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Is there anybody in there: The Therapist as Echoist

> Christianity has done its utmost to close the circle and declared even doubt to be sin. One is supposed to be cast into belief without reason, by a miracle, and from then on to swim in it as in the brightest and least ambiguous of elements: even a glance towards land, even the thought that one perhaps exists for something else as well as swimming, even the slightest impulse of our amphibious nature — is sin! And notice that all this means that the foundation of belief and all reflection on its origin is likewise excluded as sinful. What is wanted are blindness and intoxication and an eternal song over the waves in which reason has drowned.
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> Friedrich Nietzsche, *Daybreak: Thoughts on the Prejudices of Morality*

In this chapter I consider the importance of the therapist's awareness of their own echoism, and their responsibility for acknowledging its presence in the clinical relationship. I recount the experiences of other therapists who have attended my training workshops on echoism, and I explore the acknowledgments made by these participants of their own echoistic traits which may have led them into the work of therapy. Illustrating how the skills of listening, repeating, reflecting and providing a container for powerful projections are requirements of the clinical practitioner, I ask how this might predispose the therapist to making particular interpretations if these are unknown defences in her own personality. I explain how an echoistic disposition in the therapist might make toleration of the echoistic patient difficult, as well as leading to countertransference problems produced by the echoist's difficulty in staying in therapy due to the focus of attention being uncomfortably fixed on her. Finally, this chapter highlights the requirement for reflexivity, the willingness to address difficult countertransference experiences in

supervision, and a call for as much awareness of the impact of the therapist's own echoism as her narcissism.

Permeability

One active aspect of echoism to which I have become alert is what I experience as permeability in the patient. In the Defensive echoist I may be conscious of the patient's attempt to draw me in, for example by asking me how I am, or by inducing me to speak, but what is much less tangible is the process taking place in which the echoistic patient is appealing to me to do or to say something through actively introjecting me. This can result in feelings of impotence, sometimes creating high levels of discomfort and anxiety in the ensuing silence, and producing an unconscious wish, behind the more conscious urge to fill the empty space, to 'fill' the patient, as an attempt to flee from this anxiety. In attempting to understand this I find it useful to consider Samuel Beckett's *Waiting for Godot*, in which the recurring wish to quell the existential anxiety felt by the two main characters Vladimir and Estragon, is *to do something*, in order to avoid the angst produced by endless waiting. The line "There's nothing to be done" reflects a painful state which must be borne by both in coming to terms with the absence of another to fill the emptiness, and to provide a focus away from the truth of their predicament.

Aspects of echoism, like narcissism, are present in every individual but, as I discussed in Chapter Four, these become problematic when they dominate the personality. It is essential therefore that all therapists continue to monitor and reflect upon their own echoistic tendencies. The requirement to actively introject the other as part of a willingness to accept their projections, in order that they can be thought about and, eventually, understood, is a normal part of clinical practice and it is one in which the therapist's echoistic tendencies can go undetected.

I have, as part of my method, made use of *epoché*[1] (the bracketing of the therapist's own feelings). What has surprised and interested me is the way in

[1] *Epoché* (ἐποχή) means 'suspension'. It has been used in the philosophy of Descartes and Husserl to refer to the suspension or 'bracketing' of judgement in relation to matters felt to require a completely open attitude towards phenomena, to examine them as they are originally given to consciousness, before

which echoistic patients have somehow managed to pick up these bracketed feelings. Echoists seem to pick up anxiety and other feelings in the therapist in a way which can feel uncanny. This leads me to believe that the echoist has some of the qualities that can take some therapists many years to develop. For those echoists who decide to work as clinical practitioners, there is a risk that what appear to be skills could actually be being used unconsciously as defences, and it is essential that these are detected and worked on during training and supervision.

The Therapist as Echoist

It is widely accepted that therapists should have a commitment to an evolving understanding of their tendencies towards specific responses in stressful emotional situations, so that they may function in their role in the best interests of the patient. The necessity for the therapist to acknowledge and to explore, in their own therapy and supervision, any narcissistic traits she may possess, in order to understand the communications of the patient and her own countertransference reactions, is well documented. As this book shows, the impact of echoism on the other and the predisposition for the echoist to form a couple, and to play particular roles in relating, makes the necessity for such open acknowledgement and exploration of echoistic traits in the therapist, imperative.

As I say, echoistic characteristics can be found or elicited in all of us and not simply in echoists. The reader will now be familiar with these traits from the observations made in this book. Without having had the opportunity to explore these in their own analysis or therapy, however, they may be less conscious of them in themselves and in their practice. In the writing and researching of this book I have worked with many practitioners and had the opportunity of learning about their experiences with echoistic patients. One subject of lively discussion relates to the defences found in therapists, in terms of engaging with echoism, if and when it resonates with aspects of themselves.

'the synthesis of the understanding' (Kant). The term was popularized in philosophy by Husserl, who developed the notion of 'phenomenological epoché, the bracketing principle. He also called it the procedure of 'phenomenological reduction'.

In many of the humanistic therapy trainings, practitioners are required to demonstrate a range of skills including listening, mirroring, reflecting back and repeating the patient's words. As the clinician develops further, other ideas are introduced, including openness, *epoché*, and a willingness to take the patient in and to allow their projections to reside within them as a way of resonating with and understanding their feelings. It is not difficult to see that these requirements common to all therapists, regardless of modality and training, are also aspects of echoistic relating. We can see how they also correlate with the behaviours of Echo in the myth.

