

From Chapter 2 from I Love You Madly! Disturbances in Love Relations

Otto Kernberg (1974, 1976, 1980, 1995) wrote of two basic love pathologies found in the most disturbed individuals: the inability to fall in love and the inability to remain in love. Another psychoanalyst, Salman Akhtar (1999a) had added three more: the tendency to fall in love with the “wrong” kinds of people, the inability to fall out of love and the inability to feel loved.

The most severe form of love disturbance is the inability to fall in love. In order to fall in love some degree of idealization or overvaluing is necessary. In normal love, the idealization is primarily based on real qualities. In pathological cases, the idealization is extreme and can become delusional with an equal but opposite devaluation lurking beneath. However people who cannot fall in love at all either cannot feel an idealization of another or the idealization is a fickle and fleeting fantasy.

Individuals may have problems falling in love because:

1. They are egocentric, lacking the capacity to love another.
2. They dread closeness, since they associate it with the destruction of their fragile psychological world.

The next level of disturbance is when a person can fall in love but cannot remain in love. Personalities that fall into this category have the capacity for idealization and erotic desire. They unconsciously seek a magical love that is worthy of their grandiose self and also a rescuer that is transformational. However, they experience a great deal of hostility when the idealized love object does not live up to the hoped for magical transformation. They may become obsessed with deficiencies in the love object. They often fear that intimacy will reveal that they are a fraud and may project this on to the love object and come to see the formally idealized lover as a fraud. A cycle of idealization and devaluation of the other moves the person in and out of closeness. There is no true intimacy with a real person. This type of love is mainly a child’s fantasy. They fall in love with a fantasy and then punish the real person for not fulfilling the fantasy.

Individuals may evolve from not being able to fall in love, to being able to fall in love but not remain in love. They might fall in love with the “wrong people” in service to their unconscious need to not remain in love...

As I enter my waiting room, I see Karen looking unhappy to see me. I brace myself as I remember her from the past. I enjoy doing deep and meaningful psychoanalytic work. Even after many years, it still stimulates me intellectually and emotionally, making me feel fortunate to have such rewarding profession. But some patients try to drive me crazy, while I try to drive them sane. Karen feels empowered by defeating me. She sees her defensiveness as a strength.

Karen changes therapists the same way she changes men. She starts out expecting magic and when she does not get it, she devalues the person. She had been in and out of psychotherapy of one sort or another (some bizarre) since she was a teenager. When I first saw her briefly a few years ago, she was quoting from several self-help books to help her find a man. She read some passages in order to educate me. She could not understand why I had not read those books and still considered myself a serious professional. She particularly liked advice that is deceptive and manipulative. That sort of advice made sense to her. She justified her dishonesty since she assumed that men are innately untrustworthy. She was unhappy when I told her that I would not help her with deception, but I might help her to see what she was doing wrong.

Karen, looking around my office with disapproving face says, "Dr. Gordon, I came back to you because I tried everything else."

"It's been about four years." I say. "You didn't seem happy with me before."

"I don't believe in Freud and going into the past."

Karen is really saying, "Just give me the answers, but don't ask me to look at myself." People who do not believe in Freud have probably not read or understood much of what he actually said. His theories warn that people pay a price for lying to themselves. Defensive people do not like to hear that.

Karen, now 39, never married. Her love relationships rarely last more than a few months. The longest was with a married man for two years. The fact that he was unavailable may have helped it last that long. When he broke it off, Karen got depressed. That is when I first saw her. She stayed a few months. When she fell in love again, she left therapy.

Karen's blue eye scans my face for hints of my feelings about her. She had punky short blond hair and several earrings on each ear. Karen is still skinny like a teenager and dresses like one. She could easily attract a man and become infatuated for a while. Karen often picks low-functioning men. Her rationalization is that she could have more control and she hopes they would appreciate her. But Karen picks low-functioning men mainly so that it would be easy for her to devalue them and eventually reject them. When she finds a man who treats her well, she feels less passion, becomes demanding, dependent, provoking fights, and blames the conflicts on the boyfriend.

Karen notices my wheaten terrier, Roy who remains behind my chair. He is friendly and likes to greet most people.

"Your dog looks depressed. It's no wonder since he has to listen to all this crap."

"Karen, what can I do for you?" I ask. Clearly, it was Karen who feels depressed, projecting her feelings onto my dog. Karen transfers on to me that I will not be able to endure her "crap." She can barely stand her own emotions (poor affect

tolerance) so she had a hard time imagining someone as an adequate emotional container. She cannot realize how much she is already showing me about herself.

