The Patient as Existential Victim:
A Classical View

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Dr. Fosshage and his patient have earned our gratitude by their willingness to share with us a portion of their therapeutic work together. As is to be expected, it was not an easy decision, given the inevitable impact on their analytic process, as well as the concern about publication of sensitive material. In deciding to make this contribution, they have provided us with an unusual opportunity to clarify some of the theoretical stance on the conduct of an analysis.

In this fascinating clinical material, we hear an echo of "The Two Analyses of Mr. Z." (Kohut, 1979). Again, a first analysis, while helpful in bringing some order to the patient's life, ended in an impasse and the patient in a state of chronic depression. This result appears to have been related to the patient's demands for expressions of caring from the analyst, whom she regarded as helpless, apparently unwittingly entering into an enactment of a possible distortion in the analyst's report. The analyst's behavior was described as evasive and "a walking corpse." While making allowances for empathic, apparently unwittingly entering into an enactment of a major transference fantasy, some elements of which were to become clear in the analysis, the patient, forewarned by this burden carried by the analyst, and forearmed by his more empathic portrayal of the patient, and perhaps by a more open and responsive personality, Dr. Fosshage was rapidly made the object of idealizing, romantic fantasies. Whereas the patient had previously often turned to God, envisioning Him as an idealized figure to whom she could turn for uplifting guidance, she now turned to the analyst. On one occasion, the patient experienced a profound sense of comfort and safety in imagining the analyst's face traversing the sky. However, this was insufficiently reassuring, and the patient forcefully and desperately demanded affirmation and care. The analyst accepted and tried to convey her genuine caring for the patient, demonstrating her own experiences in growing up with self-absorbed and withholding parents. These interventions were accompanied by efforts to convey his genuine caring for the patient, demonstrating his own experience in marked contrast to that with the first analyst, and acting as trauma personally affecting the patient's view of herself and her mother. The patient felt emotionally abandoned by her mother, her early experiences of neediness and self-absorption, later, with a father described as powerful and vulnerable and a mother said to be paranoid and needy.

Dr. Fosshage reports several key experiences seen as typical, and acting as trauma personally affecting the patient's view of herself and her mother. The patient felt emotionally abandoned by her mother, her early experiences of neediness and self-absorption. Apparently turning to her father for connection and recognition, she felt for a time selected as "his special one," with romantic overtones, only to have this specialness denied publicly in a humiliating way. This experience led her to mistrust her own perceptions and to feel wrong and shameful. With both parents she was made to feel that she was to be responsive to their needs and "self-interested love," rather than expect them to respond to her needs.

I have given this brief condensed recapitulation in largely paraphrased form in order to set the stage for a number of questions and to suggest some alternative views.
will be focused on what appears to be a missing dimension, that of the inner life of fantasy and the contribution of the patient's idiosyncratic needs and defenses, in the processing and transformation of the undoubtedly traumatizing experiences at the hands of her parents. This is not to deny the beneficial effects of Dr. Fosshage's responsiveness to her needs for affirmation and caring, his clarification and delineation of the precariousness of her self-esteem and doubts about deserving to be cared for.

Although the author speaks of "illuminating the genetic origins" of these feelings, he seems to be using the word genetic to mean memories of experiences during childhood, especially those of deprivation and frustration of needs by the self-absorbed parents rather than genetic in the sense of the etiologic contribution made by the patient's internal efforts to master the external trauma by fantasy and defensive distortion. For example, she might well have projected her own neediness and rage onto the image of her parents, thus disclaiming her own and magnifying her parents' motivation.

Some of the historical and clinical material will illustrate my suggestion that the therapeutic process might be enriched and deepened by an awareness and search for the additional dimension of unconscious fantasy and conflict. The patient's memory of her hospitalization at age three may be useful. Here, as in the recounting of her parents' and previous analyst's behavior, we may be in a position to expand our view if we consider the possibility of screen-memory formation. While accepting and working with the psychic "truth" represented in the remembered and the manifest experience, our psychoanalytic approach must consider the additional and latent meanings. This approach is of value generally, even in the most prosaic and "realistic" kind of memory and content, and in the case of this memory, our curiosity should be aroused by several interesting signals. My own speculations included: How much can we take at face value a memory from age three? And for that matter, how does the patient know she was age three? Is this derived from documented fact, family stories, home movies or pictures? And what about all those threes: age three; three days before mother came; in Friday's dream her sister's death-like sleep for three days; and an analytic schedule of three sessions a week into the third year of analysis? All this without drawing on three as a phallic or oedipal symbol! In regard to the thrice-weekly schedule it would be interesting to know the patient's role in agreeing or insisting on that frequency. Could the meaning of three carry such potent valence as to play a part in setting up an enactment with the analyst, replaying some old scenario (mother didn't come to the hospital for three days) in a transference-countertransference collusion to express simultaneously a pressing unconscious motivation for mastery and gratification, while resisting its analysis? After some clarification of her character patterns of relating in the analysis (the "intensity" with the mother, and the "romance" with the father) the patient felt a need for a deeper "connection" and added a fourth session. The additional session did indeed seem to deepen the process by diminishing the more florid aspects of the enactment, although it is not clear that the meanings of this shift were explored as fully as they might have been.

