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A theory of psychic retreats

A psychic retreat provides the patient with an area of relative peace and protection from strain when meaningful contact with the analyst is experienced as threatening. It is not difficult to understand the need for transient withdrawal of this kind, but serious technical problems arise in patients who turn to a psychic retreat, habitually, excessively, and indiscriminately. In some analyses, particularly with borderline and psychotic patients, a more or less permanent residence in the retreat may be taken up and it is then that obstacles to development and growth arise.

In my own clinical experience this type of withdrawal and the resultant failure to allow contact with the analyst takes many forms. An aloof type of schizoid superiority is expressed as a cold condescension in one patient and as a mocking dismissal of my work in another. Some patients are clearly reacting to anxiety, and their withdrawal appears to indicate that the analysis has touched on a sensitive topic which has to be avoided. Perhaps the most difficult type of retreat is that in which a false type of contact is offered and the analyst is invited to engage in ways which seem superficial, dishonest, or perverse. Sometimes these reactions can be seen to result from clumsy or intrusive behaviour on the part of the analyst, but it often happens that even careful analysis leaves the patients out of contact. They retreat behind a powerful system of defences which serve as a protective armour or hiding place, and it is sometimes possible to observe how they emerge with great caution like a snail coming out of its shell and retreat once more if contact leads to pain or anxiety.

We have come to understand that obstacles to contact and obstacles to progress and development are related, and that they both arise from the deployment of a particular type of defensive organization by means of which the patient hopes to avoid intolerable anxiety. I call such

systems of defences '*pathological organizations of the personality*' and use this term to denote a family of defensive systems which are characterized by extremely unyielding defences and which function to help the patient to avoid anxiety by avoiding contact with other people and with reality. The pursuit of this approach has led me to examine in more detail the way defences operate and, in particular, how they interconnect to form complex, closely knit defensive systems.

The analyst observes psychic retreats as states of mind in which the patient is stuck, cut off, and out of reach, and he may infer that these states arise from the operation of a powerful system of defences. The patient's view of the retreat is reflected in the descriptions which he gives and also in unconscious phantasy as it is revealed in dreams, memories, and reports from everyday life which give a pictorial or dramatized image of how the retreat is unconsciously experienced. Typically it appears as a house, a cave, a fortress, a desert island, or a similar location which is seen as an area of relative safety. Alternatively, it can take an inter-personal form, usually as an organization of objects or part-objects which offers to provide security. It may be represented as a business organization, as a boarding school, as a religious sect, as a totalitarian government or a Mafia-like gang. Often tyrannical and perverse elements are evident in the description, but sometimes the organization is idealized and admired.

Usually over a period of time various representations can be observed which help to build up a picture of the patient's defensive organization. Later I will try to show that it is sometimes useful to think of it as a grouping of object relations, defences, and phantasies which makes up a borderline position similar to but distinct from the paranoid-schizoid and the depressive positions described by Melanie Klein (1952).

The relief provided by the retreat is achieved at the cost of isolation, stagnation, and withdrawal, and some patients find such a state distressing and complain about it. Others, however, accept the situation with resignation, relief, and at times defiance or triumph, so that it is the analyst who has to carry the despair associated with the failure to make contact. Sometimes the retreat is experienced as a cruel place and the deadly nature of the situation is recognized by the patient, but more often the retreat is idealized and represented as a pleasant and even ideal haven. Whether idealized or persecutory, it is clung to as preferable to even worse states which the patient is convinced are the only alternatives. In most patients some movement is observable as they cautiously emerge from the retreat only to return again when things go wrong. In some cases true development is possible in these periods of emergence, and the patient is gradually able to lessen his propensity to withdraw.

In others withdrawal is more prolonged, and if emergence does take place the gains achieved are transitory and the patient returns to his previous state in a negative therapeutic reaction. Typically, an equilibrium is reached in which the patient uses the retreat to remain relatively free from anxiety but at the cost of an almost complete standstill in development. The situation is complicated by the fact that the analyst is used as part of the defensive organization and is sometimes so subtly invited to join in that he does not realize that the analysis itself has been converted into a retreat. The analyst is often under great pressure, and his frustration may lead him to despair or to mount a usually futile effort to overcome what are perceived as the patient's stubborn defences.

