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Stagnation, Chaos, and Severe Character Neuroses

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There are a relatively large number of unexplored issues in treating severely neurotic, character-disordered patients. The defining characteristics of these patients are formulated in dynamic, structural, and object relational terms. A discussion of the masochistic character is presented to exemplify such features. It is suggested that treatment is an inescapable struggle due to the distinctly created transference-countertransference ambience wherein character resistances emerge as therapeutic stalemates. The milieus characterized by stagnation and chaos are examined in relation to clinical examples. Finally, three essential technical issues are considered in terms of therapists' capacity to "hold" patients' externalized material, use the countertransference, and sooner or later, interpret primitive defensive constellations and transferences.

> Everything I have ever learned about a human being, has cost me a patient.[1]

Losing a patient is but one of several possible unpleasant outcomes in working with more severe character problems. Intense experiences of both chaos and stagnation often characterize treatment of such patients and render the therapist's task one of excruciating struggle, uncertainty, and displeasure which indeed can lead the otherwise dedicated clinician to wish for the loss of such a patient. This article attempts to shed additional light on this struggle by integrating pertinent theoretical and technical knowledge.

Therapists and analysts working with more severe character pathology, ranging from the more seriously ego-distorted character neuroses and per-

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[1]An apocryphal quote often credited to Sandor Ferenczi.

versions through borderline and psychotic disorders, face a continuing dilemma in terms of distancing themselves from their patients' internal worlds. The optimum is to avoid the extremes of becoming engulfed (i.e., fused) or detached (i.e., isolated). The skilled therapist, like a mother with her infant, must be capable of entering a "therapeutic symbiosis" (Searles, 1979), while embodying the "father principle" (Abelin, 1975) to facilitate the patient's disentanglement from more regressive symbiotic ties.

The therapist must struggle with being flexible enough to empathize with and understand the patient, while maintaining adequate boundaries to carry out the therapeutic task. This is no mean feat, and as Hellman, Morrison, and Abramowitz (1987) recently reported, therapists capable of both personal flexibility and sufficient professional distance are less likely to experience the stress evoked by such behaviors as suicidal threats, passive-aggressive manipulations, and expressions of intense negative affect. These empirical findings are particularly germane to treating character-disordered patients who present, by nature of their psychopathology, specific problems both in fostering therapeutic relationships and in understanding, exploring, and mastering their intrapsychic issues.

This article considers the defining characteristics of neurotic character disorders and presents a paradigmatic illustration in terms of masochism. The unique transference and countertransference ambience created by such individuals is then discussed and the therapeutic environments characterized by stagnation and chaos examined. Finally, I consider the essential technical issues in treating patients with severe character neuroses.[2]

SEVERE CHARACTER NEUROSES

Patients with neurotic character disorders can be distinguished in three ways: (a) by their *object relational style*, which relies on externalization and addictive objects; (b) by the *dynamic basis* of their disorder, wherein reactive character traits serve to bind anxiety; and (c) by their *structural deficiency*, which reflects ego weakness and concomitant reliance on primitive defense mechanisms. These three factors combine to produce particular transference and countertransference phenomena in the therapeutic setting.

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[2]This article concentrates on those character-disordered patients traditionally considered as character neurotics. The personality disorders generally classified as narcissistic, borderline, and psychotic, although similar in many respects (albeit suffering from greater degrees of psychopathology), are not specifically examined. The prevalence of character neurotics in clinical practice has been recognized for over 40 years (cf. Fenichel, 1945; W. Reich, 1945). A large number of contemporary patients suffer from more severe character neuroses and, as such, are focused on.

Defining Characteristics

Unlike symptomatic neurotics or (delusional) psychotics, character neurotics are particularized by their attempts to "externalize intolerable inner dramas that they do not wish to claim as their own" (McDougall, 1985, p. 65). Thus, these individuals aim to discharge painful tension through constant activity or, in McDougall's (1985) terms, "action symptoms" (i.e., acting out). As McDougall (1985) eloquently elaborated, their psychic economy is dominated by addictive compromises and they require "addictive objects" (in the form of substances or relationships) to function as tranquilizers or containers for what seems too difficult to assume as part of their own "psychic theater." In order to place their internal dramas outside, character neurotics must utilize the needs and weaknesses of others. However, because addictive objects represent failed transitional objects, they create no lasting internal change. Addictive objects, therefore, must be concretely present and consequently ceaselessly sought in the outer world. Because these addictive objects have an independent existence, unlike transitional objects, they can hurt or frustrate the character neurotic who constantly must manipulate other people to prevent pain and discharge inner tension. This process is demanding, exhausting, and inevitably unfulfilling.

