narcissism is activated and must first be dealt with. Effective handling of object-narcissism and associated negatively-valued self-images (self-narcissism) results in emergence of a traumatic state in which traumatic experiences are relived. In the traumatic state primal repression can be repaired through active mediation of needs and reconstruction of past traumatic events. Effective analytic work of this sort leads to growth that is reflected in increased capacity for open functioning. The order of activated states here is neurotic, object-narcissistic, traumatic and open.

By contrast, when the analysand presents in object-narcissism, effective analytic treatment leads directly to a reliving of the trauma. If the reliving is properly handled, the patient's reliance on object-narcissism is reduced and his capacity for neurotic and open functioning enhanced. Thus, the sequence of activated states is object-narcissistic, traumatic, neurotic and open.

Analysands also present, although much less commonly, in an open or traumatic state.

Whatever the sequence, once all the mental states have been activated and identified, the analysis has reached a watershed. We call this the primary cycle, Cycle 0, or Stage 1.

Stage 2 of the analytic process then becomes identical for all types of presentation. It proceeds by way of cycles where regular movement between states, including contact with trauma occurs. Attention to unmet needs, development of affective responses and progressive symbolization occur in this way. This cycling is the process of emotional repair and growth.

Empirically, we have found that only a certain quantum of growth through immersion in the traumatic state seems possible in each cycle. When a cycle runs its course the analysand reverts to object-narcissism and a new cycle begins. See a detailed clinical account of multiple cycles in Kinston & Cohen (1988).

Following enough cycles, unrememberable and compulsively reenacted trauma is replaced by memory and symbolic representation. Critical judgment becomes possible. Object-narcissism is then voluntarily abandoned. This marks entry into the third and final stage of the analysis and ultimately to a mutually agreed termination.

We believe that our approach describes what is requisite for a complete analysis. If this is so, then neglect or mishandling of any component state should have serious consequences.

In this paper we seek to demonstrate that failure to deal suitably with each mental state as it presents results in incomplete analysis at best, and catastrophe at worst. If true, the results have direct clinical importance as well as providing a new conceptual approach to therapeutic failure.

Trauma and Catastrophe

It has long been recognized that effective psychoanalytic treatment can, and perhaps must, bring the patient to a reliving of the traumas that caused his illness. Freud's terse dictum was that the patient must "re-experience some portion of his forgotten life" (1920, p. 19).

Freud's theoretical understanding of this requirement, based as it was on his view that repression was the final common pathway to illness, did not distinguish between unrememberable traumatic events and repressed drive derivatives (1920, p. 18). It remained for Kardiner (1941) working with war neuroses, and Lipin (1963) working with ordinary neuroses, to

show that it is not repressed material but actual traumatic events that are replicated in traumatic states. They emphasized the potential for catastrophe inherent in such replication. Lipin, for example, noted that when the replication process occurs "outside of analytic protection and intervention ... instead of producing memories it often provokes disasters." (1963, p. 395).

The catastrophe that has attracted most analytic attention is catastrophe at termination. There is little agreement on the meaning of this phenomenon. Laforgue (1934), in a frequently cited paper, discussed a variety of such catastrophes, including abrupt cessation of treatment, inaccessibility, and development of physical illness—all of which he considered resistances. The view that catastrophe at termination is a form of resistance is commonly held. Firestein (1978) writing on termination noted that while the phenomenon is a "puzzle," "most writers dismiss it with casual comment." (p. 241). He cites Fenichel (1945, p. 559), Kohut (1971, p. 94n), and Rech (1950), expressing the resistance point of view. Other authors (e.g. Miller, 1965) consider it a sign of insufficient working-through. Even life-threatening catastrophes in a meaningful context are often considered accidental or irrelevant, and we have previously cited examples (e.g., Shane & Shane, 1984, p. 759; Yorke, 1980, p. 191). Kubie's (1968) opinion that catastrophe in the termination phase represents analytic failure is a distinctly minority view.

It has not been appreciated that *intra-analytic catastrophe usually means that the trauma of the patient’s life is being directly relived.*[1]

Our research supports this view and suggests that the outcome of such reliving depends on the analyst's interventions. Reliving may lead to growth or to a personal catastrophe such as illness, accident or even death.

A confiding, trusting and genuinely dependent relatedness (primary relatedness) may or may not have developed in work in the other states, and may or may not carry over into the traumatic state to become (in our terminology) *special primary relatedness*. The presence of special primary relatedness determines whether primal repression produces trauma anew (personal catastrophe) or memory and understanding.

The *projective* version of personal catastrophe (death or illness of an intimate of the patient) and apparent instances of action at a distance are frequently reported but are perhaps the least understood of analytic phenomena. They have been most comprehensively described in the small analytic literature of paranormality: see Devereux, 1953, for a collection of key papers, including Freud's six contributions; also Eisenbud (1970, 1983).

Our theory thus provides a basis for understanding the conditions under which the inevitable analytic potential for catastrophe is either realized or prevented from being realized. We will now use our understanding of these conditions to formulate and test an approach to therapeutic failure.

CATEGORIZING THERAPRUTIC FAILURES

Systematic vs Idiosyncratic Causes of Therapeutic Failure

Our approach to therapeutic failure proceeds from the considerations outlined above. We believe that to effect cure, a psychoanalysis must enter primal repression, the traumatic state, and eliminate it. This approach suggests that there are two main systematic[2] causes of therapeutic failure: (1) Some failures are due to defenses and self-protections being left intact and therefore continuing to prevent entry into the traumatic state. (2) Other failures are due to inadequate handling of the traumatic state once that state is entered.

We will not consider failures which, while perhaps numerically significant (and of great concern as regards selection and training of analysts), are not relevant to our theme—namely failures that derive from clinical inexperience or from an individual analyst's insensitivity, personal weakness, or discomfort with the full range of symbolic communication. Nor will we consider failures attributed to

clinical problems judged unanalyzable. Most literature on therapeutic failure is of this sort.

Proposed Categorizations of Systematic Failure

We are concerned with therapeutic failures in which the personal qualities and capabilities of the analyst are not in question, and which therefore go to the heart of psychoanalytic theory and technique. We suggest division into two broad categories:

1. Failures due to an analyst not facilitating a shift into the traumatic state. The patient therefore remains in a neurotic or object-narcissistic state or oscillates between these. Therapeutic benefits are then severely curtailed.
2. Failures due to an analyst enabling entry to the traumatic state but not handling the state properly. As a result, the patient is re-traumatized.

Explanation of the Categories

Category-1 failures tend to occur when the handling of object-narcissism is not differentiated from the handling of neurotic or open functioning. When object-narcissism presents, either initially or as the analysis progresses, it is not recognized and dealt with. As a result, progression into the traumatic state is interfered with. Our theory leads us to predict that such miscoordination of state and mode of intervention, if persistent, leads to collusive pseudo-analysis, interminable analysis, or artificially terminated, incomplete, analysis.

Opportunities for deep change in the analysand through confrontation of object-narcissism followed by reconstruction of trauma and active need-mediation are systematically forgone.

Category-2 failures tend to occur when the patient is helped to enter a traumatic state, but the analyst does not manage that state adequately. Category-2 failure becomes more dangerous than Category-1 because it can result in catastrophic re-traumatization.

CLINICAL MATERIAL

The Factor of Experience

Each analyst develops his own relation to theory as his experience grows, finding aspects of it more or less relevant to his practice. But every analyst's method is affected, knowingly or unknowingly, by their theory or lack of it.[3]

We intend to use published clinical material. In doing so, we are concerned to put the factor of inexperience to one side as much as possible. However, in using such material to illustrate various points, we cannot altogether eliminate this factor. Representative selections of clinical work of senior analysts are not published. Thus descriptions of failures are few even though failures may be many.

Even when there is no wish to withhold data, such behaviour occurs due to the theories held, which explain them away. The result is that the fact of failure is thought to lack scientific value and not be worth publishing. Illustrations from inexperienced analysts whose work is reviewed by senior training analysts, help us partially get around the problem.