All gradations of dependence on the retreat are found clinically, from the completely stuck patient at one extreme to those who use the retreat in a transient and discretionary way at the other. The range and pervasiveness of the retreat may also vary, and some patients are able to develop and sustain adequate relationships in some areas but remain stuck in other aspects of their lives. One of the points I will emphasize throughout this book is that change is possible even in the analysis of very stuck patients. If the analyst is able to persevere and survive the pressure he is put under, he and the patient can gradually come to gain some insight into the operation of the organization and to loosen the grip and the range of its operation.

One of the features of the retreat which emerges most clearly in perverse, psychotic, and borderline patients is the way the avoidance of contact with the analyst is at the same time an avoidance of contact with reality. The retreat then serves as an area of the mind where reality does not have to be faced, where phantasy and omnipotence can exist unchecked and where anything is permitted. This feature is often what makes the retreat so attractive to the patient and commonly involves the use of perverse or psychotic mechanisms.

I am impressed by the power of the system of defences which one can observe operating in these stuck analyses. Sometimes they are so successful that the patient is protected from anxiety, and no difficulty arises as long as the system remains unchallenged. Others remain stuck in the retreat despite the evident suffering it brings, which may be chronic and sustained or masochistic and addictive. In all of these, however, the patient is threatened by the possibility of change and, if provoked, may respond with a more profound withdrawal.

These situations are of great theoretical interest but my own concern is primarily clinical, and this means that my central preoccupation is with the way organizations function in individual patients in individual sessions during an analysis. Here it is important to recognize that the

analyst is never able to be an uninvolved observer since he is always to a greater or lesser degree enlisted to participate in enactments in the transference (Sandler 1976; Sandler and Sandler 1978; Joseph 1989). In developing these ideas in the area of pathological organizations I have taken note of the way the patient will use the analyst to help create a sanctuary into which he can retreat. I have been most concerned to follow the situation in the fine grain of the session and to describe how the patient makes moves to emerge from the sanctuary only to retreat again when he confronts anxieties he cannot or will not bear.

It was the highly organized nature of the process which struck me and which led me to use the term 'pathological organization' to describe the internal configuration of defences. The clinical picture itself has become familiar to most working analysts and has been described in various terms by a number of writers whose work is reviewed later in the book. Abraham's (1919, 1924) study of narcissistic resistance and Reich's (1933) work on 'character armour' are early examples. Riviere (1936) spoke about a highly organized system of defences, and Rosenfeld (1964, 1971a) described the operation of destructive narcissism. Segal (1972), O'Shaughnessy (1981), Riesenberg-Malcolm (1981), and Joseph (1982, 1983) have also described patients caught up in powerful defensive systems. This and other similar work has been concerned with patients in extreme situations which can be thought of in relation to those ultimate obstacles to change which Freud addressed in 'Analysis terminable and interminable' (1937). Freud linked these deepest obstacles to change to the operation of the death instinct and, in my view, pathological organizations have a particular role to play in the universal problem of dealing with primitive destructiveness. This affects the individual in profound ways, whether it arises from external or internal sources. Traumatic experiences with violence or neglect in the environment leads to the internalization of violent disturbed objects which at the same time serve as suitable receptacles for the projection of the individual's own destructiveness.

It is not necessary to resolve controversial issues about the death instinct to recognize that there is often something very deadly and self-destructive in the individual's make-up which threatens his integrity unless it is adequately contained. In my view, defensive organizations serve to bind, to neutralize, and to control primitive destructiveness whatever its source, and are a universal feature of the defensive make-up of all individuals. Moreover, in some patients where problems related to destructiveness are particularly prominent, the organization comes to dominate the psyche, and it is these cases which allow its mode of operation to be most readily appreciated.

Once recognized, similar if less disturbing versions can be identified in neurotic and normal individuals.

It is not clear if these methods of dealing with the destructiveness are ever really successful. Certainly, the forms of organization we usually observe tend to function as a kind of compromise and are as much an expression of the destructiveness as a defence against it. Because of this compromise they are always pathological, even though they may serve an adaptive purpose and provide an area of relief and transient protection. Pathological organizations stultify the personality, prevent contact with reality, and ensure that growth and development are interfered with. In normal individuals they are brought into play when anxiety exceeds tolerable limits and are relinquished once more when the crisis is over. Nevertheless, they remain potentially available and can serve to take the patient out of contact and give rise to a stuck period of analysis if the analytic work touches on issues at the edge of what is tolerable. In the more disturbed patient they come to dominate the personality and the patient is to a greater or lesser degree caught in their grip.