Looking at me insistently, she demands, "I want you to help me find a man."

"I'm an analyst not a matchmaker," I say, clarifying my role.

"I keep picking jerks," She says, shrugging to suggest her victimhood.

"What do you want?"

"I don't want to be alone... I want to be married."

"Not happily married?"

She is silent.

Karen is not ready for an interpretation. An interpretation is a translation from unconscious to conscious language. Dreams, slips of the tongue, psychological symptoms, and relationship conflicts are all forms of unconscious language. Interpretation helps a person develop self-reflection. Self-reflection can help a person be more comfortable with themselves and others. Karen wants love to protect her. She wants to be the cared for child and her man would be an undemanding ideal parent. I could have interpreted that the real reason Karen did not say, "Happily married" is because it isn't consistent with her conflicted attachment style. Her history with men proves this.

From the time I first met Karen, I saw many of the themes to come. I see her problems with attachment by how she treats me (transference).

An interpretation goes into forbidden territory into a person's most private place. I never go there without an invitation. For now, in this first phase of treatment, I make no deep interpretations; rather I clarify our roles and tasks.

"If you want me to help you to have a healthy intimacy, you must allow yourself to have a therapeutic relationship with me. It will take emotional honesty, time and commitment."

Karen says, "I don't have the time and money. They don't pay nurses what they should."

Karen feels entitled to happiness. She does not understand that she has to earn it.

"Your time and money will go to other things that will not affect your life as profoundly as psychotherapy."

“Sure. Sure.” Karen sneers in a dismissive tone.

An emotionally corrective relationship could help a person have better intimacy. Psychotherapy is the most reliable method. But here is the irony; one needs to have the capacity for intimacy to form a therapeutic relationship to start with. In other words, it takes a good patient to get to the good therapy.

These qualities make for good patients:

1. A commitment to the therapeutic relationship,
2. Openness to constructive feedback,
3. Emotional insight into one’s own flaws,
4. A capacity for concern and remorse,
5. A sense of responsibility for one’s actions and situation in life, and
6. A willingness to be a better person.

If a patient cannot do these things, there is no deep psychotherapy. There can be no increased ability for self-reflection, self-soothing, affect tolerance, resiliency and understanding others. There is no increased ability for healthy love.

“Can you help me?” Karen demands.

I am not about to tell Karen at this point that she needs to develop many of the qualities that she so dearly lacks. Instead, I remind her of the protective boundary and ground rules of the therapy. Karen knows them, but like many patients, she will test the limits to see if I am trustworthy and professional. Karen has internal chaos. She brings chaos to her relationships. The structure and limits of the therapy might help her develop more structure and cohesion within her personality.

“I lease a regular time to you out of my practice. You are financially responsible for this leased time. We start on time and end on time. There are strict privacy rules. This firm boundary and commitment will intensify the treatment. I can’t help you with intimacy without a therapeutic commitment...” As I explain the details of the ground rules, Karen grows impatient.

“I know you have control problems,” Karen says.

“If you come regularly and work hard you will probably have improvement.”

“How much?”

Research shows that psychotherapy interventions are highly effective. But the main factors that lead to improvement are the personality qualities of the patient and the therapist and their relationship (Wampold, 2001). I need to have a healthy capacity to empathize with my patients. My empathy is often expressed in the tone, timing and accuracy of the therapeutic interventions. I apply the interventions as paint from a

palette. I mix and apply as needed the right amounts of listening, questioning, clarifying, confronting, interpreting and reconstructions of the psychological past.

Mostly, I am silent when I work, actively listening to my patients. My silence in a safe atmosphere promotes a sense of autonomy and self-reflection in the patient. It also allows me to form a deep understanding of what the patient is trying to unconsciously communicate. (It is hard to show how silence works in writing. In reality, I do a lot of listening that is not evident in this story.) My empathic listening provides a psychological container for the patient's emotions. When patients cannot tolerate their affects, they can be laundered in our bi-personal field. They internalize my reactions and learn to better self-reflect, regulate their affects and self-soothe.