The other approach, which we will also follow, is to use such material as is published by leading analysts whose capability and sensitivity are beyond question.

Inexperienced Analysts

Clinical cases of inexperienced analysts are to be found in a unique book that details eight analyses conducted by candidates and recent graduates of the New York Psychoanalytic Institute (Firestein, 1978). The names of the treating analysts and supervisors are concealed. Because these were all supervised and approved cases at one of the premier psycho-analytic institutes in the world, published with its blessing by a member of the faculty, one can reasonably assume that the cases reflect the thinking and practice of the institute itself.

Firestein's book was intended to illustrate expectable problems of termination, and the author nowhere offers definite opinions about the overall success or failure of the analyses

reported. He appears to regard the analytic work as normative, producing expectable degrees of improvement albeit sometimes with insufficiently resolved problems. Anticipating in readers the "assumption that the work of more experienced analysts would have been different," he stated that such an assumption was "not justified" (p. 222).

That assumption was indeed made by the single psychoanalytic reviewer to comment in detail on the cases. Weiss (1980) criticized the way most of the patients were handled. He felt that they had unsatisfactory analyses and cited only one successful case (# 2). But he expressed confidence that experienced analysts do much better. Novick (1988, p. 308), in a paper on termination, felt that Firestein's "clinical material …clearly indicated" that only one of the eight cases (presumably #2) reached an adequate termination. He believes, in apparent agreement with Firestein, that incomplete analysis is common.

Our assessment of the Firestein cases agrees broadly with those of Weiss and Novick, including agreement on #2, the one successful case. From our point of view, seven cases are clear therapeutic failures. Of the failures, four (#4, #5, #6, and #7) failed because the analyst did not adequately appreciate the patient's material. For the reasons given above we will not use these cases as examples.

However, a summary of their common course is in order. These analyses all began in states of neurotic functioning. The patients developed transference attachments to the analysts and associated productively, and the analysts attempted to interpret relevant unconscious conflicts. But despite supervision, interpretive work was not sufficiently precise and/or deep and/or consistent to clarify the transferences and move the patients along. Some beneficial symptomatic changes occurred, which satisfied the patients, analysts, and supervisors enough to terminate more or less by mutual agreement. In all these cases (in our judgement) analytic work was insufficient to effect deep change.

Of the remaining three cases, two fall into Category 1 and one into Category 2, and therefore merit our attention. We will present each category in turn. The two Category 1 cases (#1 and #3) are similar, and we choose Case #1, "Martha R," to illustrate our points. To preserve as much of the flavour and thinking of the original as possible we will follow the language and sequence of Firestein's presentation (italicized print is verbatim Firestein). In the right-hand column is our understanding of the situation in the analysis.

CASE EXAMPLE: Martha R. (Firestein, 1978, pp5-20)

Mrs. R was a married business woman who began analysis in her latter twenties because she was dissatisfied with herself, intolerant of others, lacked confidence, was preoccupied with thoughts about her parents, and became very anxious when obliged to speak in large group settings. Intake interviews at the Treatment Center revealed masochistic traits, sexual frigidity, and envy of men. The patient was the middle of three children. Her parents' marriage broke up when she was an adolescent and her father later remarried.	
Early in the analysis the central problem developed about her verbalization during sessions: The patient feared "to let herself go" lest the Treatment Center retaliate in some way. Later, her not speaking was related to anger; she regard the analyst as a frustrating mother surrogate who showed his lack of interest by remaining silent and by not satisfying her curiosity about him personally. This was related to important oral themes in that the anlayst had introduced the frustrating elemenet of suggesting that the patient forego smoking while on the couch. She assumed that her anger at the analyst was reciprocated… She felt in a terrible dilemma about speaking. To speak freely was equated with being "crazy". Her "crazy" statements would not be acceptable and something might happen to the analyst—he might die. ….	The analyst assumes neurotic functioning.

The analyst felt from the start that had to be worked though especially was the patient's negative transference. There were numerous threats to leave. ….She was jealous of the analyst's other patients and of his family, as she had felt jealous of her father's girl friends after her parents were divorced. …

And therefore uses interpretations.

With transference interpretations, Martha gradually came to see people less as parental facsimiles. Initially she regarded her co-workers as another family to whom she responded in terms of parental (and sibling) surrogates. In time, as the transference neurosis flourished, these distortions in her relationships at work waned, and she considered stopping work to have children. One of the main symptoms was demonstrated in the transference—the feeling that she could not talk or had nothing to say. During the second year she made a good deal of progress in understanding the anger that underlay this inhibition. ….

The third summer recess was the longest of the analysis. Martha reported that she had feared the analyst would not come back at all and had mixed feelings about returning herself. Nonetheless, work resumed. Mingled with much other material, the patient expressed a fear of going "too far" in treatment.

Object-narcissism emerges as a confused urge to break off despite a fear of premature termination.

Shortly after, she began to broach the possibility of termination in further detail. She feared it meant that the analysis was being halted by the analyst because she was assessed to have completed all the change of which she was capable. The analyst's response at this point was to emphasize that terminating was entirely up to her, and he considered having broached it an indication for exploring it. …

However, the analyst assumes open functioning an responds incorrectly as if termination was realistic.

A cancellation of one session by the analyst was succeeded a week later by associations to termination and being abandoned. …. Martha had thoughts of being abandoned reminiscent of her earlier…fantasies that she was not living with her true parents. …

Patient responds openly and neurotically perceiving abandonment and representing it symbolically.

There was an efflorescence of material relating to her sexual fears—material the analyst had hoped might be brough into the open by pressure of the factor of termination. She reported a dream in which the manifest content related to damaged babies. She associated the latter anomy to damage she had caused to herself by her childhood masturbation, her damaged body damaging the emergent newborn. …

Self-narcissism manifest by negative self-images.

During the Spring of that year the question of termination was frequently in the air, in a way that reflected both the patient's and analyst's uncertainty about the best course of action. There was some relief in the idea. She… felt much more in the way of positive feeling for her mother, and… this change in feelings paralleled a similar alteration in feeling toward the analyst. … Martha repeatedly focused upon her fears of having a child—that it might be mentally retarded because she is "too old" to have children, or that should damage it psychologically through faulty child-rearing practices.

Her potential child is the new/repaired self that needs to be born but might be harmed by the analyst due to his faulty practices.

Some little while later she returned to the issue of termination with the thought that she had gone as far as she could go and the analyst was really pushing her out. She then felt frightened about ending treatment. ….

Aa the year's analytic work progressed on into May and the summer recess loomed again, the analyst came to the conclusion that the lack of a definite date for termination of the treatment was not producing the hoped-for result i.e. that the patient, herself, take the initiative and propose a date for ending. So it was that in mid-May, with the summer recess but six weeks distant, the analyst proposed that they could plan for the analysis to end at the end of June.

Analyst continues to collude with the patient's object-narcissistic avoidance.

Martha's reaction was very energetic and spontaneous. She criticized the analyst for abandoning his usual technical approach to her—which ion this context would have been to investigate the non-appearance of a specific