Character traits of these individuals serve to bind anxiety and are understood dynamically as representing compromise formations between impulses and defenses (Fenichel, 1945; Kernberg, 1984; W. Reich, 1945). The traits involve a preponderance of reaction formations designed to produce a savings in terms of anxiety, in contrast to sublimations, and consequently, demand huge energy investments. Ego-reduction is a necessary concomitant along with fatigue, irritability, and a felt absence of anxiety. These traits resemble symptoms of which the patient has no insight, seem particularly difficult to treat, and "are, so to speak, secret psychoses" (Ferenczi, 1925/1926, p. 291). A major treatment goal is to render the pathological character traits ego-dystonic, like symptoms, thus enabling the uncovering of warded-off anxiety and underlying impulses (W. Reich, 1945).

Character-disordered individuals are also characterized by structural weaknesses and the consequent use of primitive defense mechanisms. The latter include *splitting* off part of what is felt, in order to garner control unconsciously or regain contact with the lost part, and *projective identification* (i.e., experiencing part of the self as an attribute of the other). Perceptual-cognitive immaturity reflects more specific developmental deficiencies which McDougall (1985) postulated as resulting from the lack of a genuine transitional object and a minimal identification to an internal caretaking mother for self-soothing and narcissistic well-being. Consequently, there is a reduced capacity to tolerate, understand, elaborate, and eventually resolve emotional tensions. This is illustrated by a patient who

used food and alcohol for self-soothing and comforting (i.e., tranquilizing). She eventually became "addicted" to a boyfriend for such functions; upon their breaking up, she came to rely on me similarly, experiencing herself as needing me "48 hours a day." That is, I served as a preoedipal ego or perceptual-cognitive function for her which had not been well-internalized. I attempted to attenuate this structural deficit by facilitating her evocative imaging of me. Like many patients, she required interventions addressed toward her structural deficiencies in order to experience sufficiently the anxiety bound by her character traits and, thus, only later could we analyze her use of splitting and projective defense mechanisms.

Persecutory projections are frequent for such individuals inasmuch as the "drug" other fails to make provision for their happiness. A profound ambivalence toward the need-object results. Given these patients' incapacity to deal with certain thoughts and affects, the object is held responsible for the difficult, uncertain, and tormenting aspects of their experience, and the transference situation becomes impregnated with hostility and extreme dependence. Such patients experience great difficulty putting into words the love and hate toward their therapist that needs to be rendered meaningful (McDougall, 1985). The basic therapeutic issue becomes one of finding ways to get thought and affect in usable form so that it can be addressed in treatment.

A PARADIGMATIC EXAMPLE: MASOCHISTIC CHARACTER

The masochistic character or "moral masochist" illustrates the dynamic, structural, and object relational aspects of neurotic character disorders. W. Reich (1945) viewed the masochistic character as making an "abortive attempt to rid oneself of anxiety and unpleasure" (p. 245), whereas Reik (1941) highlighted the "victory through defeat" (p. 429) achieved by such a coping style. Brenman's (1952) classic analysis stressed the operation of primary drives, ego defenses, and synthesizing or creative ego functions. She described masochistic phenomena as:

> . . . a highly organized, hierarchically stratified set of functions designed simultaneously to express aggression, however circuitously, and to obtain gratification of infantile needs in fact or fantasy, however long delayed. The circuitousness and the delay are mediated by a complex organization of defensive and synthetic ego functions. (Brenman, 1952, p. 281)

The primary drives reflect excessive, immutable demands for love (determined both by real disappointments and a strong need for love) and the consequent rage when the need for love is frustrated in fact or fantasy. W.

Reich (1945) ascribed the inordinate demand for love to intense experiences of very early fears about being left alone. For example, a masochistic patient I treated would report elaborate fantasies and dreams of banging his head and splitting it open on my desk and of being killed in view of my window. Subsequent genetic material revealed an intensely terrifying experience of being left as a 3-year-old to babysit his infant sister and later being punished for running to his neighbor's house in fear, leaving his baby sister alone.

The inability to bind anxiety adequately over the loss of love is specific for masochistic characters and frequently is manifested in heightened skin eroticism (i.e., the desire to feel skin warmth). "Warm me" thus tends to mean "protect me" and may become unconsciously linked with "beat me." For example, a severely masochistic patient initially presented herself as suffering from "a highly sensitive clitoris" and would typically request both a blanket and a warmer room temperature whenever her unconscious sense of losing my love was particularly intense.

Reik (1941) regarded the unconscious sadistic fantasies of such patients as the soil in which their masochism grows. The main problem is not the need for punishment or guilt, but rather hatred for one's object. Dynamically, masochism can be understood as "inverted sadism." One analysand painfully experienced herself as "stopped up," unable to think or talk session after session. She began to plead with me to "make" her talk, while urging me to "kick" her and treat her badly. The impasse, while overdetermined, was attenuated only when we were able to examine the pleasurably sadistic fantasies she harbored toward me.