The distinction between psychotic and non-psychotic parts of the personality introduced by Bion (1957) can help to differentiate the types of organization which arise in severely disturbed patients from those which exist in neurotic and normal patients, and this is discussed in Chapter 6, where a psychotic organization is described. In psychotic and borderline patients, the organization dominates the personality, where it is used to patch up damaged parts of the ego and as a result is indispensable to the psychotic part of the personality. The non-psychotic personality is less likely to make destructive attacks on its own mind, and since the situation is less desperate a more fluid type of alternation between projective and introjective processes can occur. Despite these differences there are many elements which pathological organizations of the personality in different types of patient have in common and which come to the fore when the patient is under pressure. If analytic work attempts to help the patient deal with problems at the limit of his capacity, difficult areas are raised even in patients who normally function relatively well, and in these situations the patient is likely to make use of a retreat to which he may in normal circumstances only rarely resort.

Even in normal and neurotic patients when the retreat is often represented as a space which occurs naturally or is provided by the environment, it can be seen to arise from the operation of powerful systems of defences. Occasionally patients themselves recognize how they create the retreat, and may even be able to identify the way it serves as a defence. Mostly, however, the description in terms of defences represents the analyst's point of view and forms part of the

analyst's theoretical approach. I have found a close examination of the object relations as they emerge in the transference to be particularly helpful in revealing some of the basic mechanisms which are involved in the workings of a pathological organization. To understand the details of their structure it is necessary to know something about the operation of primitive mechanisms of defence, and in particular about projective identification, which is such a central concept in modern Kleinian psychoanalysis. These are discussed later in the book, and at this point it will suffice to recognize that projective identification leads to a narcissistic type of object relationship similar to that which Freud described perhaps most clearly in his paper on Leonardo (1910). In the most straightforward type of projective identification a part of the self is split off and projected into an object, where it is attributed to the object and the fact that it belongs to the self is denied. The object relationship which results is then not with a person truly seen as separate, but with the self projected into another person and related to as if it were someone else. This is the position of the mythical Narcissus, who fell in love with a strange youth he did not consciously connect with himself. It is also true of Leonardo, who projected his infantile self into his apprentices and looked after them in the way he wished his mother had looked after him (Freud 1910).

A narcissistic type of object relationship based on projective identification is certainly a central aspect of pathological organizations, but this is not in itself sufficient to explain the enormous power and resistance to change which they demonstrate. Moreover, projective identification is not in itself a pathological mechanism and indeed forms the basis of all empathic communication. We project into others to understand better what it feels like to be in their shoes, and an inability or reluctance to do this profoundly affects object relations. However, it is essential to normal mental function to be able to use projective identification in a flexible and reversible way and thus to be able to withdraw projections and to observe and interact with others from a position firmly based in our own identity.

In many pathological states such reversibility is obstructed and the patient is unable to regain parts of the self lost through projective identification, and consequently loses touch with aspects of his personality which permanently reside in objects with whom they become identified. Any attribute such as intelligence, warmth, masculinity, aggression, and so on can be projected and disowned in this way and, when reversibility is blocked, results in a depletion of the ego, which no longer has access to the lost parts of the self. At the same time, the object is distorted by having attributed to it the split-off and denied parts of the self.

The study of pathological organizations reported in this book has led me to postulate further complexities of structure. The kind of defensive situation just outlined can arise as a result of normal splitting in which the object is seen as either good or bad and the individual tries to get the help of the good to protect him from the bad. It is clear, as Klein herself emphasized (1952), that such splitting of the object is always accompanied by a corresponding split in the ego, and it is a good part of the self in a relationship with a good object which is kept separate from a bad part of the self in relation to a bad object. If the split is successfully maintained, the good and bad are kept so separate that no interaction between them takes place, but if it threatens to break down, the individual may try to preserve his equilibrium by turning to the protection of the good object and good parts of the self against the bad object and against bad parts of the self. If such measures also fail to maintain an equilibrium, even more drastic means may be resorted to.