Open functioning: the patient directly and

termination plan from her. She reiterated her belief that he had given up on her, with the added speculation that she had provoked this manifestation by a rather dramatic declaration of her pessimism about the possibilities for personal change. If that is "what the analyst wanted", she would stop the next day!	reasonably confronts the analyst for giving up on her.
For the next couple of weeks, Martha anxiously filled her sessions with all manner of questions about future contingencies and how to cope with them. The analyst interpreted this as an intellectual endeavour to avoid confronting her fear of loss. …. The briskness of her reaction to the choice of a specific termination date surprised the analyst as he had assumed all along that she envisaged the proximity of an ending date as he did.	Incorrect use of interpretations: analyst assumes a neurotic state and does not realize the patient is legitimately confronting him.
Martha persisted with anxious, vigorous efforts to get "answers" from the analyst and reported her belief that his silence attested to the hopelessness of her situation. The analyst consistently interpreted this manoeuvre as a defense against experiencing loss. There was an exploration of the degree to which Martha tried to exercise a controlling influence in any situation of which she was a part.	
During the final three weeks, Martha clung to her protestation that she was being forced out of analysis and had to submit to the analyst's edict. That this was not the fact was repeatedly called to her attention. Her associations led to childhood experiences in which she felt like a passive victim. These encounters were notably with her mother, and so had some bearing on her currently conflicts over becoming a mother.	
At length, some two weeks prior to termination, the analyst elaborated on this confrontation by adding that 1st-July was not necessarily the deadline. Martha had imagined that once the analysis was over, the analyst would somehow cease to exist. He offered to hold open her hours in the autumn in case she desired to return to treatment. The patient found this very reassuring. …	
In one of the last few sessions, she asked the analyst, apropos her plans for motherhood, how long one should continue to breast-feed an infant. The analyst interpreted her questioning regarding weaning time as a screen for the persisting question of when to terminate the analysis. Martha agreed, yet returned to the infant weaning situation on the penultimate session, stating that when believed her future infant should be weaned, she wished to return to discuss the question with the analyst. She declared, moreover, that she planned to write to the analyst when her baby was born. That same day, she said she felt as if she were falling apart.	
Several days later Martha terminated.	
In the follow-up interview conducted with Mrs R an unspecified number of months after termination, she appeared to be managing satisfactorily, but there was no discussion of any baby or plans for one.	Probable confirmation that the baby was a symbolic representation of her self, not a concrete intention.
The faculty supervisor of this patient's analysis heartily concurred with the analyst's optimistic attitude about termination.	

Commentary

The case material illustrates the lack of congruence between the patient's states of mind and the analyst's responses. It also shows the consequences of the analyst's failure to take corrective action.

The analysis progressed for two years by way of interpretation of neurotic material, with amelioration of neurotic transferences and, in time, a closer approach to primal repression. After the third summer recess a clear shift in predominant mental state occurred, but was apparently not noticed by the analyst.

The key features were (1) self-narcissism in the form of the "crazy" and "hopeless" self-images and ideas of a damaged baby; associated with (2) object-narcissism, in the form of pressure to avoid relating and terminate before this damaged self was dealt with in the analysis; and (3) paranoid defenses, in the form of an idea that the analysis would terminate because the analyst considered her hopeless.

Such a shift to an object narcissistic state calls for a corresponding shift in analytic handling. What is required in our view is recognition of the object-narcissism and explanation of the paranoid fears about her self-image. We believe that this would have rapidly opened the self-image and associated traumas for analytic reconstruction.

Instead, the analyst responded with frank discussion of termination. Such a move would have been appropriate to an open state of mind, but was an abandonment given the state of mind of the patient. The patient explicitly saw herself as abandoned, but this perception was not credited by the analyst. In the face of this maladaptive response, Mrs. R tended to express her experience of injury and abandonment defensively, in the form of fantasies of damaged babies and sexual guilt. She expressed in this symbolic way her doubt whether her own damaged self could be contained and repaired in the analysis, or whether she would have to leave the analysis to "have a baby," i.e. care for and repair herself by using the baby as a vehicle into which she could project herself.

This pattern of analytic abandonment probably replicated the patient's trauma. But the abandonment was unanalyzable, not simply because it was produced by the analyst, but also because this re-production was never acknowledged. Every time the material came up for analytic handling, it was responded to inappropriately. The result was termination in stalemate.

That all the material about damaged babies and ideas of having a baby referred to Mrs. R's traumatized self and her needs for repair is supported by the fact that no mention of a baby occurred in the follow-up interview. Dr. Firestein himself registered vague dissatisfaction with this aspect of the case, writing (p. 20): "The patient's decision not to have a baby until the analysis was over---partly rationalized on financial grounds---remains a puzzlement."

Discussion

Martha R's analyst-in-training interfered with her progressing beyond neurotic functioning by colluding with, rather than helping her recognize, her object-narcissistic avoidance when it surfaced.

In such a psychoanalysis the patient is kept from achieving Cycle 0 and blocked from beginning the process of repeated contact with the inner trauma (or psychotic core) that is necessary for a terminable analysis (Cohen & Kinston, 1987). Rather, the treatment hovered around a neurotic equilibrium. All that can be hoped for in such analyses is a constructive shift in the neurotic equilibrium, say a lessening of inhibitions or a reduction in guilt feelings, but not a cure of the neurosis.

This variety of therapeutic failure has a built-in protection for patient and analyst. As we have shown (Kinston & Cohen, 1986), the potential for profound analytic change that lies beyond the pleasure principle (i.e. beyond neurotic functioning) is linked inextricably to the potential for catastrophe. So in limiting the reach of the analysis the analyst avoided risk but sacrificed the possibility of major change.

A more confident analyst might have resisted the supervisor's incorrect advice and stayed involved with his patient. But the very fact that a supervising analyst made such a profound yet (from our theoretical perspective) rudimentary error of judgment suggests that theory systematically contributed to the clinical failure in this case. When only one state of mind (neurotic functioning) exists in one's conception of the patient, then it is "timely" (Firestein, 1978, p. 15) to terminate when this state has been thoroughly dealt with. Such a theoretical framework does not allow for the fact that effective interpretive work invariably leads to the emergence of other states (object-narcissism, trauma) but has no effect on them.

If the patient does progress beyond neurotic functioning into object-narcissism and thence into a traumatic state, he may be unable to return to the neurotic equilibrium. Irreversibility seems to be one of the features and dangers of this clinical movement. This means that the patient must either go further, reliving trauma with the analyst if possible, or suffer re-traumatization.

Success for the patient then depends on whether the analyst can provide help in reconstructing and emotionally understanding what happened to him. If he can, reliving of trauma results in the formation of memory, construction of healthy emotional responses, and development of a historical and critical perspective.

If, on the other hand, the analyst cannot appropriately handle the traumatic state once entered, the patient's reliving brings catastrophe in its train. This is Category-2 failure. Joseph V (Case #8 of Firestein) illustrates such a result.

CASE EXAMPLE: **Joseph V..** (Firestein, 1978, pp.176-202)

Joseph began his analysis in his thirties because of an inability to commit himself to his chosen field of study, or to any one woman, a stalemate made more threatening by several episodes of impotence the preceding year. …. His marriage had broken up several years before. When treatment began, he was involved in an ambivalent relationship with a new girl friend and had fresh concerns over his potency. …..	
In the analysis, the first major theme was the abhorrent nature of the female genital. The analyse was able to infer the existence of an unconscious fantasy of vagina dentata. The patient manifested defenses aimed at insulating him from the sight of the female genital. In the transference, he regarded the analyst like all other women—a whore who had to be used in common with other men. A triangular pattern in his sex life now became clear, and for a while Joseph was even living this out with a room-mate who had a quite active sex life.	Neurotic functioning responded to with interpretations.
Another important complex of wishes and related fantasies involved urges to impress and important man with his brilliance, then retreat for fear of exposure and humiliation in public. The analyst, in this context, represented a female bridge providing access to the renowned Freud, himself. …	
Further work permitted a revised formulation of the central fantasy as a wish to acquire strength from devouring his father. When the analyst pointed to this wish and its feared consequences as critical elements in Joseph's life style, work and sexual problems, she added that one it had been satisfactorily grappled with, termination of the analysis might be considered. … The patient reacted to the interpretation by connecting his nausea and epigastric distress to air-swallowing, and by slowly drifting to reports of passive fantasies as well as passive behavior. ….	
Recurrently, the theme emerged of the patient's urge to ruin himself before others could do so. He lacked confidence about defending his dissertation, as he felt himself to be a phoney who had stolen his brilliance from another.	Self-narcissism with negative self-images.
But his teaching had improved, and with that his popularity and prestige. ….	
When the analyst, after almost five years of work, and not long before a summer recess, again suggested that it was time to think of terminating the treatment, the patient (again) displayed regression, primarily in behaviour with women. …The analyst responded to these moves by reaffirming the tentative plan for termination. Joseph was very angry at this, mentioning his fantasies of switching [analysts]. … He asserted he was going to marry his new girl friend. He gave her a token of his troth and reported the thought that he was teasing the analyst by doing this. He imagined that she (like his	Analyst departs from interpretative approach into inappropriate action: suggesting termination based probably on timeliness.