Ego defenses, including denial, reaction formation, introjection, and projection, serve to check the threat of anxiety and the underlying unacceptable impulses. Denial and reaction formation produce the phenomenology of suffering and complaining while introjection and projection result in a provocative approach to all human relations (Brenman, 1952). This latter, more paranoid quality can be understood as reflecting the primitive defenses of splitting and projective identification which serve to externalize the masochist's unacceptable insatiable demands and hostile impulses. Thus, others may be perceived as inordinately needy while the masochist tends to be inexhaustibly giving, or alternatively, others are seen as hostile, exploitive users of people while the masochist experiences his or her chronic misfortunes and sufferings as the fault of others.

When the masochist's ego defenses, along with synthesizing or creative ego functions, are functioning reasonably well, the individual is able to modulate the primitive drives via adaptive inventions. Brenman (1952) gave prominence to the good humored "teasee" and the sly jester who unmasks others wittily while seeming to engage in self-caricature. Thus, one such patient would become particularly witty during periods of ego consolidation.

He once presented himself as a gullible fool in believing a story he had heard that I had an evening job at a seedy nightclub where I performed unsavory acts with various animals to the chagrin of my family. During these periods of successful masochism, the ego maintains an equilibrium between primitive drives, defense mechanisms, and adaptive ego functions.

"Decompensation" tends to occur when the ego's ability to maintain this balance is weakened, typically through a threatened or actual loss of love. When this occurs, the crucial ego controls disappear and the raw drive components emerge more sharply in the form of infantile need and rage. Emotional blackmail or "extortionist demands for love" surface in the form of relentless self-depreciation, suicide attempts, actual destructiveness, undisguised rage, and psychotic depression (Brenman, 1952). For example, one patient became extremely provocative toward me whenever she was visited by her mother. The anticipation of experiencing any displeasure with her mother, who had been severely depressed and quite rejecting during her early childhood, represented the threatened destruction and loss of attachment to the good mother inside. She therefore sought to externalize the cruel maternal imago onto me while extorting my love through her unrelenting suffering. On one such occasion, the patient did not appear for her session but called at the end of the hour, leaving only the challenge on my answering machine, "Where the hell are you?" She called back 10 min. later and, when I answered, berated me for not returning her call and depriving her of a "desperately needed session." Attempts to clarify that she left neither a message to return her call nor a phone number where she could be reached served only to confirm my seeking to blame her and my complete lack of concern for her. She proceeded to wail unsparingly about her pain and the urgency she had felt to see me. The situation slowly began to change in subsequent sessions when I was able to convey to her how very unloved she seemed to feel; I then wondered aloud if something had happened prior to the telephone call to cause her such pain. In fact, she attributed her upset to not having heard from her boyfriend for several days.

Provocations of the therapist in these forms or through infantile spite or masochistic silence are frequent and partially reflect an attempt to cause the therapist (i.e., need-object) to act badly, permitting the externalization of a cruel, sadistic inner object, thereby giving grounds to the reproach, "See how badly you are treating me" (Brenman, 1952; Kernberg, 1980; W. Reich, 1945). These efforts represent a perverse way of asking the addictive objects for love. As W. Reich (1945, p. 245) astutely noted, these patients are saying, " 'See how miserable I am—love me!', 'You don't love me enough—you are mean to me!', 'You *have* to love me; I will *force* you to love me; if you don't love me, I'll *make you* angry!' " (italics added). The underlying vindictive, retaliatory impulses (i.e., sadistic fantasies) must be analyzed and ego functioning rebuilt for successful treatment.

TRANSFERENCE-COUNTERTRANSFERENCE ENVIRONMENT

Pathological character traits acquire specific transference functions—namely, they prematurely and consistently intrude into and invade the transference situation (Kernberg, 1984; W. Reich, 1945). A typical transference neurosis takes time to develop and is usually accompanied by a diminishing of the patient's neurotic manifestations outside the sessions. In contrast, the transference of severely character-disordered patients, consisting of externalizations of parts of the self, plays out a pattern in the sessions that simultaneously persists in real life as well. Transference and character resistance are frequently condensed so that the transference is masked by the patient's character pathology. For example, Mr. H., a severely obsessional character with marked masochistic features, had no particular sense of me or the therapy, wasn't sure why he continued to come but saw "no reason to stop," and yet, consciously tried very hard to "get the most from therapy" by remembering and reporting in each session several dreams in prolific detail.

