An Analyst ‘at the Border’ for a Patient at the Border

by Ettore Jogan

I wish to present the clinical case of a young patient I have had under treatment for about nine years. She belonged to the sphere of severe pathologies. I will present some crucial aspects of that therapeutic path, with some technical and theoretical considerations and the explanation of the countertransferential experiences which led me into difficulty in the most critical moments. I have already characterised this experience as ‘at the border’ in the title of this paper. All patients with severe pathologies in fact lead us in their way to mental conditions at the border, i.e. at the edge, or outside our most usual and tested psychoanalytical work. I will re-consider and thoroughly examine this aspect hereunder.

The Meeting

Anna was sent to me by a colleague from another city, where the girl was studying. Anna was then 23. She deeply impressed me since our first meeting, giving me feelings of uneasiness, discomfort, suffering, and unpleasantness. She was short, and had an awkward walk. She used to wear shabby cloths, and was covered by a dark, wrinkled coat. She had lowered, lifeless, little expressive, nearly frightened eyes. She used to walk along the corridor going from the entrance to my office with a clumsy walk. She was a little limping, almost creeping, her shoulders towards the wall, as if she had to protect herself by some possible aggression, and go as unobserved as possible. She spoke very little and with a very low voice during our meetings. It therefore took me quite a long time before being able to collect some data on her life, her history, and before being able to see my way in her discomfort. She appeared to me as a heap of ruins, as a neglected person, deteriorated in her human dignity, as can be sometimes seen in immigrated women or girls begging at street corners.

We could reconstruct a little of her history very slowly and with great difficulty. I came to know that Anna had been suffering for six years, that is since she attended her high school, from a deep depression, a difficulty in establishing human relationships, studying difficulties. She experienced strong psychical suffering and anguishes. All was accompanied by a deep sensation of psychophysical tiredness which led her to loneliness, to often turn to bed, and to complain of an excessive pathologic somnolence. She had

been periodically followed by some psychiatrist, with little success and scarce conviction. She had experienced her maximum ill-being in the other city, where she studied and where she had gone to try to seriously separate and emancipate from her family. She had experienced there some clear psychotic decompensation, with depersonalisation and de-realisation experiences, as well as with delusional phenomena of a persecutory type. I came to know that not even her childhood, her latency, and her pre-adolescence periods had been happy. Anna was a mainly sad, introverted child, who little socialised. Discomfort, stress, and pathologic dynamics we could better know and define later on prevailed in her family. I tried to explain myself the depressive decompensation from her adolescence up to high school as a surrendering in her own maturation path caused by the adolescent thrust on an already existing fragile psychic field. I was positively hit by one thing in her history, that is her reasons to transfer to Trieste. At a more conscious level, her city change coincided with a faculty change, that is with her passage from biology to psychology. The latter was a field where she could possibly survey and understand her psychic discomfort and ill-being. Psychology was much nearer her own experiences than biology, even if Anna was not conscious of those reasons at the time. Another reason for her city change was even deeper and less conscious, but, in my opinion, much more interesting and stimulating. I refer here to her search for a possible place of higher well-being. Anna had had a short experience of voluntary service a year before with a group of boys and girls from different European countries at the Trieste Psychiatric Hospital. That experience had been a rare moment of positiveness and relevant well-being for her among all those previous years of ill-being and sufferance. She therefore decided to transfer to and settle in Trieste, assigning this city a hypothesis of some positive opening in the future, according to that positive and beneficial experience fragment of one year before. That vital force surviving in that suffering and ruined girl caused a deep sympathy in myself, as happens anytime I witness a struggle between life and death at mental level. That shy and nearly unobserved vital force element in a person complaining of a very strong regression lacking of energies conquered me pretty soon. I took her under therapy with the ambition of looking for those weak vital aspects to be able to broaden and strengthen them, without having, at the beginning, a clear view of the possible path, the therapeutic strategies to carry out, or the technical tools to adopt. I let myself guide from my intuition in giving a suitable setting to the patient's regression level, keeping in mind the remarks by Winnicott (1958), who suggested the fitting of the analyst-environment to the needs of the patient-child, regressed to the pre-genital stages of his psychic development.

In the subsequent development of the dialectics between the need, the fear, and the defence of the relationship, we progressively passed from two to four sessions a week, to recently come to three sessions, outside of which short meetings or communications were often possible or required. I always met the patient in front of me, since I always feared a psychotic decompensation, if I had added the iatrogenic regression of the couch to the already existing regression. (Bonasia, 1994; Hetchegoyen, 1986; Kernberg, 1975).