For example, pathological splitting with a fragmentation of the self and of the object and their expulsion in a more violent and primitive form of projective identification may take place (Bion 1957). Pathological organizations may then evolve to collect the fragments, and the result may once again give the impression of a protective good object kept separate from bad ones. Now, however, what appears as a relatively straightforward split between good and bad is in fact the result of a splitting of the personality into several elements, each projected into objects and reassembled in a manner which simulates the containing function of an object. The organization may present itself as a good object protecting the individual from destructive attacks, but in fact its structure is made up of good and bad elements derived from the self and from the objects which have been projected into and used as building blocks for the resultant extremely complex organization. In my view, the dependent self which is dominated by the organization may also be complex and not as innocent a victim as may first appear. It is not only the building blocks of the organization which need to be understood but the manner in which they are assembled and held together, because the dependent part of the self, and the analyst too, may become caught up and trapped in the tyrannical and cruel object relations which keep the system intact.

In later chapters I will try to show how in pathological organizations of the personality projective identification is not confined to a single object, but, instead, groups of objects are used which are themselves in a relationship. These objects, usually in fact part-objects, are constructed out of experiences with people found in the patient's early environment. The fantastic figures of the patient's inner world are sometimes based on actual experiences with bad objects and sometimes

represent distortions and misrepresentations of early experience. Trauma and deprivation in the patient's history have a profound effect on the creation of pathological organizations of the personality, even though it may not be possible to know how much internal and external factors contributed. What becomes apparent in the here and now of the analysis is that the objects, whether they are chosen from those which pre-exist in the environment or created by the individual, are used for specific defensive purposes, in particular to bind destructive elements in the personality.

I have argued that a central function of pathological organizations of the personality is to contain and neutralize these primitive destructive impulses, and in order to deal with these the patient selects destructive objects into which he can project destructive parts of the self. As Rosenfeld (1971a), Meltzer (1968) and others have described, these objects are often assembled into a 'gang' which is held together by cruel and violent means. These powerfully structured groups of individuals are represented unconsciously in the patient's inner world and appear in dreams as an inter-personal version of the retreat. The place of safety is provided by the group who offer protection from both persecution and guilt as long as the patient does not threaten the domination of the gang. The result of these operations is to create a complex network of object relations, each object containing split-off parts of the self and the group held together in complex ways characteristic of a particular organization. The organization 'contains' the anxiety by offering itself as a protector, and it does so in a perverse way very different from that seen in the case of normal containment, such as that described by Bion, to take place between a normal mother and her baby (Bion 1962a, 1963).

This formulation illustrates the extent to which the organization can become personified. In part this is a result of its evolution in early infancy, when many aspects of nature are experienced by the child as arising from the actions of people. In part, however, it results from the way the inner world remains one peopled by objects in relationships with each other as well as with the subject. No sanctuary is secure unless it is also sanctioned and protected by the social group to which it belongs. Sometimes it is possible to get information about deeper phantasies in which psychic retreats appear as spaces inside objects or part-objects. There may be phantasies of retreating to the mother's womb, anus, or breast, sometimes experienced as a desirable but forbidden place.

One of the major consequences of such a structure is that it is very difficult for the individual to risk a confrontation with these objects and repudiate their methods and aims. As a result, the reversibility of

projective identification is interfered with. I will argue later that this reversibility is established through a successful working through of mourning. The process of regaining parts of the self lost through projective identification involves facing the reality of what belongs to the object and what belongs to the self, and this is established most clearly through the experience of loss. It is in the process of mourning that parts of the self are regained, and this achievement may require much working through. Thus a true internalization of the object can only be achieved if it is relinquished as an external object. It can then be internalized as separate from the self and in this state can be identified with in a flexible and reversible way. The development of symbolic function assists this process and allows the individual to identify with aspects of the object rather than its concrete totality.

When containment is provided by an organization of objects rather than by a single object it is very difficult for projective identification to be reversed. It is not possible to let any single object go, mourn it, and, in the process, withdraw projections from it, because it does not operate in isolation but has powerful links which bind it to other members of the organization. These links are often ruthlessly maintained, with the primary aim of keeping the organization intact. In fact, the individuals are often experienced as bound inextricably to each other and the containment is felt to be provided by a group of objects treated as if it were a single object; namely, the organization.

To withdraw projections from one of the objects means that reality has to be faced in the area of that particular object relationship and then what belongs to the object and what belongs to the self must be differentiated so that the projection can be separated off and returned to the self. Even if defences operate singly this may be difficult, but when the object relations are part of a complex organization the inter-relationships ensure that the difficulty is extreme. The patient then feels trapped in an omnipotent organization from which there is no escape. If the analyst recognizes the omnipotence he or she is less likely to try to confront or combat the organization head-on. Such recognition, in my view, helps both analyst and patient to live with the omnipotence without either giving in to it or aggressively confronting it. If it can be recognized as one of the facts of life making up the reality of the patient's inner world, then gradually it may become possible to understand it better and as a result to reduce the hold it has on the personality.