Such individuals are likely to be disturbed in the communicative use of language, thus their pathological character traits tend to be expressed in nonverbal rather than verbal (i.e., free associative) behavior (Bollas, 1983; Kernberg, 1980; Modell, 1976; W. Reich, 1945). The use of splitting off part of what is felt and projectively identifying a part of the self as an attribute of the other, renders nonverbal and bodily cues the primary means for communication. To illustrate, Mr. L., a 40-year-old depressive character with narcissistic and obsessive features, frequently wore a tee shirt depicting an atomic bomb blast with the caption, "That's all, folks," in an attempt to depict an intensely destructive intrapsychic conflict between his desires and his primitive, sadistic superego. Thus, externalization became a means for undoing through nonverbal character traits.

McDougall (1985) discussed this means of expression as characteristic of alexithymia, wherein primitive communication predominates (i.e., words are used like cries and gestures, as acts to affect another person rather than to communicate something). This difficulty in connecting words to affect involves deficits in describing affective states and in distinguishing among affects. A disavowal of (painful as well as pleasurable) affectivity may be apparent and often tends to accompany character disorders, psychosomatic personalities, and narcissistic dispositions. As McDougall stated: ". . . alexithymic patients . . . use postures, gestures and words to stir up considerable feeling in others and actually induce them to cooperate in keeping this distance" (p. 174).

These pathological character traits, representing compromise formations between impulse and defense, lead to disguised impulse gratification in the

transference (Kernberg, 1984). Thus, Mr. H.'s intellectually insightful analysis of his own dreams not only kept me at a distance, thereby binding considerable anxiety and discomfort, but moreover gratified his more sadistic oedipal impulses to "castrate" me while simultaneously reassuring himself that I was not needed.

The countertransference with these patients inevitably is tormenting as a result of their need to express their character resistance by means of ego-syntonic externalization mechanisms (McDougall, 1985). Bollas (1983) noted how many such patients use externalization to create environments where they and their therapist can live a "life" together. The therapist becomes an addictive object as these patients convey their internal worlds by establishing an environment in the clinical situation and manipulating the therapist through object usage. The resulting externalization reflects both the patient's projective identification and the therapist's unique responses to life within the patient's environment (Giovacchini, 1979; Searles, 1986). Typically, the patient creates affects in the therapist who must then hold and contain this creation.

This process closely resembles how a baby speaks to its mother, and it produces what is an inevitable and necessary disturbance of the therapist. Bollas (1983) believed that the infant element in the adult patient speaks to the therapist through the sort of object usage best seen through the therapist's countertransference—in other words, the patient must affect the therapist so that the infant within can find a voice. Searles (1979) discussed this form of relatedness as a necessary therapeutic symbiosis. Like mothers with their infants, therapists of these patients must understand moods, gestures, and needs as utterances requiring (maternal) perception, reception, and transformation into some kind of representation and possibly resolution. For example, a particular patient of mine can evoke in me a state of terror and desire to protect myself through escape simply by means of her gaze and manner of movement in entering my office. Another character-disordered patient with hysterical features, fearful that I will not think about or consider her, needs to affect me by creating an erotic state through gestures, nonverbal features, dress and primitive communication with words.

Therapists must use particular methods in order to control and therapeutically utilize their own emotional reactions activated as countertransference in these cases (Bollas, 1983; Kernberg, 1980; Modell, 1976; Pick, 1985; Racker, 1968; Searles, 1986). Bollas (1983) poetically described this process as the therapist's necessary experience of degrees of madness—a veritable situational illness which must be treated within oneself in order to facilitate the patient's cure. Searles (1986) stressed both fostering and exploring the countertransference neurosis or borderline psychosis. Racker (1968) and Kernberg (1980) emphasized the importance of analyzing the negative countertransference (and thus restoring the positive countertransference), to preclude entering into talionic-retaliatory or escape

modes. W. Reich (1945) suggested that stagnations in working with character neurotics frequently stem from a failure to recognize the negative countertransference (i.e., countertransference resistance) reflecting the therapist's difficulties in facing his or her own sexuality, aggression, and/or narcissism. Needless to say, such patients can teach us a great deal about ourselves.

CREATED THERAPEUTIC ENVIRONMENTS: STAGNATION AND CHAOS

As these patients play out their inner dramas in the treatment situation, character resistances emerge in two prevalent forms. Each reflects the playing out of activated object relations along with the splitting off of conflictual impulses (Kernberg, 1984). I consider these two typical configurations in terms of *stagnation* and *chaos*.

Stagnation reflects an impasse or stalemate wherein significant change is lacking. W. Reich (1945) described such a situation wherein "everything the patient has offered serves a secret, unrecognized resistance" (p. 26). Patient associations may seem to flow and abundant material is produced, yet there is no deepening of the transference situation and no working through. A "schizoid compromise" is created as a means to retain a relationship lacking full emotional response (Guntrip, 1969). For example, Ms. T. offered abundant associations albeit shorn of affect. Her speech was monotonous, dry or empty, and there was an absence of feeling even in relating more traumatic events. Her dreams could rarely be interpreted, although she often provided reasonable psychoanalytic explanations. My countertransference soon surfaced in boredom, sleepiness, and indifference which in time gave way to withdrawal and hostile impulses. Following a lengthy period of holding these affects and eventually examining the basis of my reactions, I was able to begin interpreting the patient's sadistic sense of triumph in keeping her anxiously dependent, inner self withdrawn.

