Discussion: British Independent Object Relations View

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ADDICTED TO DRUGS IN THE PAST, to alcohol and to promiscuous behavior, Dr. Fosshage’s patient had become chronically depressed after her previous female analyst had consistently refused to let the patient know whether she (the analyst) “cared” about her. The patient “needed desperately and apparently frequently requested, if not demanded, to know” this, and to this end she exercised a “relentless insistence.” After managing to transform her previous analyst into a “walking corpse,” the patient leaves her and moves onto somebody else.

The present analyst is a man, who finds the patient “highly intelligent, articulate, and naturally attractive.” The patient turns the new analyst into an idealized figure, tries desperately to keep him on a pedestal, and fantasizes marrying him and living together for the rest of their lives. She gives this up for the sake of what she calls a “deeper connection” with the analyst. Together, they are going to contribute to nothing less than psychoanalysis itself! Dr. Fosshage attempts to accept and understand the patient’s “needs for recognition, affirmation and caring,” but finds himself “conveying more directly than is customary for me, through intonations, a word, a smile, my genuine caring for her.” He recognizes that he is responding to the patient’s needs for and fragility with maintaining a “caring” connection, and adds that: “The analytic understanding and process served as an overall basis for a reassuring and steadying experience.”

The patient, in fact, acknowledges that much. In the first of the reported sessions, she says: “I think you have convinced [!] me during the last few years that I’m likable and I feel that. . . .” The patient confesses that she felt critical of the analyst in a previous session. He encourages her to come out with the criticism; the message being that he can take it. The patient is apparently concerned about hurting the analyst’s feelings, and at that point makes an association with her husband:

“A—You’re really not wanting to hurt me.”

“P—No, because it’s very personal. I’ve done it with B [her husband]. Right after we got married, I just couldn’t stand him. I began to pick him apart. I don’t think I’ve ever put him back together. . . . I think part of our problem with our sexual life is that I never put him back together again. . . .”

The analyst feels puzzled: whenever the patient feels cared for, there is an emergent criticism of the caring object. After much prompting and encouragement, the patient comes out with the truth: “I didn’t like the car in your driveway . . . I hate Cadillacs, I hate them [with high-pitched intensity].” But not everything is lost, after all. The analyst decides to tell her that the Cadillac is not his. They both achieved by this “A momentary reprieve [mutual laughter].” The patient does not let go so easily though. This time the Cadillac is not the source of her unhappy feelings, it is a sweater that she did not like because it makes the analyst look “old.” In other words, I would add, it brings the analyst closer to a “walking corpse”. (In fact, the last Cadillac the patient had been in was at B’s father’s funeral).

I found this case material most difficult to comment on. There is much to be said both about the theory of the technique used, and about the theory of the mind that supports that technique. I am in considerable disagreement with Dr. Fosshage, but I will concentrate on one specific point: Why is the analyst so interested in making the patient feel “liked” and “cared for”? We are talking here about a patient who, soon after her marriage, turned her

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husband into a Humpty Dumpty, and she does not tell him so, thus keeping him in a broken state; she transformed her previous analyst into a “walking corpse” (but kept her alive in her dreams), and is threatening to do the same with her present analyst, should Dr. Fosshage refuse to support her narcissism. We know that this analyst “likes” and even feels “genuine” care for this patient. But what if this patient were not “likable”? Does this mean that we can only treat patients that we like? Or is it that Dr. Fosshage would tell some and not others that he likes them? As far as this patient is concerned, it seems that nobody should dislike her. She will certainly not allow that possibility to exist in the analyst’s mind. She seems to be, at one level, as paranoid as her mother but, at another level, she behaves as tyrannically as her father. It does not seem to me that the issue at stake is so much her depleted narcissism as her tyrannical tendencies. The analyst should feel free to like or dislike his patients, to think whatever he likes about them. It is this freedom that the patient finds unbearable in the other.

As psychoanalysts, we have a commitment to be concerned about our patients. We show our concern to them through our ethical and professional standards. This commitment and this concern are very different from the ever-present, powerful demand, coming from our patients, that we should like them. But why should this neurotic demand ever be satisfied? Is it not one of the aims of the analysis to enable the patient to stand uncertainty, to be able to cope with the frustration of not knowing? I assume that there are theoretical reasons behind Dr. Fosshage’s technique: for example, the idea of therapy as an emotional corrective experience, or the therapeutic provision of opportunities for infantile grandiosity and idealization to occur. I find it impossible to imagine this patient ever overcoming the sheer narcissistic hurt implied in her having to accept the impossibility of putting things right: whatever happened in her past cannot be changed. Unless she accepts this destiny, she will change from one narcissistic object to another, always stuck to her addiction for love, forever dissatisfied, compelled to go on debasing the caring object.

In one of my visits to the USA, I had the opportunity of listening to colleagues complaining to me that if they interpreted the negative aspects of the transference, some patients would just pack up and leave and go to a “better” analyst who would give them more positive feedback. If this is in any way true, my concern is that analysts might be trying to protect their own narcissism, rather than doing anything really therapeutic for their patients. There is no sense in this account that an analysis of what the patient does to her objects is taking place. It is quite clear to the reader that what she says of her father could very easily be applied to herself: “He’s demanding that things are perfect, but we can’t please him. No one says, ‘fuck you’ or ‘what’s the big deal’. . . . He is so disappointed and throws such a tantrum and makes us feel guilty.” Will this analysis help her to accept the possibility that she might be talking about herself?

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