I have emphasized how pathological organizations of the personality can result in a stuck patient in a stuck analysis, who may be so hidden from contact that it is difficult for the analyst to reach him. In other patients a similar overall situation results not so much from the lack of contact, movement, and development as from the fact that any

development which does occur is quickly, and sometimes totally, reversed. Once this is recognized it is often possible to see that similar, more subtle movements are discernible even in the most apparently stuck patient. As a result a more detailed description becomes possible, which involves following the patient as he makes tentative, sometimes almost imperceptible, moves towards contact with the analyst, only to retreat once more as he confronts anxiety. As the patient begins to emerge from the protection of the organization the ready availability of the shelter as a source of relief of anxiety and pain makes retreat a convenient option, and sometimes the experience of contact is so dreaded that withdrawal is immediate. Nevertheless, if this moment of contact is registered by the analyst and interpreted, the patient can sometimes gain an insight into his dread of contact, feel supported by the analyst, and as a result may gradually extend his ability to tolerate it.

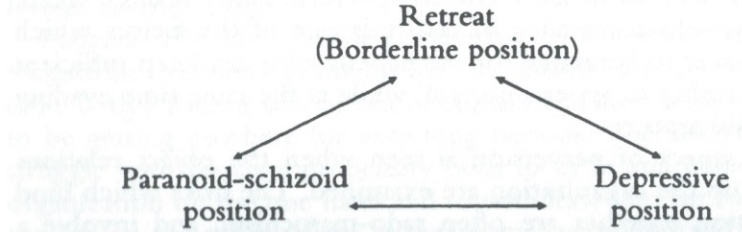
If the patient feels the analyst understands the nature of the anxieties which confront him as he begins to emerge from his retreat, he is more likely to feel supported and thus take further steps away from his dependence on the pathological organization of the personality. Here an important distinction exists between the anxieties of the paranoid-schizoid and those of the depressive positions as described by Klein (1946, 1952), and pathological organizations of the personality serve to protect the patient against both sets of anxieties (Steiner 1979, 1987). This point of view suggests that it is important not only to describe the mental mechanisms which operate at any particular moment but also to discuss their function: that is, not only what is happening but why it is happening – in this instance to try to understand what it is that the patient fears would result if he emerged from the retreat. If the minute movements are attended to, a transient and briefly bearable 'taste' of the anxiety which is experienced on emergence from the retreat can be registered by the patient and interpreted by the analyst as it becomes observable. This can allow the function of the defence to be identified and investigated. Some patients depend on the organization to protect them from primitive states of fragmentation and persecution, and they fear that states of extreme anxiety would overwhelm them if they were to emerge from the retreat. Others have been able to develop a greater degree of integration but are unable to face the depressive pain and guilt which arise as contact with internal and external reality increases. In either case, emergence to make contact with the analyst may lead to a rapid withdrawal to the retreat and an attempt to regain the previously held equilibrium.

Melanie Klein (1952) described the paranoid-schizoid and depressive positions in terms of a grouping of defences, and a pattern of anxieties and other emotions. Each is characterized also by typical

mental structures and by typical forms of object relationship, both internal and external. It is in relationship to these positions that pathological organizations can most readily be understood, and indeed the retreat can also be thought of as a position with its own grouping of anxieties, its pattern of defences, its typical object relations and characteristic structure. I have previously referred to it as a 'borderline position' because of its place on the border between the two basic positions (Steiner 1987, 1990a).

The terminology of the positions can be confusing because of the inferred connection to particular types of clinical disorder. Klein had to emphasize that the paranoid-schizoid position did not imply paranoid psychosis in any simple way nor the depressive position, depressive illness. In the same way, the term 'borderline position' is not confined to borderline patients, and although it is true that psychic retreats can be readily observed in borderline states they are also a prominent feature of psychotic patients at one extreme and of normal and neurotic individuals at times of stress, at the other. Klein herself occasionally spoke of a manic position and an obsessional position (Klein 1946), and these more organized defensive states have many features in common with psychic retreats. It is clear that not only the basic two positions but also the borderline position occur in all patients, and the notion of positions can help the analyst to consider where the patient is located at any particular time.