mother) would jealously render him sick and ineffectual, thereby breaking the engagement.	
Following the summer recess, the patient returned, indicating he was still involved with the same two women and could not commit himself to either. … Painstaking work with all his defenses led to a sequence of transference dreams following which he was again able to work as well as in July prior to the recess. …	
From that point the patient spoke of termination to a considerable extent in spite of responding to the analyst's move to the new office with a feeling that she was kicking him out.	
As termination neared, Joseph still felt unprepared to re-marry. The analyst's opinion was that the patient's new romantic partner was more realistically suited to him than the former girl, yet the relationship was not without its problems. The analyst disagreed with the patient: she thought Joseph was ready for a new marriage venture.	Further inappropriate intervention.
The analyst felt some uncertainty about the timing of the termination, yet her supervisor considered termination to be indicated.	
During these final months the patient described a fantasy in which the analyst took him, all rolled up into a ball, and with the peremptory comment, "enough of this nonsense" threw him out of the window.	
In December the analyst went on a brief vacation. During her absence, the patient became engaged. When treatment was resumed, the focus of the work became the fiancée's children. Joseph regarded them as a gift from the first husband. He then reported a fantasy that his analyst was pregnant.	Engagement suggests emergence of primal relatedness. Focus on children and fantasy of an analyst pregnancy symbolizes the new self to be grown in the analysis.
Although the analyst felt that the patient was heading toward a period of difficulties, she also felt that the patient would not be able to proceed further with the work of coming to terms with the analytic termination without, in fact, ending.	But analyst comes to the wrong conclusion.
The final fortnight of analytic sessions did not differ from what preceded. Joseph continued to regress in both ego functions and drive manifestations and these persisted through the last days. As had occurred in the earliest portion of the analysis, the patient on the couch reported that his verbalizations were punctuated with images. One reappearing image was of the vulture, linked associatively to the devouring mother and to retribution for his oral urges. In the transference, the vulture had very early been less appreciated as a representation of the analyst and linked to resentment of his obligatory passive position with regard to her.	Material is not suggestive of a satisfactory termination. He knows his infant-self has not grown, that he will have to develop on his own because the analyst-mother is not there to help him.
He spoke as well of wishes to be fed or to be retained in a corner of the analyst's office or waiting room. There were images of himself as a child of lilliputian size, or as Jack and the beanstalk climbing up his own beanstalk—the penis he wished to obtain from the analyst.	
=================Mr. V terminated.==============	
A year after the conclusion of his treatment, Joseph contacted the analyst. He revealed that he had married his fiancée not long after the termination, the marriage had not been going well, and that he desired some guidance concerning his stepson. The analyst referred the family to a counselling facility. ….	Primary relatedness persists and includes the analyst who, despite her previous views, responds to the patient's needs.
Three months later, Joseph again got in touch with the analyst, requesting some additional treatment, type unspecified, to help him "unfathom" his marriage and decide about a new trend in his career. He and the analyst agreed to resume the analysis the succeeding autumn—some nineteen months after the first termination.	
=================Mr. V resumed.==============	

Mr. V presented himself as impoverished and rather helpless. He was estranged from his wife, living apart, feeling quite guilty, and confused about what to do. After several months he did effect a legal separation and financial settlement. In this context he experienced the recurrence of abdominal pain more severe than before.

Self-narcissistic negative self-images presaging a move to the traumatic state.

The analyst's efforts to direct Joseph to examine his anger mad him irritable and led him to complain of not being treated properly by her. This led to a review of the special features of this treatment situation (low fee, unusual appointment hours), the analyst noting that these special features seemed to gratify the know childhood fantasy of being an exception child, and the wish to receive something from a man via a woman. ….

Analyst uses interpretations, which are inappropriate for self-narcissistic and traumatic states.

[Mr. V's] increasingly severe abdominal pain led him to seek medical diagnosis. Angry feelings, some overt and others disguised, were increasingly demonstrated. Complaints about the analyst accumulated. … He resented what he regarded as in appropriately "cold" treatment.

Traumatic state progresses.

His internist diagnosed colitis, but without any ulceration. Joseph was advised to restrict his diet and given an antispasmodic.

The analyst's steady efforts to encourage the patient more actively to investigate his defenses and symptomatic phenomena recurrently provoked his anger. The major source of his rage, however, was his confrontation with the fact that some of his most strongly invested wishes were not likely to be gratified either by the analyst or the outside world. More specifically, the analyst would not be able to give him a tremendous penis, academic distinction, or make of him a psychoanalyst. …

Analyst misperceives the deterioration and rage as neurotic and persists in state-inappropriate interpretations.

Material arising from work with dreams permitted the interpretation that he wished to leave the analysis and that his somatic complaints of cramps and diarrhea were substitutes for anger and anxiety. Further, it was possible to suggest to the patient that his fear to work more intensively with the analyst was an updated edition of his long-term fear of the vagina.

After the summer recess, Joseph expressed … strong persistent doubts about the usefulness of further analysis at that time. His colitis had improved somewhat in connection with the appointment. It appeared to the analysis that the patient still preferred to have his sense of personal inadequacy "cured" through the gratification of wishes for magical changes rather than the hard work of analysis.

======Mr. V terminated for the second and final time.=======

The patient was seen for follow-up interview approximately two years after the second termination, and he and the interviewer had a long and cordial discussion of his analytic experience. …[His[marriage [had] turned out to be a disaster. …. At the point of consulting the analyst, one and a half years after his first termination, he felt he needed emergency aid in trying to decide how to resolve the troubled marriage. This brief effort to continue the analysis was altogether shrouded in amnesia, despite its having occurred only two years before the interview. …

The year following the end of the resumed analysis was the most difficult imaginable … The patient was depressed and his colitis was active. He was working at a new teaching position, establishing himself as the students' most highly regarded instructor in his department. …

Progression of the traumatic state.

Slowly, he climbed out of the abyss. After that year, he was able to move to his own apartment. … His colitis gradually came under control. Every so often, however, through dietary experimentation, he tested the state of his intestinal reactivity, which was usually brisk—pain and diarrhea for as long as a week. …

Approximately a year before the follow-up interview, at the suggestion of a girl friend, Joseph went to observe an encounter-type therapy group. He elected to join the group and considered that he had gained much from it in contrast to his experience in analysis. …. Just a couple of weeks before, he initiated some individual psychotherapy once weekly with a woman therapist. .. The supervisor of this analysis summarized his perspective of any analytic process as involving a working through of certain basic wishful fantasies of the patient. After these fantasies have been intensively investigated in terms of their evolution throughout the patient's maturational years, in terms of their derivatives, and in terms of their associated defensive ramifications, it is timely to terminate. He believed that these considerations were appropriately applied in this case, and the termination carried out suitably.	This limited theoretical perspective explains the progress of the analysis.

Commentary

The difficulty in Mr. V's case began when the analyst, in conformity with her and the supervisor's theoretical ideas, advised the patient to terminate when he was not ready to do so. In fact, Mr. V was poised to move out of his neurotic functioning, as indicated by a willingness to deal with painful negative self-images (phoney, thief, small, inadequate). Such movement should have been a signal that object-narcissism was in the offing e.g. via premature termination, as with Mrs. R.

However, the analyst interfered with this development by herself suggesting termination. Her action provided a projective substitute for the patient's object-narcissism. She persisted in this state-inappropriate activity despite Mr. V's healthy angry reaction. The analyst thus confirmed the patient's experience of rejection.

The analysis at that point was distorted by the analyst's rejection of the patient and her demand for his compliance. Mr. V persisted in trying to express his unpreparedness and experience of rejection but finally complied with the analyst and terminated.

Up to the point of the first termination the situation was quite comparable to Mrs. R's analysis. But for some reason, probably an inner relatedness that had tempted him to reveal negative self-images, Mr. V tried again.