First Stage – Search for a Symbiosis

The first three years of treatment were spent in welcoming the patient in a benevolent holding atmosphere, in favouring her very scarce and timorous communication, as well as in an empathic listening to her experiences, her current difficulties, her history and life experiences that had led her to given paths. The material of our sessions developed on two fronts. On the one hand, the daily survival difficulties were faced, where a pathologic tiredness and hypersomnia dominated, which left Anna little space to carry out her daily common activities, i.e. taking care of herself, of her home, attending some lesson, and some short period of study. On the other, a rich material concerning her own family emerged. Those experiences started to organise during our sessions as a history that could be built, as ties and dynamics that started to have an increasingly great representational organisation, as well as a higher possibility of being represented and expressed by words. Anguish, sufferance, introverted and undifferentiated regression started to have some meaning, some representation, and some definition. A family profile with its remarkably pathological dynamics slowly and progressively emerged. That representational definition could refer to something similar, defined by Bollas (1987) as ‘known unthought’. Her family was based on a patriarchal vertex, where the father exercised power in a notably despotic way. He was a retired worker of southern origin, masculinist, and regarded his wife and his three daughters as inferior beings. He was touchy and quarrelsome, and dogmatically always considered the others as responsible of his own troubles. He had been educated in a violent way by his father, and had continued that violent attitude with his wife and daughters too.

Her mother had a depressive temper. She was slave of the continuous power and disparagement of the father. She was intellectually rather limited, unable of affective relationships, as well as of a psychological sensitivity. She was masochistically busy in her housework, where she did her utmost in cooking and materially nourishing her daughters,

as that was the only way to show mother attention and affection. Anna had two elder sisters. They also showed some psychiatric problem. The elder one seemed to show a false hypomanic self made up of a false self-confidence and efficiency, where regressive depression and passivity stages linked to bulimia alternated. She had stopped giving her university examinations for about four years, and was not able to carry on her own growth project. That sister never decided to look for a psychological aid, despite Anna's repeated incitements. Her middle sister – even if still living in her parents' home – was the only one to be able to come to at least an economic independence, and was a nurse. She had anyhow some relational problems with people in general. She was surly, very quarrelsome, and could not keep and cultivate long lasting relationships.

Dynamics within the family were remarkably destructive. The father carried home all stresses, problems, conflicts, and ill feelings heaped up at work, and discharged them on the mother, who had to act as a container for the evacuative projective identifications of her husband. The elder daughter had to act as a bearing and damper between her parents, and for each parent in that game to massacre, precociously taking on herself an adult role, with the subsequent construction of a false hypomanic self, and great difficulties in her subsequent maturation. Anna had been carrying the weight and grief of her mother's refusal since her birth. Her mother had openly and repeatedly stated that she absolutely did not want the third daughter, and that she was already tired and exhausted by the first two, who were for her more than enough. Anna remembered, and it was imprinted in her experiences that her mother had always shown her an open irritation, a continuous critic to her as a person, and to have been used as a protective shield against the father's anger since when she was a child, deviating on her her father's aggressiveness. Anna's family situation could be included in the trans-generation family pathology defined by Goretti (1997) as 'violated minds', where parents traumatically psychologically 'abuse' of their children to keep their own precarious psychological equilibrium. It seemed important to me that Anna could also formulate reality elements at thought level in that process of reconstruction and representation of the intra-familiar traumatic relational condition. In these instances, as stated by Bonfiglio (1997) and Izzo (1998), 'the fact of not identifying reality aspects should cause a iatrogenic effect, thus favouring the conceptualisation of each reality as a fancy, and therefore inhibiting knowledge processes'.

The therapeutic relationship with Anna developed starting from persecutory experiences of suspicion, fear, alarm state, also very detectable in the external human relationships, in the search for a protective and consolatory relationship. Anna's intra-

psychic condition perfectly fitted the description by Winnicott (1958) of a child lacking precocious mother cares, and therefore missing the interiorisation of a good interior object. This child lives a persecution condition, and is likely to be candidate for a paranoid evolution of his personality. Anna was frightened of the world, and without energies for an autonomous life. She had regressed to staying in bed in a somnolence state.

Anna started to make use of the therapeutic relationship in a broadly nourishing and reassuring way. The sense of persecution was reducing, and a weak self was organising. That process passed through a strong dependence on myself. I was assigned a mother function of 'reverie' I had to somehow carry out. The patient's regressive needs were difficult to be contained in the first years of treatment. The emotional, countertransferential burden was particularly heavy for me. The reassurance and consolation needs with respect to the persecutory anguishes expressed themselves with the need for physical meetings with me, since the introjection and interiorisation processes of a good object were still difficult at psychological level. Anna fairly often looked for some contacts with me outside the sessions. It could be through some telephone calls, the request for some additional appointment, or some short 'invasions' in my office during my work pauses, or even during the sessions with other patients. That acting probably had manifold meanings. At a more immediate and conscious level, Anna pointed out her childish and regressive aspects with a net Ego deficit in organising and keeping her interior life with the relevant painful emotions, as well as in suitably facing the exterior world. She expressed a strong need for a concrete and physically present object able to play a role as a holding, a consoler, a mental metaboliser of her primary anguishes. Anna probably tested me at a pre-conscious, or unconscious level. She wanted to see if I was able to face the hit of her requests, and if my affection, commitment, and responsibility in her regards were higher than the discomfort necessarily caused by her pressures. In a really transferential and fully unconscious dimension, Anna made me live the painful mental intrusiveness she herself had been subject to by her primary objects.