The patient can withdraw to a retreat at a borderline position where he is under the protection of a pathological organization from either of the two basic positions. This theme is elaborated later in the book, where use is made of a triangular equilibrium diagram to illustrate that as the patient emerges from the retreat he may find himself confronted with anxieties from either of the two basic positions.



When the analysis is stuck there is very little, if any, movement discernible in this equilibrium, and the patient becomes firmly established in the retreat protected by the pathological organization and only rarely emerges to face either depressive or paranoid-schizoid

anxieties. In less stuck situations, which of course occur in patients who may nevertheless be quite ill, and even psychotic, more movement is discernible and shifts occur in which anxieties are at least transiently faced. Here the loss of equilibrium may give rise to severe anxiety and immediate return to the retreat, but it may also enable analytic development to take place.

A striking finding with some examples of a pathological organization of the personality is that the organization is adhered to even when some development has taken place and the need for it no longer appears to be so convincing. It is as if the patient has become accustomed and even addicted to the state of affairs in the retreat and gains a kind of perverse gratification from it. The part of the patient which is in touch with reality is often seduced away by bribes and threats, and the whole organization keeps itself together by creating perverse links between its component members. Indeed, perverse mechanisms play a central role in pathological organizations, particularly in cementing the organization together and underpinning its immovable structure.

A particular type of relationship with reality which is characteristic of retreats plays an important role in preventing the move towards the depressive position which is necessary for development to occur. Freud, in his discussion of fetishism (Freud 1927), described how the patient adopts a stance in which reality is neither fully accepted nor fully disavowed, so that contradictory views are held simultaneously and are reconciled in a variety of ways. In my view, a central aspect of the perverse attitude is reflected in this kind of relation to reality. It is important in *sexual* perversions, where some of the basic 'facts of life', such as the difference between the sexes and between the generations, are simultaneously accepted and disavowed, but it has a more general applicability to any aspect of reality which is difficult to accept. In particular, we see it prominent in the difficult task of facing the reality of ageing and death to which a similarly perverse stance is often taken. A perverse pseudo-acceptance of reality is one of the factors which makes the retreat so attractive for the patient who can keep sufficient contact with reality to appear 'normal' while at the same time evading its most painful aspects.

A second aspect of perversion is seen when the object relations which make up the organization are examined. The links which bind the organization together are often sado-masochistic and involve a cruel type of tyranny in which objects and the patient himself are controlled and bullied in a ruthless way. Sometimes the sadism is obvious, but often the tyranny is idealized and develops a seductive hold on the patient, who appears to become addicted to it, often gaining a masochistic gratification in the process.

It is only with long and painful work that the patient begins to feel he has the capacity to say 'no' to the attractive pull of the perversion as alternative sources of help become available. He may then feel less entrapped by the organization and feel he only need turn to its protection at times of particular stress. As the addictive properties lessen he is able to free himself more and face psychic reality. Once this becomes even partially possible, mourning and loss lead to a partial recovery of parts of the self and the dependence on the organization is further loosened. It nevertheless always remains part of the personality where the patient can retreat when reality becomes unbearable. If it is recognized for what it is – namely, an area where perverse relationships and perverse thinking are sanctioned – the patient may accept an occasional need to adopt these methods without idealizing them. The protection of the retreat is then seen to offer a temporary respite from anxiety but no real security and no opportunity for development. Like other elements in the inner world, it can then be viewed more realistically and the patient can come to terms with it.

This preliminary outline will be expanded in the following chapters. It is clear that a psychic retreat can be conceptualized in a variety of different ways. First, it can be viewed spatially as an area of safety to which the patient withdraws, and second, this area can be seen to depend on the operation of a pathological organization of the personality. The organization itself can be seen as a highly structured system of defences and also as a tightly organized network of object relations. The retreat may also be usefully related to the paranoid-schizoid and depressive positions and can then be seen to function as a third position to which the patient can withdraw from the anxieties of either of the former. Finally, the perverse nature of the retreat can be viewed from the point of view of the patient's relationship with reality on the one hand and in terms of the sado-masochistic type of object relationships found, on the other.

Patients who find themselves trapped in a psychic retreat present formidable technical problems for the analyst. He has to struggle to cope with a patient who is out of contact and an analysis which seems to be getting nowhere for very long periods. The analyst also has to struggle with his own propensity both to fit in and collude with the organization on the one hand and to withdraw into his own defensive retreat, on the other. If the analyst comes to understand some of the processes better, he is more able to recognize the patient's situation and to be available at those times when the patient does emerge to make contact possible.