Some of these meanings become clearer in the first reported session (Wednesday). She doesn't like the added session, fearing she can't generate enough material, but this fear, clearly a rationalization, is soon revealed as a wish to avoid the emergence of new feelings, feelings previously avoided by idealizing and erotizing the relationship with the analyst. The first of these feelings is that she won't like the analyst, and while she insists that having been convinced by the analyst that she is likable and therefore not worried about his liking her, she is still worried about hurting his feelings with her criticisms.

Her concern represents a most interesting shift that I would conceptualize as moving from a narcissistic defensive level to a more object-related conflict around guilt over hurting a loved one. The previous need for affirmation and caring from the idealized analyst cannot be ascribed simply to a deficit owing to a lack of empathy from self-absorbed parents. Rather, the patient has
recognized that the idealizing and romanticizing had defensive meanings of avoiding “deeper connections” with feelings of love, hate, guilt, and obligation toward important people in her life, past and present.

The analyst is here faced with several choices. Should he pursue more fully the reasons and nature of the shift, including the patient’s insistence that her feeling more likable (and therefore less in need of proof of caring and affirmation from the analyst) is due to his convincing her she is likable? Might her “understanding” be a disclaimer of her own agency made possible by identifying with his expressed feelings of liking and caring for her, which have alleviated or neutralized feelings of guilt and shame? If so, this disclaimer must be analyzed, somewhere and sometime, although perhaps not now, when the patient’s affective focus has turned to conflict about guilt over hurting the analyst.

And regardless of prior theoretical stance, the analyst is properly moved by the force of the material to consider viewing this development in terms of conflict, however briefly. From recognizing the defensive function of the idealization which, when lifted, revealed guilty, hurtful wishes, the analyst now wonders if, in turn, the criticism of car and sweater serves a protective function. Which of course it does if only in the sense of concealing some fantastic view of the deadliness of her rage when her wish for love from a strong father is frustrated.

But the analyst backs off, returning to the view of the patient as too narcissistically vulnerable, and in need of reassurance that the analyst was not old and weak as represented by the Cadillac and sweater. So he reassures the patient that the Cadillac is not his, thus encouraging her to return to her narcissistic defense of needing strength and energy from an idealized man. Yet, from the way the patient was working and confronting her guilt in her earlier part of the session, she seemed capable of tolerating the frustration of not immediately being reassured that the analyst was not old and weak. She might well have tolerated an interpretation conveying the understanding that she must feel a lot of pressure from her guilt about criticizing him and would feel relieved to go back to the previous reassurance and idealization. Indeed such an interpretation might also have sustained her in her advance from enactment of her narcissistic defense to further analysis of the struggle with her anger and guilt in the transference.

In spite of the analyst’s concern about the patient’s capacity to tolerate an interpretation, the patient is caught up in the process and reports an upsetting but significant dream in the next session (Friday). The dream is horrifying and emotionally wrenching. Her husband’s father is dead, but suffering terrible pain. Family and friends have the duty of suffering with him, trying without hope to console and soothe him in his living, suffering death. It is hopeless; the patient couldn’t stand it and had to leave.

The patient immediately knows the dream is about the analyst and her concern that she has hurt him and could hurt him more because he seems so vulnerable. She needs to keep him idealized because she can’t deal with his pain. After momentarily (and perhaps prematurely) connecting the dream figure with her father, the analyst brings the focus back to her transference insistence that he is vulnerable and she can and has hurt him terribly. He offers two different interpretations: one, that the patient has to abandon the more connected relationship with him and return to the narcissistic idealization of him in order to protect herself from his pain and neediness and, two, that she does this in order to protect him from her. I believe both are valid, but the analyst does not help the patient see how the first (the more narcissistic level) serves to defend her against the second (the object-related guilty level). In fact, while apparently having some awareness of this level of guilt conflict, the analyst generally seems to prefer to focus on the patient’s narcissistic need to preserve herself by idealizing, by getting energized and affirmed. He thus allows the patient to avoid confronting more fully what she seems aware of and talks about without really comprehending. That is, that she is struggling with guilty feelings about angry wishes to hurt.