Even though with shy attempts, she succeeded in organising a more active self, less squeezed by the object persecutory excessive power, and this was stressed by her external inter-personal relationships. The purchase of a cat of which Anna lovely took care for some months appeared within the growth and development of her self. Many sessions were devoted to the kitten, its growth, its development, and the relational events between Anna and the kitten. The kitten acted as a self-representational element in the reality of her interior world, as an evolutionary and self-repairing trend. On the one hand, the cat – in his

animal essence – represented the instinctual element able to develop towards a sound narcissistic direction, as well as towards a balanced dialectic condition between dependence and independence. Those who are familiar with cats know that those aspects are fairly well interpreted by those animals. On the other, I seemed that the cat could also act as a transitional object, considering its role as tactile and cenaesthetic consoler, in absence of a symbiotic-analyst mother. It was curious to see that the propulsive, growth element showed, in its self-representation, in the concreteness of the external reality[1], as for instance in the cat experience. The very rare and short dreams continuously characterising that patient repetitively instead showed catastrophic scenes of dissolution of the self, and therefore prevailing traumatic contents. Unfortunately, Anna's direct experience with the kitten had to be stopped, because, on growing, the little animal showed not to be a flat cat, and not to enjoy the limited space of Anna's small home. It behaved in a dangerously self-harmful way. A more suitable accommodation had to be shortly found. Given Anna's remarkable social isolation, she could not find any satisfactory alternative accommodation for the kitten. The only perspective solution was that I took it in my home, where it could have enjoyed a wide space with a garden, nearby fields, and the company of other cats. The cat episode put me in a quite conflictual condition. By concretely living and interacting with the patient – that is accepting her cat in my home –, I seemed to fail to my function as a therapist-analyst. I seemed to betray my professional identity, to clearly come out the limits of that identity – a condition Anna often forced me to at mental level. At another, deeper level, I anyway seemed to have to do that as the cat represented, in my opinion, Anna's emerging vital self, and it was my duty to look after and take care of him. Should I have kept more neutral and have left Anna's cat to his fate, I would have fled incoherent with respect to my professional and ethical motivation of fighting aside the psychic viability, especially when this is compromised and threatened.

Anna could luckily find other cats – street cats – on which to shower her cares and attentions. She showed very good and efficient in those reparative functions, which were also, projectively, self-reparative.

The Separation

Anna's conditions improved a little after a few years of treatment. Her tiredness and pathological somnolence condition a little reduced also thanks to the pharmacological

[1] The process falls within the oneiric function at the wake state, as stressed by Bion (1992).

cares meanwhile accomplished by a colleague psychiatrist, as well as by a continuous monitoring with specific endocrinological cares. During our therapeutic path, a remarkable thyroidal disorder and a not better identified suprarenal gland disorder were in fact found out. Her conditions also fairly improved at a relational level. Anna more bravely stayed in the world, defended her rights, moved more, expressed herself more despite her vulnerability and frailty through her emerging self, fed and supported by the therapeutic relationship. She expressed and showed herself as a little child who does not know how to direct his movements. She sometimes behaved in a shy and inhibited way, some other time, in an angry and aggressive – anyway always excessive – way. In this context, Anna matured the need of separating from me – her symbiotic mother –, from the dyadic relationship, to look for her triadic condition that could have given a new impulse to her growth and development.

Anna's persecutory anguishes were still present in her external interpersonal relationships, while they had nearly cooled within our therapeutic relationship. Anna therefore decided to move towards a group analytical therapy, progressively leaving her individual therapy with me. According to Anna's imagery, she thought of identifying a higher possibility of living and processing her persecutory anguishes in a group. Within my countertransferential experiences, I felt that Anna was looking – through the group – for approaching the oedipal area of the 'Third' , after living a good enough mother symbiotic experience in her relationship with me. I intimately favoured Anna's idea. It anyway looked as an expression of a maturation trend. I furthermore hoped for an actual external help, that is a 'Third' who could relieve myself of the notable emotional burden that Anna's symbiotic dependence made me feel.

Her project was unluckily not successful, and the failure of that path hypothesis fell like a violent avalanche on our relationship. This fact produced the most critical period in our therapeutic experience, and was doubtless the heaviest period for me from a countertransferential point of view. Later on, that showed to be a necessary and unavoidable path, and, luckily, also a fruitful one.

According to my suggestion, Anna turned to a colleague therapist working with groups. As I could reconstruct facts later on, when I had to deal with them in first person, a destructive dynamics developed between Anna and my colleague during the initial talks that should have been preparatory to the entrance of my patient into a group. Anna developed a seemingly contradictory relationship I well knew, since she had already

developed it in my regards. She in fact showed dependent and unable on the one hand with my colleague, and even a little aggressive in a self-affirmative way on the other. In my opinion, those dynamics meant a slow progress in Anna's growth. Moreover, they aimed at testing the therapist, if she actually accepted and welcomed Anna as she was. My colleague negatively reacted to Anna's behaviours, mainly judging them as destructive, aggressive, paranoid, manipulatory[2], and anyway incompatible with a group work. That refusal by my colleague caused Anna a serious trauma with strong emotional reactions. That refusal connected Anna to her past traumas – especially linked to refusal –, that is not to be accepted and loved by her mother.