When an infant fusses, a mothering figure holds, launders and helps to contain the child's emotions (Bion, 1962a). Children internalize this early emotional environment in their implicit unconscious memory. Research has found that a person's capacity for self-reflection, affect regulation, self-soothing and a core sense of self and others evolves from this early interaction. These infant attachment and brain studies have led to a reformulation of psychoanalytic treatment. We now believe more than ever that working with affects in an empathic relationship is one of the most important growth factors in psychotherapy (Fonagy, Gergely, Jurist, Target, 2002). If I intervene out of my own discomfort with the patient's emotions and just focus on symptom relief, I am not acting as a good container. Seeing Karen's problems in terms of her symptoms would reinforce her assumption that she is unknowable and that only the surface counts.

I use questions to take a patient deeper into personality. Questions may be used to get more information necessary for an interpretation or a reconstruction. Clarifications help improve reality testing, so that a patient might not continue operating on assumptions that are irrational or false.

When a patient is considering acting out in a destructive manner, there is often no time for an interpretation aimed at developing a more mature personality. I use confrontation to remind the patient of the consequences of acting out.

Interpretations of unconscious transferences, defenses, resistances and conflicts promote more insight and psychological maturity. Reconstruction of repressed areas of a patient's life helps develop a more cohesive sense of self. Reconstructing a psychological history can help patients make sense out of their symptoms and relationships.

I can never know a patient's true history. But having a sense of a continuous self that was built over time and can continue to grow over time is an important insight. Reconstructions allow a person to master problems that could not have been understood, tolerated or resolved earlier in life.

Almost everyone can benefit from venting in a supportive atmosphere. Most people find that the therapist's questions, clarifications, confrontations and even

suggestions help them with symptom reduction. But a psychoanalytically informed psychotherapist is specifically trained to use interpretations and reconstructions while acting as a good emotional container so that there is an actual maturation in personality structure.

Freud's goal of psychoanalysis was to achieve a profound growth of the mind so that the person can work and love better. Interpretations and reconstructions of the unconscious self-defeating side of personality are important ingredients to such profound changes.

Unfortunately, interpretations and reconstructions are frequently of limited value with patients who are concrete in their thinking and have little insight. For those individuals, cognitive-behavioral interventions that are symptom-focused may be more effective. These interventions are similar to the psychoanalytic interventions of questioning, clarifying and confronting.

There are few psychotherapists inclined to devote an extra five years of postdoctoral work in training and their own psychoanalysis required for a specialization in psychoanalysis. There are few patients willing to put in the time and money for anything more than surface symptom relief. Psychoanalysis would then seem to be a dying art and science. However, with a growing body of neuropsychanalytic research to support it (Schore, 2003), psychoanalysis has become one of the largest divisions of the American Psychological Association. I have found that with every patient a psychoanalytic formulation is useful in helping me to understand what symptoms mean in the context of the whole person (McWilliams, 1994, 1999).

I understand Karen's off-putting defenses. She is scared. She has an insecure attachment style probably due to traumas in her childhood (Ainsworth, Blehar, Waters, and Wall, 1978; Bowlby, 1982; McCarthy and Taylor, 1999). Karen feels that it is best to trust no one, pretend to be self-sufficient, demand intimacy but avoid it.

In the initial stage of treatment (Howard, Moras, Brill, Martinovich, and Lutz, 1996), the first thing to do is to give a patient hope that things can get better. When patients come into treatment, they are often demoralized. When Karen said at the beginning of the session, "Dr. Gordon, I came back to you because I tried everything else," she was telling me how demoralized she is. She does not want a therapeutic relationship with me. She does not believe that anything good could come from a committed intimacy. She thinks that if she stays too long in a relationship, she will be disappointed and hurt. Karen came back only after all else failed. But she wants a magical cure.

The next phase of treatment often is about reducing symptoms, learning new skills and insights. That can happen in a few sessions to a few months. But her problem is not about a lack of skills. It is a deep fear of intimacy that is most likely based on a damaged self and trauma from childhood. However, Karen does not want to go there.

Few patients stay long enough to go into the third phase of psychotherapy, the reconstructive phase of treatment and have personal growth. It could take years to change personality traits in order for a person to have personal growth and a better capacity for healthy love (Gordon, 2001; see figure 1; and also, Monsen, Odland, Faugli, Daae, et al. 1995). Reconstructive treatment such as that found in psychoanalytic psychotherapy, requires the patient to form an intimate alliance with the therapist and to self-reflect. I am concerned that Karen could not do that enough. She is too defensive for it. Karen needs to think that the answers to her problems will come from an idealized rescuer. She is waiting for her messiah.

I say, "How much improvement you make depends on what you put into it. I will need to see you twice a week to start, otherwise we will not get deep enough to change personality traits."