Lasting periods of stagnation reflect particular disturbances of the patient's inner world. According to Kernberg (1984), patients who deny the emotional reality in the transference or who ultimately deny the help received from the therapist suffer from unchanged grandiosity in severe narcissistic structures. Others view the situation as a necessary passage on the patient's way to finally facing the frightening sense of isolation and the ultimately withdrawn infantile self (Fairbairn, 1952; Guntrip, 1969). Such patients use the treatment to replace life, expressing by their behavior the urgent wish and magic command that therapy continue forever without any change in their daily reality. Modell (1976) described this as a "cocoon fantasy." Therapists can easily collude with such processes unconsciously by coming to feel that the patient will experience any challenge to this stable

equilibrium as an unbelievable act of cruelty. Certainly, the situation should not be ruthlessly exposed inasmuch as such defenses against more archaic, psychotic terrors of implosion or explosion are necessary due to insufficient psychic structure in the form of truly caretaking maternal imagos (McDougall, 1985). The alexithymic and psychosomatic patients must drain external relationships and object relations of their meaning by attacking their own capacity to capture and use affect as a signal for thought. However, the created stalemate can be augmented or attenuated by the therapist's capacity to use the countertransference, to hold the patient's externalized material, and sooner or later, to interpret its unconscious meaning.

Chaos pertains to a therapeutic situation reflecting severe distortions and/or pathological behavior patterns which either suddenly emerge or become apparent over a period of time. This is marked either by patients' active attempts to destroy the therapeutic environment or by their violent expulsion of affect (and its mental representations) resulting from decompensation. The former represents the activation of the deepest levels of aggression (Kernberg, 1984), whereas the latter relates to the breakdown of alexithymic, defensive attempts to keep archaic, psychotic terror at bay (McDougall, 1985). In either case, chaos ensues as the patient destroys three essential elements in the treatment situation: (a) time, (b) the therapist's concern and dedication, and (c) the therapist's cognitive understanding and empathy (Kernberg, 1984).

With the destruction of time, temporal perspective is lost. It is as if time halts between sessions and as if both patient and therapist will live forever. In destroying the therapist's concern, love, and dedication, patients relentlessly accuse their therapists of not loving them. Love is destroyed with a cruelty that is projected onto the therapist. For example, a patient would frequently begin her sessions by asking, "How are you going to make mincemeat of me today?" Any intervention would then be attacked—words became malevolent assaults and silences were experienced as savage demands. Closely related is the destruction of the therapist's cognitive understanding and empathy. In this case, the helpfulness of human understanding is rendered meaningless or worse, a sadistic attack on the patient. Thus, Mr. L. experienced my efforts to empathize with the pain he felt from a rejecting boss as my self-aggrandizing effort to blame him for being too sensitive.

Vicious cycles are evident in such chaotic circumstances wherein patients experience a sense of relief in provoking their therapist's counterattacks. When the therapist persists in not responding to hatred with hatred, the patient's envy and resentment of the therapist's commitment and dedication reinforce the guilt over mistreating the therapist and, concomitantly, further the patient's need to escape from guilt. Klein (1957) described this situation as a negative therapeutic reaction. Further provocation is undertaken until finally the therapist loses patience and counterattacks. When this

occurs, the patient has sadistically acted out a triumph over the therapist (further increasing his or her guilt and the need to defend against it). For example, Ms. M. had been attacking me vitriolically for several weeks, accusing me of exploiting and not caring sufficiently about her. I was able to contain and examine my countertransference hatred until, after one unrelenting series of attacks, I responded in kind by sadistically interpreting her projective processes. She experienced my rage and responded with considerable relief as she noted, "Well, at least you're human." Her attacks ceased for the time being while she undertook reparative efforts. Although her momentary triumph was relieving, her guilt and defensive needs were solidified as evidenced in intensified subsequent provocations.

TECHNICAL ISSUES IN TREATING SEVERE CHARACTER DISORDERS

There are several fundamental technical considerations in treating these patients. Kernberg (1984) described the characterological goal as humanizing such individuals, an aspiration calling for the long road toward understanding which inevitably takes the form of chaos, depression, and suffering. I discuss three essential technical issues pertaining to this goal. These concern: (a) the nonspecific effects of all therapeutic interventions in terms of the holding environment, (b) the therapist's use of his or her own subjective states of mind or countertransference, and (c) the interpretation of primitive defensive constellations and transferences in order to improve patient ego strength. These three dimensions are separated here primarily for expository purposes inasmuch as there is considerable overlap within the clinical encounter. Nonetheless, the first two more directly foster the progress of psychoanalysis or psychoanalytic psychotherapy, while the latter dimension effects some lasting change in the patient. I briefly examine each of these according to how they typically emerge in treatment.