Anna aggressively reacted against my colleague, and also came to a physical fight with her. She subsequently turned her aggressive reaction against me as well. She accused me of a remarkable responsibility in her negative events with my colleague. She deemed me responsible for sending her to an incompetent, hard-hearted person, very worried of her professional image, as well as of her own equilibrium. She furthermore accused me of protecting my colleague in a non-critic and partisan-like way, more concerned with the interests and the good image of the class than with the patients' interests. The accusatory and vindictive tone increasingly grew. Sessions became heavier and heavier to face for me. Anna furiously left the sessions several times before their conclusion, violently slamming my office door and kicking the entrance door.

I was impressed – of her furious anger – by the energy she could express in that moments, while she was usually rather out of sorts and passive. That aggressive persecutory experience towards myself seemed to me positive beyond the emotional heaviness Anna made me live in that period, and that could also lead to an irreparable breaking of our relationship. That element in fact re-composed a certain splitting that risked to radicalise, that is to live the relationship with me as a mainly symbiotic and good one, and the external relationships as very separating and therefore bad and persecutory. The aggressive relational position with a bad object was then directly brought within our relationship.

I recorded Anna's accusations and claims as elements linked to her projections and projective identifications. I believe that that stormy period of our therapeutic path can be defined as a 'transferential psychosis', according to Etchegoyen's (1986) conception, taken up by Searles (1986) and Rosenfeld (1987), where there occurs an incapacity to

[2] I agree with Racalbuto (1989) in criticising Kernberg's therapeutic approach, which privileges the

distinguish fancy from reality, and the present from the past, that is to be able to discriminate between the original object and its transferential repetition. After living again the refusal and relinquishment traumas ascribable to her mother, Anna spread her aggressive and vindictive anger against me as well. I was in fact transferentially associated to her parents in a relationship of collusion and narcissistic complicity where she, as a daughter, was set aside and sacrificed. I remarkably outdistanced my colleague at a reality level. I in fact regarded Anna's aggressiveness as a self-affirmative growth sign if compared to the regressive condition where the self was nearly non existing. My colleague instead regarded that aggressiveness as a destructiveness and attack sign. Anna well knew my differentiated position, but I was anyway put in the melting-pot of the 'bad parents', and accused of complicity with the refusing colleague-mother. I felt that that was one of Anna's projective transferential experience where I did not recognise myself, and that re-proposed – in the colleague-therapist-myself relationship – the relational experience of Anna's parents, where the father's authoritarianism covered the mother's affective inability, and where the mother sacrificed her daughter to save herself, thus offering her as a target for the father's angers. That transferential re-edition of the relational dynamics towards myself was clear for me. On the other hand, Anna's anger and aggressiveness turned to my actual person, to the here and now, that is towards my 'actual' negativity of that moment. In my opinion, transferential psychoses are just made up of an actual, momentary, reductive flattening of clearly transferential phenomena.

In that occasion and given Anna's experiences, she had to face a further, certainly painful growth passage in the therapeutic relationship with me. Until my colleague's refusal, I had mainly represented her symbiotic, pre-ambivalent mother, tuned on her regressive needs. In that moment, she instead perceived me as a separate object, with its own mental position, that moved in a triadic dimension. She could not tolerate that I – even if on different positions, more favourable to her, compared with my colleague – did not condemn my colleague for her 'narcissistic worry and wickedness', but I at most regarded her as not professionally and personally ready to face such serious and heavy problems as Anna's ones. The fact of not being in perfect symbiotic harmony with Anna's experiences of anger and aggressiveness towards my colleague meant for her that I fully betrayed her, justified my colleague, and sacrificed her in the name of a class collusive solidarity. The passage from perceiving me as a symbiotic object to perceiving me as a separate object caused dramatic persecutory feelings in Anna. As also shown by Searles

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interpretation of borderline patients' aggressive aspects, and neglecting experiential aspects.

(1979, 1986) in this regard, that passage is always rather delicate and crucial within the therapeutic process of people acting at a borderline level as in Anna's case. The separation from the object easily falls within a persecution area. The relational mechanism is still very primitive. It therefore moves on schizoparanoid positions, that is if you, the object, are not in full symbiosis with me, you are necessarily against me. At a countertransferential emotional level, it was very difficult for me to bear that situation, as I did not know well what technical tools I could adopt to come out of the relational impasse. I was fully aware I could not adopt genetic interpretations, because they would have not been accepted, and would have aggravated the situation even more. They would have probably become a defence for my role, and self-protective for my wavering emotional equilibrium. I therefore stayed on the here and now of our relationship, and tried to survive the aggressive attack. I kept on variously confirming that, for me, our separation position did not mean a persecutory, neglecting, or betraying catastrophe, but only the awareness of different personal worlds, different paths and experiences, different competence, different ages, that can anyway communicate each other, produce some exchanges, and keep deep feelings. I believe that my accepting her angry persecution feelings, and my steadiness in my separation and triadic position later on allowed Anna to overcome that persecutory relational position, placate her anguishes, and interiorise a non-persecutory separation feeling. Anna maybe succeeded in producing the passage defined by Winnicott (1971) as the 'object destruction and its survival'[3].