The crucial turn of events came when the analyst accepted Mr. V back into treatment. In doing so she went against her explicit theoretical judgement that the work was complete because "the patient was able to interpret the unconscious meaning of his associations (or verbalizations) unassisted" (p. 181), and therefore that nothing "less than a very traumatic circumstance could elicit return of his symptoms" (p. 188). Such acceptance is a typical example of sensibly breaking the rules based on the analyst's awareness of a state of primary relatedness.

As we would expect, in the resumed analysis the move toward primal repression continued. This manifested in deterioration in Mr. V's life situation, object-narcissistic confusion, and a profusion of negative self-images.

Unfortunately, however, the analyst was not equipped to capitalize on the very opening she had created. Mr. V's mental state called for acceptance and clarification . Had this been provided, a more explicit reliving of his trauma, and hence useful reconstruction, might have resulted. But the analyst, not understanding what was happening, responded with orthodox interpretation. Mr. V's anger at the inappropriate treatment was again misperceived.

Despite the analyst's failure, Mr. V did not withdraw. He had passed the point of no return, and his re-traumatization gathered momentum, uncontained by the analyst.

Our theory suggests that because a traumatic state occurred without the benefit of special primary relatedness, serious harm and even personal catastrophe was now inevitable. In Mr. V's case re-traumatization took the form of an iatrogenic traumatic neurosis with an

apparently new physical illness. Again, interpretation and suggestions to terminate were the only interventions the analyst could offer.

Failing to get a proper response from the analyst, Mr. V did terminate for the second time. This termination was followed by a disastrous year. Mr. V had active colitis and was seriously depressed. He slowly "climbed out of the abyss" with the aid of an internist, a girl friend, an encounter group, and psychotherapy with another therapist. The longer-term course of his, apparently severe, physical illness is not made clear in the case report.

The sad irony is that primary relatedness apparently existed between Mr. V and his analyst, to judge from her regard for him and his consistent positive feeling toward her. But this precious resource could not be mobilized to handle primal repression *because the analyst lacked the necessary theory to inform her clinical approach.*

Experienced Analysts

As previously noted, it is tempting to regard the clinical difficulties described in the previous section as a function of analytic inexperience. However, this would still indict the supervisors who supported such handling. Evidence that the failures are not simply products of poor supervision or inexperience, however, emerges from similar outcomes in the published reports of renowned and highly experienced psychoanalysts. Some examples have been reported briefly in an earlier paper (Kinston & Cohen, 1986).

Here we will examine in detail the work of two such analysts to test further our hypothesis that certain theoretical assumptions systematically interfere with the optimal handling of an analysis.

We have chosen two of the world's foremost modern psychoanalysts, Ralph Greenson and Herbert Rosenfeld. Both are recently dead. Both are men with deserved international reputations as clinicians, scholars and teachers. In addition, they represent the two main theoretical traditions, ego-psychological and Kleinian.

Category-1 Failure

To illustrate Category-1 failure we choose a case published by Ralph Greenson (1965, pp. 277-314). It was presented and published to illustrate a "typical and uncomplicated" (p. 283) analytic working-through process. The patient, whom he does not name, is designated here as Mrs. A. She showed considerable change in her neurotic functioning but her analysis ultimately ended in a Category-1 failure.

Case Example: Mrs . A (Greenson, 1965, pp. 277-314)

The patient came for psychoanalysis in her late twenties complaining of depression, boredom, and a state she described as “not being with it”; she also complained of lack of sexual response with her husband and recent obsessive fantasies about a sexual affair with a Negro or Arab.

Early in her analysis she described a history of childhood chaos. Her father abandoned the family when she was an infant and she was raised by her mother, an immature alcoholic woman who alternated between doting and neglect as she pursued other men. Mrs. A experienced a series of stepfathers and boyfriends, poverty, and frequent moves. Her younger brother was constantly belittled by the mother. Despite all this she “managed well in school and socially” and when she left home at age fifteen found work as a clothing model. Five years later she met an older married man whom she “set out to marry”, succeeding after five years.

The patient began her analysis determined to uncover all her painful experiences because was very eager to get well. She was particularly frightened by her recent obsessive-compulsive idea to have an affair with a negro. In the first analytic hours, she confessed her biggest secret: masturbation. She felt terribly ashamed because she believed this revelation would make her appear loathsome and repulsive to the analyst. …

Already in the first hours she associated and equated her masturbatory activities with all sorts of shameful infantile toilet experiences. Talking about masturbation was like being seen or heard on the toilet, like being found incontinent, or being examined anally or vaginally. All this meant she would be revealed as dirty, wet, and smelly, and therefore objectionable and loathsome. To associate freely was like being asked to lose control of herself. She could relinquish control as little in the analytic hour as in sexual relations. She was constipated on and off throughout her life, just as in the analytic hour where she felt she could not produce. Above all, she was unable to let go while being seen. She could have a small clitoral orgasm in masturbation because then she was alone.

Neurotic state: preoccupation with wishes and fears.

She was constantly preoccupied with the fantasy that the analyst would suddenly become disgusted with her and break off the treatment, which paralleled what she had imagined her father had done. To [prevent this] one had to be clean, controlled, continent, and cultured. … The patient recalled seeing h er mother lying in bed deeply asleep, with her naked body exposed, and the patient recalled feeling that her m other’s body was ugly and repulsive. Associated to this highly charged memory were ideas that she had rotten insiders, which she had inherited from her mother.

Emergence of negative self-images portending a potential move to object-narcissism or the traumatic state.

Forms of resistance were repeatedly demonstrated to the patient: the fantasies behind her shame and fear of rejection were clarified and amplified, and attempts were made to get to the childhood events which were the origin of these reactions. The patient then felt ashamed of having resistances and tried to cover them up and hide them until she slowly became aware that the analysis of her resistances was an important part of her treatment and not a short-coming.

During this period, the patient discovered that she already two months pregnant. At first, she reacted to the pregnancy as another manifestation of her “bad insides” and had fantasies of some malignant or deformed growth within her. She experienced her pregnancy as derived from the bad husband; the hateful, frustrating father; moreover , becoming a mother meant becoming like her bad mother. The interpretations of her hostile oral impulses toward her husband and mother and their internal representation by the pregnancy helped to alleviate these feelings. She then had the fantasy that I was the father the baby and it then became a good baby. At this time, after approximately six months of analysis, the patient joined me in another way: in forming a “working alliance” with me, she began to detect and try to understand her resistances. …

Concretization of a baby-self needing help to grow via the analysis, with awareness of a damaged infantile self.

However, interpretations continued.

This alliance could be an object-narcissistic collusion to protect against emergence of the trauma.

She now became aware of a variety of strong sexual feelings and curiosity about me. Whereas previously her masturbation occurred without fantasies or with blank fantasies, now there an abundance of masochistic humiliation fantasies, with a great deal of active and passive oral sucking and biting. Whereas previously she was terrified of being watched in any sexual activity. Now she became aware that being watched added to her excitement. The obsessive idea of having an affair with a Negro or Arab symbolized for her sadistic, primitive, and dirty sexuality, which she now realized could also be exciting. Via her oedipal transference feelings, the patient was able to recall memories of overhearing sexual relations between her mother and stepfather. At first these memories made her cringe in shame and fear and she resented and despised her mother and stepfather. But as her current sexual responses began to change, she realized that her original childhood reactions may well have been different from the screen memories she originally reported. … Her sexual activity with her husband … became more satisfactory. … A baby daughter was born to her about the end of the first year of analysis.

Excitement is a common feature of object-narcissistic states.

Interpretation is used rather than acknowledgement of trauma.

In the second year of her analysis, the patient became aware that when she was alone she would talk to me instead of talking to herself. The analyst had become the most important person in her life and her analysis constantly

Primary relatedness emerges.

absorbed her attention. … Her sexual relations continued to improve although she become more aware that her marriage was not a satisfactory one.

Under the protection of the strong positive transference to me and the improved sexual relations to her husband, the patient was now able to recall her great love for and dependency on her mother. Then a new neurotic symptom came to light: the patient would awaken from sleep with the awareness of having rubbed the roof of her mouth until it became sore. This symptom was linked in the patient's mind to memories of her mother's fastidious cleaning of mouth and vagina. The homosexual dreams occurred in which the patient was making sexual overtures toward her daughter with her mouth. Interpretation focused on the patient's early sexual feelings toward her mother.

