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How the Therapy Worked: The Case of Dr. Pickles and Ann

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The author writes a discussion of Judy Pickles's case description drawing on his control-mastery perspective. He views the ubiquitous dramas that characterize this analysis as challenges to the patient's pathogenic beliefs, taking the form of implicit questions through action and interaction. The questions relate to salient themes in this patient's traumatic lived experience with others, recontextualized and worked through in the analytic situation.

It is a Pleasure as Well as an Honor to Participate in this Self psychology conference. I practice and theorize within another contemporary psychoanalytic perspective, but I have always admired and learned from the distinctive contributions of colleagues working within the self psychology tradition. If you listen carefully, you may even detect some hints of their influence—perhaps slightly distorted—in my presentation.

It is also a pleasure to discuss Dr. Pickles's work with Ann. Dr. Pickles's work is highly individual and outstanding. I admire her compassion, perseverance, flexibility, and resourcefulness, as well as her openness and honesty with herself, Ann, and us. As the treatment proceeds she relies increasingly on her own understanding and intuition rather than "going by the book", that is, by official prescriptions of what

constitutes doing therapy or analysis. Most important, her patient makes significant progress. Ann becomes somewhat more integrated, more whole, and more vital. Her affects and her traumatic childhood experiences are becoming less sequestered, less split off from the rest of her psychic life. She feels less fraudulent, more "real." She is at times more lively, more playful, freer. She shows a greater capacity for mutuality with her husband and with Dr. Pickles. She is more trusting. She is beginning to be able to enjoy sex. She is far from complete. She has much more to do, but she is on a progressive course.

Now a comment on three aspects of control-mastery theory that is particularly relevant to my discussion of this treatment:

First, we assume that patients want to overcome their problems and work very hard to do so—unconsciously as well as consciously. Moreover, they ordinarily work over a long period on a specific set of closely interrelated problems and on overcoming the pathogenic beliefs from which these problems stem. In following a case, we try to understand what Ann is currently attempting to accomplish. We also observe how the therapist or analyst's attitudes, interpretations, and interactions with the patient help or hinder Ann's work. For example, Ann works over a long period on remembering, re-experiencing, communicating, and validating her story and its meanings. She is also, of course, intensely afraid of doing so. Many of the dramas of the treatment concern her efforts to convey her story with the help of the analyst.

Second, we believe that an increase in a patient's sense of safety is the essential precondition for therapeutic progress. This concept derives from Joe Weiss's **(1952)** early intuitions and ideas about the phenomenon of "crying at the happy ending." This concept has continued to inform our views about how psychotherapy works.

Finally, we emphasize an empirical approach to how psychotherapy works. We evaluate the therapist's or analyst's interventions by whether they help the patient rather than by any theoretical prescriptions about how therapy or analysis *should* be done. We examine a treatment as it happened, rather than as we think it should have happened.

I shall begin my discussion with a brief and general overview of the treatment to date. Subsequently I will examine more closely a few specific treatment events.

I propose the following storyline:

Ann gradually developed confidence in Dr. Pickles's capacities as a reliable therapeutic caretaker. As Ann's sense of safety with Dr. Pickles

increased, Ann became able to deepen the work. She became more able to talk about and to relive her childhood traumas with greater completeness, more detail, and more vivid and painful affect. She also became able to enact with Dr. Pickles the powerful dramas that have been reported to us as the five "episodes."

Ann had somewhat similar episodes before therapy began and earlier on during therapy. But Ann was alone with these prior incidents, which took place as mysterious, unconscious, dissociative acts. In contrast, the five episodes were distinctive in that they took place as a central part of the therapy. They occurred in the context of the therapeutic relationship. They directly engaged Dr. Pickles: They aroused powerful affects in her and compelled responses from her. Ann was no longer alone with crippling and self-destructive beliefs, unbearable affects, and dissociated acts but was working on her problems with an engaged and attuned caretaker.

The five episodes have individual precipitants that are useful to understand, but first I wish to assert the larger point that these are a necessary, crucial part of the therapy. They took place within the therapy because the patient felt safe enough to allow them to happen in ways that directly involved Dr. Pickles. They were essential to Ann's progress; she could not recover without them.

A similar understanding of such processes is presented by **Winnicott (1958a)** in his discussions of regression. He noted that certain patients—patients with serious environmental failures—are, as he put it, brought into analysis by an internal caretaker. They may not entrust the analyst with this function for years, if ever. Instead, Ann samples analysis "as a kind of elaborate test of the analyst's reliability." Only then does the patient feel safe enough to turn the caretaker function over to the analyst and allow herself to regress. She dares to regress in the hope of reworking and resolving the childhood developmental failure.

I was reminded of Dr. Pickles's resourceful, original, and individualized approaches to her patient when I read Winnicott's **(1958b)** comment on a case he treated: "I cannot help being different from what I was before this analysis started. … The treatment and management of this case has called on everything that I possess as a human being, as a psychoanalyst, and as a pediatrician. I have had to make personal growth in the course of this treatment that was painful and that I would gladly have avoided" (p. 280).