In that occasion, I realised how could be difficult for a person acting at a symbiotic-dyadic relational level to compare with a triadic-oedipal position I actually represented in that moment trying to intrinsically integrate the positions of Anna, my colleague, and mine. I also realised how much that oedipal position could be felt as threatening and excluding, rather than generative, maturational, and stimulating a more creative dimension approaching the symbolic area.

We could overcome those aggressive persecutory feelings within our relationship, and build a relationship with a good, steady, constant, but separate object after some months of hard work and very heavy emotional comparison. That passage was for Anna a remarkable step ahead in her growth. It showed positive at different levels, i.e. it improved her tiredness and somnolence condition with a consequent ability to invest her energy in her studies, improved her mood and her relationship with herself with a consequent higher attention to her physical aspect. Anna therefore started to be a pretty and nice-looking girl.

[3] That is the passage from the 'subjective' object to the 'objective' object, with the ability of 'using' the object.

After reaching a certain self-esteem level, Anna started to move with less fear in her daily life, as well as in her human relationships, even though very poor and superficial. It is interesting to notice that Anna could – long after living and overcoming her persecutory feelings towards me – take back some aspects of that persecutory feelings to the relational experiences with her parents. She therefore later on gave herself a genetic interpretation I could not previously do, and could then set a certain emotional distance with the primary negative objects.

The past few years of therapy have been directed towards a more depressive relationship. It means that the patient – having reached a higher stability, a better non-persecutory separation from the object, and a higher, more integrated and legitimate representation of the self – transferentially presented some experiences of interior void, affective coldness ascribable to an emotionally and affectively absent mother object. Her mother had not been in fact able to invest anything for her daughter at an affective level. This type of interior relationship can be assigned to the group of depressed patients defined by Zennaro (1997) as patients with emotionally absent mothers, and partially derived from the 'dead mother' concept of Green (1985).

That stage was marked by the need of a warm and affectionate relationship, no more addressed towards intrapsychic, or inter-subjective relational dynamics, but more aiming at the construction of particularly positive emotional atmospheres and states of mind likely to be reached in our meetings, and that could not be reported, or represented at a more structured psychic level. We moved in the area of the affective states defined by Correale (1997) as basic, or vital affections, and to be distinguished from discrete affections. Anna simultaneously acted towards me in a therapeutic and reparative sense, thus showing a great attention and thoughtfulness towards my physical and psychic frailties, as I had some health problems in that period. Anna's attitude – even though noticed by Zennaro (1997) in the depressed patients – seemed authentic and even mature, not linked to the transferential dimension reported by Searles (1986), where patients tried to act as therapists for analysts, because they were accustomed to act as therapists for psychically-ill parents since when they were children.

The then current condition was still far from being satisfactory, even though clearly improved if compared to the therapy initial condition. Anna had reached and kept on conquering new, important steps in her psychological growth, even though being rather disadvantaged for a broader inclusion in life. Her studies proceeded very slowly, even

though a certain impulse had been recorded in the previous year. A more concrete autonomy from her family was therefore still very far. Human relationships were still very poor given her remarkably vulnerability, and a dependence and concentration on the relationship with me was still very present. Those reality elements quite weighed on the future of Anna's life, and fed some, not easy to face worries in each of us.

Some Remarks starting from the Case

As hinted at the beginning, I would like to start the debate on the case from the emotionally very heavy countertransferential experiences I lived with that patient. Since when I have been more intensely dealing with severe pathologies, I have come to the conclusion that not enough emphasis is given in the literature on the subject to the painful countertransferential experiences analysts unavoidably live in those therapeutic processes, apart from some authors, as, for instance, Searles (1997) and Giovacchini (1989) in the United States, and Zapparoli (1992, 1994) in Italy. After overcoming the patient's diffidence and persecutory fears in the treatment initial stage, there increasingly emerged the strong, difficult to limit need of a dependent relationship with a totally available, welcoming, accepting mother object, that could at most approach the patient's regressive needs of nourishment and re-assurance. That need very often exceeded our agreed setting – then set at four sessions a week – with consequent telephone calls at home, emergency calls for some additional appointments, short meetings outside our sessions, or 'invasions' in my office during the sessions with other patients. My patient's behaviour was intrusive at a concrete level, as well as for my psychic equilibrium I tried to keep both at a professional and at a private level. I must admit that I often experienced that intrusiveness by patients in presence of severe pathologies. Giovacchini (1989) dwells enough upon the theme of severely disturbed patients' intrusiveness when he speaks of the trend by severely disturbed patients to attack and twist the analytical setting with their intrusiveness. That event occurred with my patient too. That type of relationship must however not be confined to a mere destructive aggressiveness, or to a negative therapeutic reaction, but to much more complex and articulated relational and transferential dynamics. At a more strictly transferential level, those patients propose the intrusiveness suffered with their significant objects in their relationships with analysts, as had occurred to my patient as well. A rather paradoxical condition occurs at an immediate relational level. As analysts, we suggest an analytical setting to those patients too, even