Continued assumption of a neurotic state, focus on wishes and neglect of possible traumatization.

At that point her husband became seriously ill and this seem to undermine her sense of security and interfered with their sexual life. Mrs A. in response became frighted of her potential homosexuality. She recalled instances of her mother mocking her brother's penis.

Her husband died after many months of illness and Mrs A whent through a relatively normal period of grief and mourning. Shortly thereafter she fell in love with a different kind of man. He was of her age group, artistic, and not particularly masculine. The patient now had many overtly homosexual dreams about her daughter and later about other women. She felt intense urges to be extremely close to the analyst, inside him and having him inside her., linked with memories of intense voluptuous feelings towards mother's body. Her increased freedom to experience such voluptuous sensation was liberating. She had vaginal orgasms with a lover and was able to have bowel movements without shame or embarrassment. She felt better about herself, her body, and her potential for academic attainment, making plans to return to school.

In the fourth year of analysis, the frank homosexual dreams occurred more frequently and were less distorted. The patient became conscious of oral homosexual impulses towards her daughter and was able to feel with conviction that she must have had similar impulses toward her mother, which were reciprocated. … It seemed plausible to reconstruct that when the mother was drunk, which happened often, and they slept together in the nude, which was their custom, there was a goodly amount ofr bodily contact in a state of diminished consciousness. This must have been intensely pleasurable and traumatically exciting. At any rate, the patient was able to accept this reconstruction and to work with it. …. Simultaneously … there developed outbursts of primitive rage against the penis of the man. Whereas previously she had thought she loved the extremely large penis, she now resented it and considered it brutal, demanding, greedy, heartless etc. These feelings came out not only toward her sweetheart but also toward me. I was now lumped together with "the god-damned men with their stiff cocks who are just looking for any old hole". She realized that causing a man to ejaculate was a victory; a symbolic castration which she enjoyed. To have a penis in her vagina was an opportunity to choke it, strangle it, or devour it. …

Speculation about childhood events rather than a reconstruction of trauma using analytic evidence.

In response, the patient is in a rage and the penis represents the analyst and his analytic method.

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Now she preferred men who had a certain admixture of feminine qualities. She could then enjoy heterosexuality which also had some qualities of homosexuality. The men with feminine qualities permitted her to fantasy that she was that man and now she did to that man what she had hoped her attractive childhood mother with a penis would have done to her. At this time in her analysis, she went through a phase of aversion to all men and would masturbate with a toy. This was based on the formula: who needs you goddamned men: I have my own penis. She dreamed of wild animals who tore the insides out of people and ripped off their limbs. The hitherto hidden penis envy had erupted and brough deep oral-sadistic wishes to the fore. … Shortly after, the patient began to consider finished her analysis. …. We agreed upon a tentative termination date … some eight months later. …

Omnipotent denial of need is a typical object narcissistic state protecting a needy damaged infant-self.

Although she was not longer in love, she was able to have vaginal orgasms on occasion. … The obsessive idea about a sexual affair with a Negro had long disappeared. The patient was able to acknowledge some lover for her mother, and to see her good qualities as well as obvious weaknesses. … She realized that she still had some misgivings about her ability to cope with her mother, but she believed that in time this too would be overcome. … The analysis was interrupted as planned after four and a half years of work.

The only sure protection against her trauma re-emerging is to leave the analysis.

Commentary

Dr. Greenson appears to have kept the patient in a neurotic state and prevented her from proceeding beyond it. The neurotic-state material periodically included references to actual traumatization. Hatred and terror of her mother and stepfather for exposing the patient to their intercourse, negative self-images such as "bad insides," and associations to the "traumatically exciting" experiences of sleeping with her drunken mother, all point to events of a traumatic sort. However, Dr. Greenson consistently interpreted such material as a manifestation of repressed sexual pleasure rather than as allusions to devastating experiences with lifelong damaging conseq-uences to the personality.

This had the effect of deflecting the patient away from primal repression. Dr. .Greenson did eventually attempt to reconstruct one traumatic childhood situation of repeatedly sleeping naked with the drunken mother. This was done, however, without first helping the patient enter a traumatic state within the analysis.

Typically, Dr. Greenson's emphasis was on how "intensely pleasurable" the experience must have been. From the point of view of our theory, this was not a reconstruction at all because it was neither rooted in the experience of reliving a trauma, nor was it aimed at clarifying for them both what the actual experience did to the patient's life.

Our theory leads us to expect that such pseudo-reconstructions would leave the neurotic reaction to the trauma unchanged. Indeed, it led to the intensification of a neurotic tendency to displace affect rather than a resolution. The patient's rage was stirred up but remained directed toward displaced objects, part-objects, and the self. The patient had "outbursts of primitive rage against the penis of the man" This intense reaction, understood and interpreted by Dr. Greenson in terms of castration anxiety and penis envy, led to a complex series of actions—break-up with the man she had been in love with, a turning toward feminine men, and then a clearly narcissistic "phase of aversion to all men". This outcome illustrates the dangers of reconstruc-tion when that procedure is under-stood to mean the reconstruction of an infantile neurosis as opposed to the reconstruction of actual traumatic events and their consequences. Proper reconstruction, by contrast, would have resulted in an emotional understanding of this part of her history, including a linking-up of her transference rage with the traumatic reality of her life. We believe this would have led to a very different outcome.

But Dr. Greenson's acknowledgment of trauma, inadequate though it was, did push the patient toward a traumatic state. In addition to her confused rage, she had dreams of destruction ("animals who tore the insides out of people and ripped off their limbs"). Such movement, according to our theory, reflects activation of object-narcissism. The patient then exerted pressure to avoid further relating by stopping the treatment before this horribly damaged self had to be dealt with.

At that point Dr. Greenson, having no usable conception of anything beyond neurotic functioning, did not perceive this change in state for what it was. He misperceived it in precisely the manner of Mrs. R's analyst, and responded with frank discussion of termination, as if Mrs. A was functioning spontaneously and non-defensively. He thus colluded with the patient's block against reliving trauma. In our view, he should have recognized at this point that the shift into object narcissism was an anxiety-laden invitation to approach and enter

the realm of primal repression where details of the trauma would be revealed.

As with the cases of inexperienced analysts, the primary relatedness that Dr. Greenson had laboured so long and effectively to engender, was squandered when it was needed for this crucial transition.

Despite the richness of transference fantasies and the extent of interpretive work the patient never achieved Cycle 0. She never experienced the cyclic analytic process that leads to repairing childhood damage, and so she was left with quite limited gains. The limitation is reflected in the wan description of the patient at the end of the analysis—a woman rid of her obsessive love fantasy but no longer in love, and able to have vaginal orgasms on occasion.

Category-2 Failure

The Kleinian analyst, generally speaking, is in a better position to tackle the patient's move toward primal repression. Kleinian theory is, after all, focussed on object-narcissism, usually termed "narcissistic organization." So, the Kleinian analyst is not misled by emergence of object-narcissism but rather expects it, and handles it skilfully and directly.

However, the Kleinian analyst is no better equipped than the ego psychologist to handle the emergence of trauma itself. He knows there is a psychotic core but does not have any specific approach to its handling. Thus the patient is likely to be in a precarious position similar to Joseph V, reliving trauma with an analyst lacking a theory that tells him how to modify his handling.

The following case of H. Rosenfeld (we will call the patient Mr. B) shows the analyst working to construct primary relatedness after the patient has entered a traumatic state in its absence. This case illustrates catastrophe befalling one of Mr. B's intimates i.e. a projective catastrophe.