The technique of dream interpretation evident in this clinical material seems to be influenced by the same tendency to remain on
baleful neediness and has thereby deprived of any inner life, we should ask why she is so sensitive and vulnerable and so obligated to sacrifice herself to alleviate the mother's suffering. I believe the answer lies in the clearer version supplied by the patient's suffering and thus feels obligated to do it. In the fourth session, the dream's motive became clear: to alleviate the patient's suffering and thereby become more aware of her reactions and how they came about. When the patient then asks how she can change this obsession, the analyst takes an educational stance by reassuring her that she is becoming more aware of her reactions and that they are not as frightening as she thought. He also suggests that she is learning to take care of herself by actively choosing not to depend on others, as in the crypt dream. The patient, directly asking for reassurance, says, "You really think so?" The answer: "I really think so." The patient does indeed feel reassured, and she goes on to speak of the helpful effect of being able to tell the analyst the things she despises about him. Finding that he was strong enough to withstand this and not be a reassuring experience, the patient no longer feels the need to rely on the analyst's reassuring behavior to demonstrate the effectiveness of a reassuring approach in helping a patient feel better.
Conclusion

This case report demonstrates how an accepting therapeutic relationship accompanied by clarifications of character patterns of behavior and defense can be beneficial. When strengthened by a permissive, educative approach from an empathic parent-figure serving as a model, the experience over time can lead to significant change. This change can be conceptualized as resulting from a combination of learning from experience and identifications with the therapist (transmuting internalization). To some extent these processes occur in every analysis, according to some of the "transference environment," the "therapeutic alliance," and the "transference cure." This is probably what Freud had in mind when he remarked, "we may treat a neurotic any way we like, but he always treats himself psychotherapeutically. That is to say, with transference" (Ferenczi, 1909, p. 55). The implication here is that the patient will gradually accept help by becoming aware of the transference material, will use these gains as resistance to deeper exploration.

I have no doubt that under Dr. Feisthage's empathic treatment this patient will be benefited subjectively and functionally. I would suggest that, with the analyst's lead, the patient's own needs and wishes will eventually emerge in a more mature and coherent fashion. If the analyst were to follow his patient's lead (and his all-too-brief glimpse in the beginning of the week and the analyst's interpretive help to explore the dimension of his guilt).
defensive layering of the feeling cared for—diminished idealization—guilty criticism sequence) into the patient's dynamic inner conflict and its contribution to her vulnerability. Lacking this dimension, the patient is confirmed in her view of herself as existential victim of self-absorbed, unempathic parents and others who inflict their pain and suffering on her. In this regard, we might consider Kohut's warning (unfortunately forgotten) of the existentialist fallacy of building a theory of the mind upon conscious experience, leading "toward an abrogation of the importance of the unconscious" (1972, p. 659). If I may borrow a Kohutian concept (amended for gender) I would advocate helping the patient widen her self-image as Tragic Woman (with its resistance meanings) to include Guilty Woman.

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Discussion: A Developmental View

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OUR TOPIC IS HOW OUR THEORIES SHAPE our psychoanalytic technique, and Dr. Fosshage is to be thanked for presenting clinical material that allows for such an exercise. I will initially be more specific about our points of divergence, although we have points of convergence as well; the purpose of this exercise is, after all, to focus on what distinguishes one set of theories from another, and how these differences affect technique.

We seem most to differ in the general area of to what extent the analyst is what has been called a "real new object" and to what extent he or she is a transference object. Implicit in this contrasting point of view is another; namely, is Dr. Fosshage's patient best understood as suffering from a deficiency or a conflict disorder. The theories that support the clinical concept of deficiency disorder go hand in hand with placing an emphasis on the analyst as a real new object whose empathic attunement compensates for the previous empathic failures of the primary objects. By contrast, another set of internally consistent concepts would hold that the empathic failures of the primary objects create ego structural malformations, conflicts, and compromise formations; that these are later played out in life as well as in the various narcissistic transferences in which the initial insult with its resultant means of responding are reenacted. In such unconscious scenarios the