though with suitable flexible arrangements. That setting is seen as the most correct and favourable methodological and technical condition to promote their psychic growth – stopped or hindered by traumatic experiences – with a specific aid by the analyst. Patients however seem upset and annoyed by our tools. They do not understand their meaning. Our language and way of acting are totally alien to them. They need and look for other things. For example, my patient looked for an actual, tolerant, friendly, reassuring, and loving mother, and not for an analyst acting in an analytical way. A conflict therefore emerges between analysts offering one thing, and patients requiring another one. There are two different ways and levels of acting, expecting, and reasoning. Analysts try to be useful to patients analysing them. Patients try to obtain an actual, tangible aid as real objects just in function of their strong primary needs.

In the specific case of my patient, intrusiveness was not only linked to the transferential re-edition of her intrusive interior objects, but to her attempt of attracting attention in a seductive way as the privileged and more loved daughter compared to other sons-patients, to compensate for the affective void caused by her mother's disregard. I agree on this regard with what written by Savoia (1991) on the explicit, or implicit requests to change the setting by some severely disturbed patients. That should be 'the need that analysts showed to love them, and to love them individually, as persons, even more than their own psychoanalytical setting'. In those cases, the fact of requiring analysts to 'betray' the setting is not so much linked to the patients' oedipal wish to attack the good-companions of their analysts-mothers, but rather to the more primitive wish to feel them too (patients) very important for the others (analysts-mothers), or at least equal to the good companions (analytical rules).

Patients' intrusiveness and setting attack carry some very regressive needs urging – as in the case of my patient – on the analysts' minds, and cause uneasiness, discomfort, and, in more critical conditions, a remarkable psychic sufferance compared to their usual, more structured operational level.

Analysts feel induced to exceed their analysts' identity limits, as well as their limits of cohesive and integrated identity as persons, as they are obliged to act at rather regressive levels, which are usually physiologically removed and so remain under normal conditions. I believe that that condition is a remarkable attack to the analysts' sound narcissistic integrity. Analysts' regression to very primitive levels of mental acting makes me think of some statements by Winnicott (1958), when he talks about the pre-oedipal

transference types, and the ‘primary maternal preoccupation’. It is true that analysts must adapt themselves to their patients’ needs when they ‘lack primary cares’ able to promote their psychological growth. It is however equally true that – as I test things – that adaptation and identification with the very regressive needs of patients-children imply a sort of psychic ‘disorder’ analysts have to give way to. Winnicott (1958) states that, when mothers give birth to their children, they should be able to regress to the ‘physiological psychosis’ of putting themselves at the level of the children’s regressive needs, identify with them, and then ‘recover’ from that psychosis when children’s growth conditions allow it. Winnicott adds that not all mothers are able to fall ill from that physiological psychosis due to their own problems. In order to work with severely disturbed patients close to the psychotic area, I deem it important that analysts learn that ability to ‘fall ill’ in a psychotic way to reach their regressed patients without being greatly upset, and caught by psychosis. So that that process of de-structuring at psychotic levels, functional to the patients-children’s needs, and its recovery do not run excessive risks, analysts’ minds require a background assistance granting the constancy of the triad, as well as mothers need their husbands to support their interior triad not to surrender and be swallowed up by psychosis and the dyad. According to my personal experience, that background assistance was given by the severe pathology discussion team, where my colleagues used to confirm me enough my exposure to the countertransferential ‘regression’ with patients, and simultaneously kept me hooked up to a more mature and triadic direction. An approach to the patients’ more regressive levels can be extremely hard for analysts, also due to their own specific problems – like for some mothers, according to Winnicott –, as their pre-genital areas, or those close to psychotic areas have not been enough analysed during their own analyses. In this respect, Zapparoli (1994) would suggest a deeper analysis for those analysts willing to deal with patients from the psychotic area.

With respect to those countertransferential problems analysts have to bear with severely disturbed patients – that is to keep at a regressive acting level to reach patients, with the relative emotional distress involved in it –, it is important to have a valid support. In my experience, the support was the discussion team of my colleagues, just because the regressive position of an analyst’ mind – maybe forced by a certain intrusiveness, as in the case of my patient – is a weakness and sufferance element that analysts can hardly keep for long. Analysts however feel in difficulty since they are attacked in their formal external setting, or in their mental interior setting. The risk of such a difficulty condition is that analysts start to defend themselves, and somehow counter-attack patients. The most

common defence reaction in those cases is – according to Giovacchini (1989) – a pedagogic-like attitude towards patients to try to convince them to re-enter the ranks of a more-structured setting, easier to follow and keep for analysts. Those defensive attitudes by analysts risk to limit relationships to a too mature level leaving out patients. Patients need in fact to bring their most regressive, and sick aspects to analysis for long periods. In this case, analysts put too narrow limits, and in a premature time, whereas patients need to move within broader areas, especially within the regressive ones, and to take analysts outside their usual limits. Those limiting attitudes by analysts risk to cut off, from the analytical work, some of the patients' relational aspects and aspects of the primitive selves that could be also further processed and transformed with a more tolerant and confident attitude.