Case Example: Mr. B (Rosenfeld. 1965, pp. 180-199)

[Mr. B] was twenty-one when he started analysis with me. … He had always been slightly hypochondriacal. However, a severe hypochondriasis developed after a sexual daydream.	
The patient was born in Europe. He had one brother three yeaers older. He cannot remember very much of his early childhood until the age of six, when his father suddenly lost all his money and the whole family had to go to relatives in another European country, where they lived very poorly in one room. Shortly after this it was decided by the parents the the mother should share her bed with the patient, and the father with the elder brother. This arrangement apparently continued until the patient was nearly twelve years old, when he rebelled against it after hearing people remark that it seemed unsuitable for such a big boy to sleep with his mother. When the patient was sixteen, the family left Europe to escape from Nazi persecution.	
During the first period [of analysis], which comprises roughly four and a half years, the patient became aware of various problems which gradually improved, but his hypochondriasis, particularly the pressure in his chest, remained most resistant to treatment.	
First he began to realize his extremely envious and jealous rivalry with his brother. He also became aware of the intense oedipal relationship which was reinforced by the lengthy period during which he had been sleeping with his mother. It became apparent that the loss of his father's money and position was attributed by the patient to his own omnipotent fantasies. At this period severe castration anxieties seemed to be in the foreground, and the patient was frequently preoccupied with homosexual fantasies. … When he became aware of his own envious rivalry with women, some of his sexual difficulties, particularly the omnipotence which the analysis had revealed, cleared up. He developed a number of fairly satisfactory relations with girls but he never acknowledged that he was better.	Neurotic functioning, handled by interpretation. Obvious improvement.

The patient had always been afraid of marriage. At the age of twenty-four he met a very attractive girl to whom he became engaged, but at that moment very severe anxieties set in. He was afraid of being trapped and completely destroyed in the process. There followed fifteen months of severe indecision and anxiety with constant hypochondriacal complaints, before he made up his mind to marry. He was still convinced, on his wedding day, that he would collapse physically, but nevertheless went through with it.

Object narcissistic fantasies of self-destruction. Fears of collapse suggest awareness of primal repression.

A few weeks before the marriage he had a dream that he was walking with his fiancée towards his room. Suddenly a door opened and a mulatto appeared, who was a gangster who had tried to rob his room. The patient challenged him and put his hands into the gangster's pockets, without being able to discover anything stolen. The mulatto had a smile on his face. There were two people standing nearby. The patient shouted for help, but they did not make any move to help and the mulatto escaped. The patient realized that he would now feel afraid of him, and in physical danger for the rest of his life, since the mulatto would never forgive him for having challenged him, and would sooner or later take his revenge.

Dream reveals severe narcissistic anxieties.

I interpreted that the mulatto represented the patient's sadistic omnipotent hero-self, which his proposed marriage was forcing to come more into the open. … The escape of the gangster seemed a pictorial representation of the mechanism of splitting. … The patient seemed afraid that as he now knew more about his sadism and madness, he would be in constant fear of being suddenly overwhelmed by it.

Interpretation of narcissistic anxieties.

The three years following the mulatto dream, which almost coincided with the patient's marriage, may be considered as the second period of analysis. The patient's hypochondriacal symptoms…increased considerably. At time the patient almost completely lost interest in outside life, being obsessionally preoccupied with his illness. At first, the marriage seemed to be more successful that the patient had hoped. However, a few months later, the patient's mother became seriously ill with cancer of the throat and died. … [H]e felt intensely responsible for killing her. His guilt feeling continued for many months; he was preoccupied with her eath and seemed constantly identified with her, and had fantasies of her feeling very lonely, sexually frustrated, shut up and bored in her grave. … As the months went on, the patient felt worse and worse. He got no satisfaction from his wife or work.

Traumatic state emerges as evidenced by loss of interest in living. Preoccupation functions as an object-narcissistic shield.

No evidence of primary relatedness, and death of an intimate is possibly a projected catastrophe. The illness relates to the throat, the organ the patient and analyst use for healing.

Gradually during the analysis he linked physical feeling in his head with a mental one and described it as "concern in his head". He felt persecuted by this concern and sometimes explained that it seemed to run after him wherever he went. He wanted to get rid of it because it did not know what to do with it, and he also felt that it was quite unbearable. While constantly trying to expel the concern, he was also afraid to lose it, because he often thought that if he succeeded in getting rid of it, he would no longer be able to love or care. … He wanted the tension in his head to be cured, which implied that he wanted to have his mother restored, but he could never decide whether the concern was a good or bad thing, because he could never make up his mind whether the damaged mother was really a good mother or a revengefully persecuting one. …

Deterioration with access to a healthy self capable of love but which he fears and rejects.

Potential for primary relatedness.

This period of analysis was concerned with working through the confusional state, ,,,During this period, [he] became particularly silent. …. Sometimes he said he was bored and unable to get any satisfaction in life and that he was worried about the constant pressure in his chest. I made many interpretations about the meaning of the patient's behaviour. For example, I interpreted [his] constant heavy breathing in the sessions as a projection of his physical and mental disturbances into me, but he never gave any conscious acknowledgement that I was correct. … This behaviour was very repetitive and went on for many months.

Confusion is a hallmark of object narcissistic functioning. as is boredom in an analysis.

Such interpretations are confrontations, which is appropriate for object narcissistic states.

About this time, he had two dreams which considerably helped to overcome the almost complete hold-up in the analysis. In the first, he was in my consulting room. I, the analyst, seemed to be depressed and frantic about his lack of progress. In my despair I took some fluid and rubbed it into his head. After this, I looked into his eyes with an ophthalmoscope. Apparently I saw that some change had taken place inside him because I looked more satisfied. He watched me all the time during this procedure, and as soon as he saw that I felt better, the pressure in his chest disappeared. He was again silent after telling me this dream. … I interpreted … the patient's silence…as an expression of his complete passivity as a result of the massive projection of his anxieties into me.

The dream symbolizes primary relatedness as a fluid and indicates the analyst can see the self, which is undergoing some healing.

The analyst keeps the focus on object narcissism.

In [another] dream, he was walking in the street with a friend of his called Sidney. He wanted to visit somebody known to both of them, in a hospital. He asked Sidney the way but, to his horror and amazement, Sidney remained completely silent. … I interpreted to the patient that Sidney stood for a part of himself, the part which horrified and amazed him because the Sidney part of him refused to give me, the analyst, any help in finding access to the physical sensations which disturbed him so much. … The patient volunteered to describe the unpleasant characteristics of Sidney. … I interpreted that he was envious of my physical and mental health … he wanted to have my health and give me his illness.

More confrontation.

[These dreams] gave the first indication that the patient realized that he could be cured of one of his most intractable hypochondriacal symptoms—the pressure in his chest. Gradually … the patient's behaviour changed. He talked much more the analysis, and he also became more responsive; for example, he acknowledged my interpretations as correct when he thought so, which he had never done before. For the first time, he admitted that he wanted to make an effort to get better, but at this apparently favourable moment, a new anxiety developed. The patient feared that he had been waiting too long, that he had missed his change, which meant to him that he felt he had gone too far and could not undo the damage that he had done. … He was convinced that his stomach had been destroyed beyond repair, mainly by neglect, and it now became the centre of his continuous hypochondriacal self-observation and preoccupation. … [He] was convinced that he was developing an ulcer or cancer. An X-ray examination revealed that there were signs of some gastritis. The patient felt little reassured by this and the severe hypochondriacal anxieties went on for almost a year. ...

Emergence of primary relatedness enabling cooperative behaviour.

Eruption of object-narcissism and negative self-narcissistic imagery.

Fears of death relate to nearness of the traumatic state.

During this time it seemed that the analysis had also turned into food. He complained of the analysis being boring, and of his always getting the same interpretations. This transference situation seemed to be a repetition of the patient's feeding experience, which had been outwardly normal. … He had obviously been unable to enjoy the feeding.

Analyst realizes a trauma with roots in early infancy is being replicated.

The patient gradually became more conscious of his fear of what the analysis might reveal. …

About this time the patient had a dream that he was looking at the breasts of a young attractive woman through a keyhole. Suddenly the breasts changed and became ugly and withered. The woman came out of the room and ran after him, apparently to have sexual relations with him. He was frightened and tried to fight her off, but she touched his penis. He woke up with an emission and felt utterly exhausted. In his associations, he related the woman to his mother, whom he often looked at when she undressed in the bedroom. The dream was interpreted n terms of projective attacks on his body.