Provision of a Holding Environment

Both Modell (1976) and Kernberg (1980) stressed the importance for patients with ego weakness of the nonspecific curative effects of all therapeutic interventions. Such nonspecific effects are believed to derive from auxiliary ego functions carried out by the therapist. In contrast, the more specific effects of psychoanalytic psychotherapy and psychoanalysis are derived from interpretation and involve transformation by integration. The nonspecific effects, particularly during periods of stalemate, stagnation, and chaos, involve the provision of a holding environment (Winnicott, 1965) consisting of affective holding and cognitive containing. In the former, the therapist is experienced as a "holding mother" whose presence

provides an "illusion of safety and protection," cognitively and emotionally absorbing as well as tolerating the patient's chaotic and stagnant material. The latter entails integration or metabolization of this material via interpretative comments.

McDougall (1985), in elaborating on the affect pathology of character-disordered patients, emphasized the importance of furnishing a strong holding environment so that the words that are missing or deadened can once more become alive in order to render verbal representation possible. Such patients can indeed be understood as suffering from a developmental failure of the holding environment (Modell, 1976) or from the lack of a nurturant, truly caretaking maternal introject as an object of identification (McDougall, 1985). The therapist thus becomes a "transformational object" (Bollas, 1983), perceiving, receiving, and transforming the preverbal, infant elements in the adult patient by providing the maternal function of holding the infant. This holding environment supplies an illusion of safety and protection from dangers from both without and within (e.g., aggressive impulses), an illusion that is otherwise absent for such patients, particularly during periods of stagnation and chaos. The basic therapeutic issue for the patient becomes one of acquiring a feeling of trust in the therapist and his or her capacity to accept, bear, and understand feelings of love and hate (McDougall, 1985). This frequently entails the therapist's more actively creating the requisite illusion by maintaining an emotional position of acceptance, patience, and empathy. Modell (1976) even suggested that the healing forces of such holding environments have biological roots.

The therapist's holding functions in chronic stalemates frequently involve accepting the patient's unconscious aggression without being overwhelmed by it (Kernberg, 1984; Winnicott, 1949). Thus, the analyst "must be prepared to bear strain without expecting the patient to know anything about what he is doing" (Winnicott, 1949, p. 72). In this way, even in the most hateful patient, a potential for loving and living is nurtured. Such periods of "quiet togetherness and intimacy" (Kernberg, 1984, p. 250), wherein the therapist is simply present, empathically and intuitively understanding, must be distinguished from more defensive retreats into passivity and silence which reinforce patients' feelings that their envious attacks destroy their therapists' creative, independent thought processes. Such a patient switched into treatment with me after experiencing a 6-month hypnotherapy with a therapist who purportedly induced trance while remaining silently present after directing the patient to "experience your own creative healing forces at work so that you can feel good about yourself." My new patient said he was tremendously helped by such a treatment and was only coming to me to try a different approach (knowing that I also was skilled in hypnosis). In initially discussing the nature of his difficulties, he soon became enraged with me, stormed out of the session, and later telephoned to say that he wouldn't be back because he "didn't want to have to discuss

things that would only make me hate myself again." Needless to say, the therapist's tolerance for one's own and others' aggression is extremely important in working with such individuals. In this case, I was left holding the hatred of someone never to be seen again.

Such holding functions appear to facilitate the necessary ego consolidation for these otherwise ego-weakened patients. Characterologically, or perhaps during those periods of regression typified by stagnation and chaos, such patients do not experience a sufficient therapeutic alliance to be afforded the illusion of the magical protection of the analytic setting (Modell, 1976). Interpretations are not mutative in such an atmosphere of insufficient self-object differentiation.[3] Interpretations tend therefore to be dismissed, not heard, resented as intrusions or criticisms, or may otherwise simply function as a part of the holding environment, signalling the therapist's empathy and understanding. To illustrate, one such patient during a chaotic interval, experienced my interpretive comments as intrusions and in no uncertain terms told me, "Shut up, will you!" Another patient did not hear my words as opportunities to understand herself, but rather heard my voice as a soothing background like a wind chime.