The interiorised colleagues' team was decisive for me at that stage. It in fact allowed me – through its brotherly role – to abandon myself without excessive anguishes to more childish and regressive positions with a partisan-like attitude. It meanwhile kept me anchored to a more mature direction perspective through its benevolent parental role.

A second moment was very heavy to bear at countertransferential level. It was when the patient lived and expressed her 'transferential psychosis'. I believe that that is a very delicate, almost crucial moment in the therapeutic process of borderline, or psychotic patients. Those are stages when patients must face separation processes, and that is a particularly difficult problem for them, as repeatedly stressed by Searles (1982). The fact of not distinguishing between fancy and reality, and between the original object and the current object put analysts in great difficulty, that is not to be able to get out of the negative role of the original objects patients put them in. In the case of my patient, I still had a sufficiently autonomous mental space to be able to live her attachment towards me as a consequence of the transferential re-edition of her negative experiences towards her parents. I could recognise a projective mechanism towards me in her acting. Since I recognised my total conscious extraneousness to my patients' experiences in that sense, I tried to also identify myself in her point of view, and to better understand according to what mental mechanism she acted in that moment. After experiencing the refusal trauma with my colleague, my patient had identified – in my colleague and myself – the aspects of narcissistic parents, more worried of their well-being than of the well-being of their own children-patients. I also tried to empathise with my patient's position, thus admitting that there could be some narcissistic element, both in my colleague and myself, in our attitudes, that is of defence of our interior mental equilibrium. I had then to infer that, at

least for myself, that could be one of my mental components at stake in that moment with my patient, and not certainly the most important one. My worry about how to be able to help my patient's psychological growth despite her refusal trauma experience was instead much more important in the complexity of my countertransferential experiences.

I could then intimately act at different levels of mental representations and dynamics. I kept the positions of my patient, my colleague, and my own position in mind, trying to integrate integrable aspects, and keep non-integrable ones separate. Thus, I kept my mental acting within a more open space, clearly linked to the triadic dimension. I meanwhile noticed that my patient moved on a dimension with a single, that is persecutory, relational meaning, where my colleague and I only had that negative, destructive meaning. That mechanism can be included in the perception of the object as '*pars pro toto'*, described by Searles (1979, 1986).

I do not know whether some tested technical prescriptions able to accompany and lead to the positive solution of a transferential psychosis exist. Searles (1982) stresses that it is very difficult for borderline patients to reach a separation position from the object, and forecasts that those patients must develop a satisfactory symbiotic transference with analysts in the therapeutic process for a fairly long time, to be able to later on face the painful separation and recognition processes with the analysts' aid. According to some authors like Searles (1986), Giovacchini (1982), Boyer (1982), Feinsilver (1986), Pao (1979), and starting from Winnicott (1958), patients with that pathological level – that is borderline and psychosis – have great deficits, and traumatic experiences just at a symbiotic level. I seem that Searles' remarks and indications can be partly compared to Winnicott's indications. Winnicott lets understand that analysts must mentally approach patients with great primary care deficiencies, and create and suggest an atmosphere of 'primary maternal preoccupation' in harmony with their regressive needs. Analysts will have the opportunity to work in a classical way – that is on conflicts and defences – with a broader use of interpretation only in a second moment, when patients' selves are enough organised.

In the case of my patient, we could luckily overcome the persecution feelings and the aggressiveness broken out in her when we had gone ahead in the separation dimension, despite my countertransferential emotional heaviness. Perhaps, that was possible thanks to a previous good symbiotic stage – lived in the relationship –, as predicted by Searles (1982), where I partially acted for my patient as a welcoming and

loving mother (Winnicott, 1975), and partially as a confirming and reflecting self-object (Kohut, 1971). On the other hand, my patient succeeded in organising a sufficient stability, confidence, and cohesiveness of her self to face the pain for the loss of the symbiotic object, and not to reduce and condemn it – as separate object – as a bad, persecutory object, very partial in its meaning.

That passage is maybe possible with those patients whose paranoid sides are not so strictly organised. I in fact happened to have to surrender, and end the treatment with some other patients much more anchored on paranoid positions, just because it was impossible to overcome the separation impasse. In those cases, I as a person was fully superimposed to the persecutory, or anyway negative transferential object, and my separation was fully reduced to the original negativity. I was unable with those patients to open another relational dimension with a different meaning if not the destructive one. I was struck with those people by the very quick passage, without any possibility of mediation, from one extreme to the other, that is from an idealised symbiotic relationship to a separation relationship immediately perceived as persecutory. That ruining into a relational persecution, or negativity closes the approach and opening road to transitional spaces, creativity, play, potential spaces (Ogden, 1985), and, subsequently, to the oedipal position, the triadic, and the symbolic. The persecutory dimension therefore stops a full range of virtually present mental activities, productivity, and creativity, that cannot be developed due the impending danger the vulnerable self constantly experiences. In my imagination, persecutory experiences stopping any further possibility of psychological development of the self appear to me – with a medical metaphor – as not healed physical wounds (here is the reference to the traumatic experiences) that must be constantly tamponed (with the symbiotic relationship), and that make mobilise all the resources of the surrounding tissues to be somehow kept under control. The resources of the surrounding tissues have not the possibility to freely and independently move and develop, just because they must be constantly engaged to face the traumatised areas of the wounds. All vital processes of the areas are therefore concentrated and stopped there, on the wounds.