The patient now became much more dependent on the analysis. It was often possible during an analytic hour to help him to understand his fears and give him some relief. He developed at this time a suspicion that while I contained the cure he wanted, I might sadistically withhold it from him. … he

The reference to schizophrenic patients suggests that the psychotic core was being presented. But the analyst

felt that all the anxieties in his body would join together, persecute and destroy him. … I was reminded her of my experiences with schizophrenic patient. After this phase of treatment, the patient was much improved, though still needing analysis. His hypochondriasis had changed more into neurotic anxieties, which were less severe and of a more temporary nature. HE was also able, for the first time, to undertake long business trips abroad, and he was able build an important business organization.	used Kleinian-type interpretations of internal relations with a bad breast, hopes for a good breast etc

Commentary

This treatment started off with a period of four-and-a-half years during which Dr. Rosenfeld appropriately used interpretation to deal with Mr. B's neurotic anxieties. As he improved symptomatically the analyst became aware of Mr. B's object-narcissistic indifference to him ("he never acknowledged that he was better" despite obvious improvement) but did not confront it. Thus Mr. B did not become aware of his extreme difficulties with closeness to the analyst, or of the acting-out and projective qualities of his marriage plans. Dr. Rosenfeld seemed to hope that the marriage might force these anxieties "to come more into the open".

On the eve of marriage the patient presented a complex dream expressing deep neurotic and narcissistic anxieties, that initiated a prolonged deterioration. At that point Dr. Rosenfeld emphasized elements of Mr. B's warded-off negative self (the "sadistic omnipotent Nero-self") and the accompanying terror. This contrasts with Dr. Greenson's method at similar points, of focusing on strictly instinctual conflicts and thus keeping the patient in neurotic functioning. Dr. Rosenfeld's method seeks elements beyond pleasure-principle functioning and (according to our theory) promotes movement towards a traumatic state (the Kleinian psychotic core). This movement was manifested by a worsening of Mr. B's hypochondriasis and by obsessional self-preoccupation.

The two states of mind that then emerged were object-narcissism (expressed through his hypochondriasis and continuing blocking of the analyst's primary importance), and a traumatic state. At that point, correct handling would have focused on confronting Mr. B's object-narcissism with explanations and reconstructions of his trauma from knowledge of his history and evidence in the analysis.

However, Dr. Rosenfeld's tactic at this point, in keeping with his theory, was to continue interpreting unconscious fantasy-based conflicts. Thus, like Dr. Greenson, he veered away from a traumatic state as it was emerging.

In this context of failure to change tack and to respond appropriately to the new states, Mr. B's deterioration continued unchecked. After several months his mother developed cancer and died. This death satisfies the conditions of an analytic catastrophe of the projective type. Mr. B felt personally responsible for the death, an attitude that was apparently not challenged by Dr. Rosenfeld.

From this point on the case progressed quite differently from the similar case of Joseph V, because Dr. Rosenfeld's analytic creativity ultimately got the better of his theory. He stuck with his patient and found a way to shift his technique and handle the deterioration.

The shift in handling came about in response to two dreams. One portrayed the relationship to the analyst as a life-giving fluid. The other portrayed the patient's object-narcissism. Dr. Rosenfeld acknowledged that the patient was having his first realization that he could be cured. He then confronted, strongly and directly, Mr. B's object-narcissistic passivity---"the part of him [that] refused to give me, the analyst, any help."

Those interventions led to a dramatic change. Mr. B relinquished his object narcissistic aloofness for self-narcissistic awareness and immediately felt the terror of being damaged, perhaps irremediably. Again symptoms worsened suggesting nearness to the traumatic state. His terror of destruction took on psychotic qualities, with ideas of reference and delusional fears of death (cancer): actual

gastritis developed, and medical physicians were consulted.

Mr. B became more dependent and it was possible for the analyst to "help him to understand his fears and give him some relief" during sessions. This attitude and behaviour culminated in a direct reliving within the analytic relationship of a hope-destroying situation with a sadistically tantalizing mother. Without explicitly identifying the historical root of this trauma, Dr. Rosenfeld accepted and promoted the reliving and tried to make sense of it.

The consequence of this reliving was dramatic improvement, with a transformation of the psychotic-like experience into neurotic functioning. Progress was not however based on theoretical expectations or guidance but on intuition and a professional determination not to let the patient down.

The end of the analysis was not described and it is therefore not possible to judge the ultimate success or failure of the treatment. We do not know the longer-term effects of this type of handling of a traumatic state. Our theory suggests that clinical gains could be unstable unless and until explicit reconstructions are obtained either within an analysis or outside it.

CONCLUSION

The detailed cases in this paper support many brief examples in our previous publications and suggest that psychoanalysis conducted along one or another currently acceptable theoretical lines promotes either a Category-1 or -2 failure. The cases also show that in experienced hands, use of existing theory does provide the patient with valuable insights, and that theoretical limitations can be overcome intuitively to some degree.

The literature contains many cases of analysts of all persuasions responding to the emergence of object-narcissism or trauma by creative and unorthodox work to achieving results like Dr. Rosenfeld's. In fact, Dr. Greenson's own companion case to Mrs. A (1965, pp. 301-309) aimed at illustrating modifications of standard technique and was just such a case.

The conclusion of this study, most plainly stated, is that psychoanalyses that adhere to currently accepted theoretical dictates are likely to lead to one variety or another of clinical failure—either incomplete analysis or analysis that precipitates personal catastrophe. As a science, psychoanalysis is now more burdened than helped by one of its major assumptions, of a single state of mind (repression) as the final common pathway to neurosis, and thus of a single form of technical responsiveness. The Kleinian and Kohutian modifications point in the right direction but do not go to the heart of the problem.

Psychoanalysis appears to have withdrawn too far from its original territory and purpose. Psychoanalysts are unclear that they possess a radical treatment for repairing the consequences of psychic trauma incurred through actual life circumstances. Direct consequences like crushing guilt, inappropriate anxiety, inhibitions and constricted relationships can all be removed.

The radical treatment that is psychoanalysis, however, involves serious risks that must be faced and handled. Thorough analysis that aims to reactivate past trauma so as to provide an experience of repair brings the patient-analyst pair to a region of mind and relatedness where time breaks down, the patient becomes unable to function, and past events re-emerge. How this necessary and desirable approach to a traumatic state is conducted, and whether the trauma becomes a personal catastrophe or a nucleus of growth, depends on how the analyst handles the different states of mind as they unfold in the analysis. To accomplish this, the analyst needs guidance from an explicit theory.

A professional discipline like psychoanalysis should possess theories that directly help aspiring practitioners within the clinical context, rather than throw up roadblocks to be overcome by personal ingenuity and creativity. That this is not now the case is demonstrated by the dismal record of supervised cases presented above, and by numerous examples from the literature.

The goal of providing such help to analysts and their patients can now best be accomplished by advancing to a theory demonstrably able to address a full range of psychic phenomena profitably. Evidence is accumulating that without a theory of psychic states and state specific methods, the trauma that underlies human mental illness cannot be properly managed and repaired.

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[1] The direct reliving of traumatic events is a psychoanalytic instance of a class of events known in biology as "phase singularities". Time becomes nonlinear and the person literally relives traumatic experiences of the past. Other sciences are developing the theoretical tools needed to understand such phenomena (e.g. Polkinghorne, 1985; Winfree, 1987), and psychoanalysis needs such tools also. An important effort in this direction, using mathematical catastrophe theory, is being made by Sashin (Callahan & Sashin, 1987; Sashin, 1985).

[2] By "systematic causes" we mean causes that derive from the psychoanalytic system of treatment, as opposed to either individual qualities of the analyst or the properties of the case being treated. We are using the word as it is used in statistics to describe a "systematic error", that is, a "persistent error that cannot be attributed to chance:" as opposed to a "random error" (Random House Unabridged Dictionary of the English Language, 1987).

[3]