Therapist's Use of the Countertransference

Technically, the therapist's use of his or her own subjective states of mind is essential with such patients.[4] As a result of the patient's use of externalization mechanisms, the therapist is employed as an addictive object wherein the patient's freely associated ideas and affects become relocated and the full articulation of the preverbal transference evolves in the therapist's countertransference (Bollas, 1983; Garfield, 1987; McDougall, 1985; Modell, 1980). Moreover, because the patient's already deficient observing ego tends to be swept up in the emerging preverbal transferences, the unconscious aspects of the patient-therapist interaction "in the here and now" be-

[3]Modell (1976) discussed the role of the holding environment in facilitating the necessary ego maturation for accepting self-object differentiation. Kernberg (1980) attributed the need for such holding not primarily to the failure to differentiate the self from the nonself, but rather the failure to integrate good and bad self- and object-representations which creates an inability to trust and rely on an object in the face of aggression toward it (this is particularly reflective of the pathology of borderlines). A more complete discussion of these differing views is beyond the scope of this article.

[4]Freud (1912) first indicated such use of the therapist's subjective states when he declared that the analyst "must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (p. 115). Hann-Kende (1933/1953) later suggested that the emotional responses of the therapist could be used as facilitators of the analytic process. Kleinian-oriented analysts subsequently focused on the clinical use of the therapist's response while differentiating more integral countertransference from pathological countertransference reactions (Heimann, 1950; Money-Kyrle, 1956; Racker, 1968; Segal, 1978). Other classical and interpersonally-oriented analysts have imaginatively developed these ideas in the clinical setting (Little, 1951; A. Reich, 1960; Searles, 1986; Tower, 1956; Winnicott, 1949).

come crucial toward understanding the object relations being played out (Kernberg, 1984). As Searles (1986) put it, ". . . the analyst's 'own' personal torment needs to become translated into a fuller understanding of the patient's childhood-family events and daily atmosphere" (p. 214). The skilled therapist must inevitably explore his or her subjective state of mind and reactions to the patient in order to put the preverbal element into some kind of speech.

Therapists working with such patients ideally "split" themselves into two sides—namely, an experiencing and a more distancing side. The highly skilled and invariably less stressed therapist is better able to maintain both sides, or, as discussed by Hellman et al. (1987), the necessary flexibility and boundary firmness. Bollas (1983) discussed this distinction as a generative split based on the therapist's capacity to permit his or her use as an object of the patient's transferences. Simultaneously, the therapist must be capable of maintaining objectivity precisely at times when it is most challenged (Kernberg, 1984). Pick (1985) addressed "walking the tightrope between experiencing disturbance and responding with interpretation that does not convey disturbing anxiety" (p. 157). In other words, the therapeutic functions of observing, assessing, and holding must remain intact while the therapist tolerates intense countertransference attitudes and feelings.

In Bollas's (1983) provocatively subtitled article, "Notes to the Patient from Oneself," prominence was given to the therapist's learning to use himself or herself as "the other patient" in working with patients who rely on using their therapists to convey their infantile life. In this way, and Bollas believed in only this way, can the therapist bring back to the patient what has been lost or bring those parts to the patient's attention that may never have been known. As I previously noted, this use of the countertransference further reduces the likelihood of the therapist's becoming retaliatory or escaping, and undoubtedly enables a better provision of the requisite holding environment.

Two types of interventions ensue from using countertransference as a source of material with these patients—namely, the indirect and the direct expressions of the therapist's subjectivity (Bollas, 1983). In the indirect use, the therapist becomes a witness for his or her own feeling state and may offer this feeling state for the patient's consideration by telling the patient what is sensed about him or her. For example, one such patient of mine was sullen, silent, and actively withdrawn during a particularly stagnant period. I suddenly had a fantasy of walking in a crosswalk with my infant daughter and being unable to protect her from the onslaught of a speeding, recklessly driven automobile. I tried to leap up with her in my arms but the car bounced up to hit her. I felt enormously pained and helpless, realizing I had lost what I felt was most precious to me. In reflecting on the fantasy and my affect, I eventually chose to communicate them indirectly by offering the patient my hunch that he seemed to feel unable to protect what he most

valued inside (in view of his mania, which we had previously termed his "nursery school Mussolini," mowing down anything in its path). He initially became more withdrawn and then very sad as he spoke of being terrified.

The direct use of the countertransference refers to the rare occasion wherein the therapist describes how he or she feels in being the patient's object. For example, during an intensely chaotic interval with Mr. W., I began to feel utterly helpless, impotent, and a failure as a therapist as he attacked mercilessly. My hatred for him was mounting and I began to feel like strangling him in order to feel some effectiveness and end the torment emanating from countertransference anxieties of a more psychotic proportion (cf. Winnicott, 1949). I chose to express helpless rage directly by telling him, "I am experiencing myself as unable to do anything to reach you—a complete and utter failure as your therapist." As I recognized him beginning to sit back, I asked, "What do you think might be going on?" To my surprise, he seemed human again and somewhat relieved as he responded, "That's how I always feel."

