DISCUSSION of the paper by THOMAS M.BROD

Psychoanalytic Psychotherapy : Narcissistic Rage, the Erotic Transference and the Suicide Contract.

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WARREN KINSTON

29 Netherhall Gdns, London NW3, U.K.

It is always a privilege to read an account of a psychotherapeutic treatment, and an extra privilege to be invited to discuss the account. Like all honestly presented clinical papers, this one raises issues we are all struggling with, particularly in our work with more difficult patients. It also invites us say "I wouldn't have done that" until one realizes that "I wasn't there".

I intend briefly to clarify Dr. Brod's use of the term "erotic transference", give my view of its meaning in this case, and conclude with some questions to clarify my conceptualization. I will not discuss the suicide contract. I will present little material to support my views - I think Dr. Brod's material cannot be bettered. Further, I will be brief, as I look forward to a lively general discussion.

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Terminology in psychoanalysis must be carefully defined or scientific discussion becomes impossible. I would prefer that the term "erotic transference" be used in a general sense to refer to the appearance, phenomenologically, of sexual wishes & feelings in the transference.

This phenomenon can then be sub-divided as follows:

a) Sexualization of the transference. During the analysis of some patients, male and female, experiences such as depression may be temporarily defended against by sexualization. This may occur at any time and the sexuality may be conscious, preconscious or unconscious. Typically it resolves either with interpretation or with passage of time and the underlying stress.

b) Transference love. This is the typical oedipal reliving of childhood sexual and affectionate feelings for the parents. It appears late in an analysis, functions as a resistance and its resolution only follows careful interpretation and working through.

c) Eroticized transference. This was described by Freud (1915) and more recently by Saul (1962), and Greenson (1967). Usually the patient is female.

Sexual feelings and demands for sexual gratification develop at the onset of the analysis and erotic pleasure during the sessions blocks therapeutic work. It is based on a primitive form of attachment and underlying hatred. Transfer to another analyst is a common management recommendation.

There is no"(d) Adult sexuality." The essential inequality of the therapeutic relationship in which one person's emotional life is placed in the hands of the professional-other, inevitably precludes adult sexuality whose essence is mutuality. Adult sexual states of mind are private and part of the self-analytic task (Meltzer 1973).

In the light of this categorization, where does Ms Lachmar fit ? I have rejected adult sexuality and transference love is clearly not appropriate. The erotic experiences had an early onset, but they did not totally dominate therapy and there was a sense of work getting done. She had periods where the erotic transference disappeared completely e.g. to be replaced by taking Quaaludes and a relationship with the drug-dealing boyfriend. It would appear that the eroticization is essentially defensive and does not represent the "eroticized transference".
Greenson (1967) suggests his patients were "more like impulse-ridden addictive characters with psychotic tendencies" - but the crucial point is that they were apparently settled middle-class neurotic housewives. Dr. Brod's patient <u>is</u> impulse-ridden, addictive and with psychotic features.
As a final point, there was no moment when Dr. Brod considered transferring the patient to another therapist - nor I am sure did any of us ever consider that alternative.

What do we know about such intense defensive sexualization of the transference ? Not very much - but a few things have emerged in recent years. Firstly excessive and unrestrained affect or instinctual expression is an indication of ego deficit which reflects defective integration of the self-representation. I do not need to argue the relevance of narcissistic features as they are central to Dr. Brod's thesis. But I do wish to indicate a direct link. Annie Reich (1960) pointed out how narcissistic pathology becomes "especially noticeably in the methods used for self-esteem regulation". Today we would broaden self-esteem to include all components of the self-representation and its regulation.

Does this apply to Ms. Lachmar ? In Session 2 she says that she does not have a clear sense of who she is. What then becomes "especially noticeable" ? The erotic transference! This, I suggest, is part of her self-regulation, i.e. the therapist participated with the patient (not colluded) in creating an existence for Ms. Lachmar. This existence permitted quite a varied number of intense experiences which had coherence and social value. Therapy felt alive - not dead, as possibly occurred in her phase of listless depression. Attention from the therapist was high and the patient could focus attention on herself in relation to the therapist. The crucial stabilizing function of attention is not generally given its full due. As an aside, I believe that patients with freer access to their fantasies and feelings may do better simply because the analyst can more easily pay attention.
While the above speculations may be true, they are still insufficient to explain the intense erotic transference.

There are two further points I wish to make and in this I am particularly drawing on my experience with a 30 year old male pervert (whom I will be reporting on in another context at the Thursday morning IPAC Paper session) and a girl with anorexia nervosa, who had been in therapy for 7 years and went through an intense erotic phase in which, unknown to me, she told those about her including University staff, that I was going to marry her after the conclusion of the treatment.

The narcissistic transference can be highly erotic because it stems from childhood experiences of fusion with mother at times when the child is used as an instrument for the gratification of mother's narcissistic needs. When the child acts as such a self-object for mother, he shares in mother's intense pleasure, which being primitive may be highly sexual and even ecstatic. The intimate connection with suicide is obvious in both the child's loss of individuality (=death) and rage and helplessness at having to give mother what she wants. We have to ask Dr. Brod (as the patient did) : What did you want ? What could catch your interest ? My anorexic patient barely spoke to me for about a year, during which time she missed two-thirds of her sessions and created havoc for herself and those about her in the outside world. She poured hopelessness, listlessness and futility over therapy for about 4 years. A similar patient referred by me for psychotherapy was rejected as being unsuitable, i.e. not giving my colleagues what they wanted.

Which brings me to my second point. I believe that Ms. Lachmar's erotic experience was related to her psychic pain. Pain being related to the difference between the way things are and the way the patient wishes them to be. As your patient said eventually, erotic gratification was not what she needed, nor was it what she directly wanted. She wanted fusion with you which she thought could be mediated via sexual intercourse. The pain of separateness can have an extraordinary intensity. In Dr. Brod's two vignettes, dysphoria is given a central place. My perverse patient used to compare his perversion with heroin. One of the vignette patients used drugs and Dr. Brod mentions that while Ms. Lachmar used drugs the erotic transference disappeared - you will recall the suggestion that it dulled her motivation.

However, despite a concluding reference to her as dysphoric, I found the account of treatment remarkably lacking in pain: there was mention of anxiety, excitement, rage, frustration - but little of pain.
I think this is crucial. I suspect this woman was incapable of spending a "lonesome weekend pining". I believe that she spent weekends in "painful isolation". The difference is not a matter of words but of conceptualization. I see the account therefore as an episode in generated, not spontaneous, emotions: a product of this woman's narcissistic mental organization.

Is this a criticism of a failed technique ? Not at all. Has Dr. Brod helped this patient ? Unquestionably and by one crucial act: he has been trying and he has <u>survived</u>. The patient has had enough strength to elicit his attempts and he has played his part. Because of this the quality of her life will improve. Whether therapy can and will progress beyond this is something I am sure Dr. Brod has been working hard on. If progress is not possible, the patient will either suffer recurrent break-downs or make a chronic unsatisfactory adaptation.

This brings me to my questions.
These pertain essentially to the two previous therapists who did <u>not</u> survive. How long did she see each of these ? Did she develop a similar erotic transference and how did they handle it ? Did she attempt suicide with them and how did they handle it ?
I put these questions for two reasons: they may provide evidence for my conceptualization (or against it), and the comparison between yourself and them, particularly their abandonment of her, must have been in the forefront of her mind in the early weeks, months, even years of therapy - unless of course over this period she was mindless from terror and pain.

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