The Opening Phase

I will take up more specifically a few important therapeutic processes, starting with some in the opening phase. The task for both participants was to make it safe for Ann to remember her traumatic experiences and share them with Dr. Pickles. We have reason to believe that she did not have any person in childhood who could hear her story, believe it, validate it, and help her with her unbearable feelings.

Her father threatened to kill her if she disclosed his abuse of her; he blamed her for causing his mistreatment and punished her verbally and physically for her badness and shamefulness. Alone with her suffering, it would have been unbearably painful for her as a child to remember clearly and to believe what happened to her and now, in therapy, to "pour her heart out" (to quote Niederland's, **1981**, instructions to holocaust survivor patients) to a stranger offering help.

Dr. Pickles, in the beginning, directly encouraged Ann to talk and frequently interpreted to Ann that her feelings of dirtiness and self-loathing were *not* because she was disgusting but because she had been treated as though she was disgusting. This and other similar interpretations seemed to help the patient, who did present more of her story. But soon Ann challenged the therapist's approach as not helpful. I will state her objections like this: You are interpreting to avoid facing my feelings (Dr. Pickles believes this to be partially true); you are like everyone else—you want to tell me what to think or feel about what happened rather than listen to me; you are interpreting to get rid of my complaints rather than hearing them.

I believe that Dr. Pickles's initial stance was helpful: It communicated that Dr. Pickles would not blame the patient or find her disgusting if Ann proceeded with her story; it communicated that Dr. Pickles would not deny that traumatic mistreatment had occurred.

Nonetheless, Ann's criticisms were relevant, and Dr. Pickles dramatically altered her stance. She became quieter, more relaxed, silently "being there" with the patient, or, as Dr. Pickles also characterized it, she was "bearing witness" to Ann's story. It is clear that Dr. Pickles was not only attuned to Ann's traumas and suffering but also experienced them in herself through transient identifications and, further, that Dr. Pickles's own feelings were communicated to the patient.

This dramatic transition in Dr. Pickles helped to usher in a deepening of the analytic work. Ann remembered and told more about her childhood

abuse, torture, and deprivation, and eventually carried out the five episodes described in the presentation.

The First Episode

In the first episode, Ann announces that she feels suicidal, describes a plan to kill herself by crashing her car driven at high speed into a large tree on the way home from the session, declines medication or hospitalization, and forbids the therapist to disclose her suicidal feelings to other potential helpers: her husband, her physician, her close friend. She refuses to let Dr. Pickles contact her regarding this and she refuses to contact Dr. Pickles before taking actions to kill herself. The patient then rises to leave.

Dr. Pickles was not a happy camper. She tells us she felt frightened and helpless and was temporarily immobilized. This was a life-and-death situation; she was forbidden to contact others who could help. She felt as though "my hands were tied behind my back."

But as the seconds ticked by, Dr. Pickles recovered and hurled herself into the breach. She blurted out, "I cannot work this way, Ann. You and I are in this together. I care about you, and I don't want to see you hurt yourself in a vulnerable moment!"

Soon, Dr. Pickles recovered her capacity to interpret. She said, among other things: "I wonder if the way that I'm feeling, helpless and hostage to your refusal to allow us to draw on outside protective resources, is similar to how you felt helpless and hostage to your father and grandmother when you couldn't turn to anyone inside or outside the family for help or for protection."

This may or may not have been decisive, but Ann softened. She agreed to phone Dr. Pickles that afternoon and to stay overnight with a close friend. Dr. Pickles and Ann spoke each day by phone for a while, and Ann agreed to call before doing anything to hurt herself. Later Ann saw her physician for antidepressant medications. I have three comments:

1. Ann is genuinely suicidal. Her motivation to kill herself is based largely on survivor guilt. She believes she is responsible for her mother's death three minutes before her birth and, moreover, that *her* own life, her very existence was at the cost of her mother's death. She believes she does not deserve to enjoy herself, to have pleasure, when all the good things of life were snatched away from her mother because of Ann's birth. These beliefs

are likely to change slowly and to require a mourning of her mother's death as well as further analysis of her guilt.

2. Although Ann's suicidal feelings were genuine, I believe the episode enabled her to test Dr. Pickles by posing in action two implicit questions:

   The first was whether Ann had a right to live, since her life was at the expense of her mother's. Dr. Pickles, acting as a substitute mother, provided a strong—if necessarily only temporary—positive answer to that question.

   The second implicit question posed this dilemma: Can anyone cope with responsibility for the life or death of another person when she or he cannot share that responsibility with anyone else? In that room, as the seconds ticked away, Dr. Pickles was alone and momentarily helpless as Ann had been alone and helpless repeatedly in coping with feelings of responsibility for her mother's loss as well as for sexual abuse and torture that could not be revealed to anyone else.

3. I believe that Dr. Pickles's ability to function without self-blame **(Sampson, 2005)** in the midst of this crisis helped Ann derive strength in coping with her own feelings of responsibility, guilty enforced secrecy, and aloneness.