Therapists working with such patients must identify, cognize, and give verbal representation to their own associations, images, sensations, and affects. As Bollas (1983) so aptly stated:

> In order to reach many of our contemporary patients . . . it is necessary for the analyst to use himself more directly as an area of shared knowing through his experiencing. From his experiencing he can establish not only the value of feeling states and subjective states, but he can find a way to use this form of countertransference experiencing for eventual knowing. (p. 34)

Interpretation of Primitive Defensive Constellations and Transferences

Character-disordered patients employ such primitive defenses as splitting, projective identification, denial, omnipotence, idealization, and devaluation. The operation of such defenses has a serious ego-weakening effect. Tactful and well-timed interpretation, particularly in terms of exploring and resolving the primitive transferences, is thus necessary to improve ego strength, integrate part-object relations into total object relations, and facilitate the gradual development of an observing and integrated ego function. Brenman (1952), for instance, testified to the importance of such defense interpretation among masochistic characters.

Various parameters or tactics (cf. Levy, 1987) are necessary when employing interpretation with such ego weakened patients, particularly during stagnant or chaotic periods. This is due to the patients' lack of sufficiently internalized (maternal) self-soothing, their difficulties in integrating verbal communication, and the inadequate or regressive fading of the observing

(nondefensive) ego functions. Schafer (1982) emphasized the importance of avoiding a constantly adversarial tone, in part by helping such patients recognize their ability to resolve conflicts differently (whenever such abilities appear). Kernberg (1980, 1984) discussed the establishment of parameters of technique as well as the structuring of the patient's external life in order to protect the therapeutic situation from the danger of severe acting out or in. These parameters include clarifying patients' understanding of their therapists' interpretations and focusing on the immediate reality of the patient's life and ultimate treatment goals (in contrast to the more limited transference analysis) in order to disentangle life goals substituting for more realistic treatment goals. For example, a female supervisee's unmarried patient in his 40s originally requested a "Jewish, heterosexual woman therapist in her 30s." Shortly thereafter, his unrealistic life goal, masquerading as a treatment goal, was revealed as he spoke of just wanting to feel loved and cared for by his therapist. In the second year of therapy, during a chaotic interval marked by disappointment, he began referring to treatment as a "failed marriage."

Other writers, including Pine (1985) and Schaffer (1986), specified several related issues in offering interpretations to similar patients. Pine (1985) stressed giving interpretations in the context of support in order to protect the fragile patient from excessive stimulation while simultaneously being encouraged to grow and change. The therapist attempts to maintain the patient's highest level of defense while providing a holding object relational context in order to advance interpretation. For instance, this involves closing off any implicit expectations as to the patient's responsibility for associative responses to an interpretation to reduce the likelihood of panic or flight while highlighting the therapist's consistent presence by using supportive words and reassuring tones. Schaffer (1986) discussed these issues in terms of an "affirmative analytic attitude" wherein interpretations explicitly demonstrate genuine appreciation for the adaptive value of the patient's behavior and/or for the patient's ways of unconsciously maintaining his or her lifestyle despite its problems.

Many interpretive, clarifying, and confrontive tactics and attitudes reflect an optimistic outlook in contrast to a quiet, masochistic submission to a patient's omnipotent control of sessions. Such therapist tactics are considered helpful in resolving stalemates manifesting as chaos and stagnation (Kernberg, 1984). For example, the therapist can actively confront the patient during periods of stagnation with the fact that nothing is happening and exploring why this is so. Kernberg referred to this as "impatience in the here and now" (p. 244) and considers it far better to be a "bull in a china shop" (p. 246) than to collude with the patient's character resistances. This active approach (directed toward the patient's destruction of concrete psychotherapeutic work) reconfirms the therapist's concern, intolerance of impossible situations, and confidence in the possibility of change. Such

confidence in the patient becomes the therapist's basis for strength in confrontation as it is thereby freed of punitive implications. Likewise, therapists maintaining such basic trust in their patients' capacity to learn reduce the likelihood of being drawn into guilt stemming from the patients' accusations that the therapist is attacking them through interpretations.

CONCLUSION

In contrast to both lesser and more severe psychopathology, there are a relatively large number of unexplored issues concerning both the defining nature and treatment of severely neurotic, character-disordered patients. I have attempted to clarify a portion of these by considering the dynamic, structural, and object relational features of such patients prior to briefly examining both the inevitable transference-countertransference reactions and ensuing therapeutic environments of stagnation and chaos. Treatment is an inescapable struggle and, in hoping to ease both our patients' and our own tasks, I have discussed three fundamental technical considerations in resolving these stalemates. These involve holding patients' externalized material, using the countertransference, and interpreting primitive defensive constellations. Although there are no shortcuts on the long road toward characterological change, a greater understanding of the unavoidable pitfalls in treating such patients will reduce the severity of the therapeutic chaos, stagnation, and inexorable stress within the treatment process.

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