According to my experience, in those impasse conditions, patients and analysts renounce to a project of further evolution, maturation, and interior change after a rather heavy conflictual period. In those cases, we must acknowledge our limits and the limits of our work. Zapparoli (1994) states that some paranoid nucleus, and some symbiotic trend in some patients cannot be overcome through a psychotherapeutic approach. It is questionable here whether things are really so, that is whether our analytical tool must

acknowledge some insurmountable limits intrinsic to the method itself, or whether it is the case that we have not yet been able to find some sufficient investigation means with relevant, more suitable and effective tools.

In insurmountable symbiotic conditions, I experienced some manipulatory moves that would aim at forcing analysts-objects to accept their primitive mental working levels as normal and mature, thus judging analysts' acting as anomalous, pathologic, or at least far from reality.

I seem that the support by the colleagues of the work team on severe pathologies was decisive also in those moments when patients – as in my clinic case of 'transference psychosis' – force analysts to a very heavy emotional pressure, and flatten them to a very limited persecutory role, with a single meaning that tends to exclude any other dimensions and contents. In those cases, analysts experience a kind of emotional and thought asphyxia, where patients' projections and projective identifications place them. Even if analysts' minds are enough sound and organised to bear such a weight and be able to keep an analytical acting on the intra-psychic and relational events occurring in the therapeutic process, the presence of the by then interiorised team colleagues gives a special life impulse and oxygen supply to the analysts' minds working under asphyxia conditions. The team, with its harmonious blending of separate voices and minds contributing to make up a fairly continuous talk with an open dynamic to further developments, enlivens the minds of the analysts working with difficult patients. It is just so because – through its components – it lets see different intra-psychic worlds, different approaches, differentiated views that – with their wealth – keep analysts' minds open to broader spaces of transformation, change, and further evolution. In my opinion, the team furthermore can always keep alive a relationship included in a wider context, that the primitive mental relationship proposed by patients with severe pathologies tend to make collapse.

Final Remarks

In conclusion of the presentation of my clinical experience, I would like to summarise some points I consider very important to be kept in mind approaching the treatment of patients with severe pathologies. At a personal emotional level, the treatment of severely disturbed patients implies the fact of having to bear and tolerate not easy to keep inconveniences, discomfort, and sufferance. I believe it is possible to approach that

type of mental setting after a slow and progressive professional and personal maturation, made up of a higher and higher theoretical examination of severe pathologies, as well as a self-analytical examination of one's own psychotic areas and narcissistic frailties stimulated by severely disturbed patients. In those cases, the paradox that each of the two – the patient and the analyst – live in his own way must be often tolerated (Giovacchini, 1989). The setting within which analysts will try to lead their therapeutic paths will be somehow attacked by patients. It will be not for the patients' presumed predisposition to destructiveness – as hypothesised by a certain theoretical setting –, but simply because it cannot be understood at a mental acting level by patients, and, therefore, extraneous and unsuitable for them. Patients with severe pathologies cannot bear the ambiguous, deceitful, and symbolic aspects of the analytical setting. Analysts will have to keep a flexible attitude keeping the paradox itself. They will have to keep a perspective mental analytical setting, even if they cannot always apply it, and will let them to be used, for some periods, as primary, almost concrete and real objects, close to the regressive dependence. Countertransferential experiences must be explicitly acknowledged and given dignity, even if they are painful and suffered, to be able to better examine and investigate patients' complex transferential and relational events starting from those experiences (Heimann, 1950; Little, 1951; Racker, 1957). The fact that the examination of patients' intra-psychic events stems from analysts' countertransference is by now part of psychoanalytical methods. As analysts are specially exposed with their own emotional experiences to fail to keep their analytical function, and anyhow lose their own creative ability, the need is felt in presence of severely disturbed patients of a special assistance and support we have identified in the colleagues' team. If we succeed in keeping open the dialectic between our countertransferential direct experiences and emotionally and thought richer, more spacious, and creative representative dimensions, we may be able to investigate and better know the complex pathologies and the complex relationships proposed by patients with severe pathologies through a continuous comparison on our clinical work. We hope that – moving in that direction – we can still enlarge our knowledge and effectiveness with respect to the limits within which we move today in this field. I like to remind in this regard, the latest book by Rosenfeld (1987), where this important author and big clinic of psychotic pathologies tries to exceed himself. Rosenfeld is a good example of a person open to the wish of research and knowledge. He is an example of a person who never stops and is never satisfied with his limits – beyond his theoretical setting and his

belonging to a school of thought –, and who could run the risk to withdraw into an ideological persistence.

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