Two Other Episodes

I will comment briefly on the other episodes:

I believe the second episode may be a way of testing out and confirming the extent to which Ann can use Dr. Pickles as a reliable, effective caretaker in helping her with dangerous dissociative acts. In this episode, in contrast to episode 1, Ann openly depends on Dr. Pickles's help and complies with instructions from the beginning of the phone conversation (which the patient had initiated).

I do not know what triggered this episode, but the content of the episode suggests that Ann was working on the deeply held belief that she is irrevocably contaminated by her father's sperm; that is, she must not be free of her father's influence. This belief is itself a compliance with her father's perceived wishes.

The fourth episode seems to be concerned with the validity of her memory, which, as I suggested earlier, remained in doubt in childhood because she could not share her experiences with any caretaker. This meant not only that she could not validate the traumas that befell her but also that she could not readily even remember and review them in her own mind without facing

unbearable feelings alone. Moreover, as Drs. **Stolorow and Atwood (1992)** have pointed out, in this circumstance without an attuned caregiver, the memories and the unbearable feelings are split off, sequestered from the rest of the person's psychic life.

In presenting the package of "evidence" to Dr. Pickles, Ann defied her father as well as her frightening beliefs about disclosure. Therapist and patient opened the package together so that Ann could examine the proof in the presence of an attuned and validating helper. But even in this relatively safe context, the discovery that the abuse began earlier than she remembered threatened her own sense of the validity of her memory, and she fought against Dr. Pickles's reassurances. I think this episode is one part of a long process not only of validating the mistreatment and thereby overthrowing her father's edicts and interpretations but also of coming to trust her own experience and to overcome her own denial of what happened to her.

Better or Worse

I should now like to comment briefly on the special section of Dr. Pickles's report title, "To Present or Not to Present Our Work: Perturbing the System for Better or for Worse."

To step out flatfootedly, I think it was for the better. First of all, I think it was essential that Dr. Pickles discussed presenting the case with Ann, shared the write-up with her, and allowed her to choose to okay the presentation or to veto it.

Moreover, I believe that their discussion of this issue was a highly productive period of therapeutic work. I believe it helped Ann to make progress in several areas.

Let me count the ways—but briefly:

1. Dr. Pickles took the initiative in planning to speak to the world (or at least our small part of it) about the father's sexual and other parental misdeeds, which the patient had sworn to keep secret on penalty of death. The father's posthumous revenge now applied to Dr. Pickles. Dr. Pickles was aware of the warning, and she defied it. I think that Dr. Pickles's initiative made it easier for Ann to feel freer than before to defy her father and to overthrow the secrecy ban in her own life.

2. I think that the discussion of whether to present the case turned out to be a veritable practicum on mutuality in relationships. As we know, no one gave Ann much choice about anything in childhood. Moreover, there were many instructions in nonmutuality, for example, the sexual abuse and tortures; the secrecy that was good for the father and his family, but was bad for the patient; the act by which Ann was given life, the mother was given death. It was often difficult for Ann to believe that if something was good for her husband, it wasn't necessarily bad for her. If the analyst expressed an idea, the patient feared she must abandon her own idea. During the practicum, Ann learned she did have choice and that something (such as the presentation) might turn out to be positive for them both.
3. In addition, there was a closely related clarification of Ann's belief in her power to harm others. She said that she could not veto the presentation because it clearly enthused Dr. Pickles and was very important to her. Dr. Pickles acknowledged that she would be disappointed but not devastated. This straightforward intervention functioned as a powerful interpretation: that one can disagree in a good relationship without destroying the other person or the relationship. This interpretation made a distinction that is essential to mutuality and intimacy, including sexual intimacy. Ann is just beginning to experience sexual interest and pleasure.

These various trends—beginning to experience wholeness, vitality, selfhood, and mutuality, as well as partially overcoming Ann's conviction that she is destructive, with a slight reduction of her intense survivor guilt, all seem to me to be coming together in what Dr. Pickles characterized as "perturbing the system."

Conclusion

Finally, I was fascinated by Ann's eloquent and convincing explanations of why she did not wish to give up her belief that her mistreatment and suffering was in some way her own fault.

I was reminded of Fairburn's **(1952)** equally eloquent comment that "… it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (p. 17).

More concretely, Ann implies that if her suffering has no meaning and is an accident of having had a bad parent, there is nothing of her left. Life is

ruled by the devil or is a cosmic joke. Her suffering is for nothing, and she has no identity.

I think the idea of loss of meaning also implies a loss of psychic connection to the only parent she ever knew, and the only family she ever knew. It is painful to lose attachment to primary objects, even if those attachments are themselves painful and demeaning. I believe that these attachments may gradually be relinquished as the analyst (and other intense attachments) increasingly substitute for the lost objects. This process is accompanied by more or less overt mourning.

I think that something like this is beginning to happen to Ann and will continue to happen for some time. She will, of course, also mourn the mother she never knew.

Thank you for your attention to my attempts to understand Ann and her treatment.

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