In the case of what we have called the *ordinary individual*, these echoistic behaviours listed above may be regarded as the very important skills required to perform the work effectively. If, however, an echoistic therapist is working with aspects of narcissism in a patient, or with aspects of echoism, or with an echoist, then the lack of awareness of the therapist's own potential for the echoistic use of primitive defences may lead to the very opposite of growth in the patient's mental life and indeed actual life.

Earlier in the book I described the nature of echoism, and I considered the behaviours which can be attributed directly to the echoist as *active* rather than passive. In their thinking about narcissism, therapists are less focused upon traits common to the narcissist, than to how they interact with us, and act upon us in the clinical situation, as well as the ways in which they relate to others in the world. The same applies to echoism, and I believe that we need to pay as much attention to our own echoism as we might to our narcissism, and to retain a capacity to differentiate between our own echoism and that of the patient.

In working with the patient's narcissism the echoistically inclined therapist may be unaware of her own permeability and therefore not as alert as she might be to the projections of the narcissist, which will tend to feel natural, making them harder to interrogate and interpret. Another hazardous situation to which the echoism of the therapist may contribute, is an invisible power-relationship in the room, in which she becomes intimidated by the narcissistic patient or flattered by his seductiveness and his assertions that the therapy really is working and helping him. She may also feel responsible and inadequate if the patient asserts that it is *not* helping them. Being able to account for the unconscious role her own echoism is playing in this process enables the therapist to identify what the patient is doing more clearly, and, in the supervisory relationship, to help her supervisor

to gain a detailed understanding of the processes within which she is involved. This insight may prevent a repetitive recycling of a hidden mode of relating that I have described as ENC pairing.

The consequences may be quite different if the therapist is working with an echoistic patient and is unaware of her own echoism. A patient who is unable to speak about herself may be experienced by the therapist as *resistant* when the silence becomes too uncomfortable. If an echoistically inclined therapist feels actively drawn to fill the space produced by the passivity of the echoist, she may consciously or unconsciously become resentful towards her patient, frustrated at what might feel like the patient's punishing use of a psychic retreat.

Reflexivity and supervision

In the course of training many practitioners have come to recognise some of their patients as echoists, having previously conceptualised them as narcissistic, *As-If*, or borderline personalities. Collating the thoughts and experiences of these therapists has produced fascinating insights. In these discussions a major concern that has emerged is the danger of encountering what might present as a lack of self, or a false self, and concluding that the patient is unsuitable for therapy[2]. This emphasises the need for the concept of echoism to be regarded seriously. In order for therapists to be able to consider the impact of their own echoistic traits on their clinical relationships, it is also vital for supervisors to be aware of the concept and alert to phenomena that the therapist may be less conscious or even unconscious of in herself, and which is only available for understanding afterwards and with another.

If the therapist herself possesses echoistic traits but is not conscious of them she is in danger of using them unwittingly and with little or no awareness of the consequences. This is made more likely in terms of the numbers of individuals with strong echoistic behaviours whose natural habitat might easily be found in the therapist's role where she can exercise these aspects of herself. These can pass largely unnoticed by herself or even a keen supervisor, who, without having an explicit awareness of the processes of echoism, may be unable to make the requisite observations in amongst what looks like the natural run of a clinical session. I think most supervisors would be equipped to identify and to explore

[2] And see Chapter Six, *Mistaken Identity*

narcissism being enacted by the therapist, but their supervisee's echoism is likely to remain far more elusive.

One real danger is that a therapist unable to take responsibility for her own echoism might inadvertently project echoistic aspects of herself powerfully into the patient. Such an event is likely to result in the therapist's denial of the anxiety at being with another who reminds her of herself, anxiety which may elicit narcissistic defences in the therapist. In consequence, she may unwittingly enact the very same relationship that the echoist seeks in the world but, being unable to observe it, she would therefore fail to interpret it, because it would remain unconscious. I have conceptualised this dynamic, with which I have become familiar, as the forming of an echoistic-narcissistic couple (ENC[3], see chapter 8). If this interactive process goes unnoticed, the patient's pattern of echoistic relating can be further reinforced.

My work suggests that another aspect to which the therapist needs to be alert, and open to experiencing, is the role of an ego-destructive object – particularly if she herself has such an object. When I run training events on Echoism, I ask therapists to listen to the different and dominant voices of the objects in their minds. This interactive exercise, which usually takes place near the end of a course, once there is some trust in the group, can elicit powerful reactions and valuable insights.

Vignette

Serena, a Person-Centred Therapist who attended an event on Echoism and Narcissism, took part in the aforementioned exercise. She became concerned that she could herself be an echoist. She also reflected on the method of therapy in which she had trained, and she became aware that specific features of her approach might well have lent themselves to colluding with, and to reinforcing, certain defences in her patients rather than challenging them. She described using mirroring and echoing back the patient's own words, and she said her approach encouraged offering "unconditional positive regard"[4] to the patient. Serena explained that her ability to offer these skills had led her into her profession, and that they were very natural for her. She reported, however, becoming aware throughout the day of the dangers of offering these to a narcissistic patient, one of

[3] ENC – an echoistic narcissistic couple who form a complex dynamic of relating

[4] One of Carl Rogers' core principles of Client-Centred Counselling

which was her fear that she would collude with him and, in all likelihood, be susceptible to forming an ENC relationship with him.

The group members asked her how she felt her own echoism might affect echoistic patients, and wondered whether she had worked with any that she would now consider to be echoistic. Serena remembered a patient with whom she had started work, and whom she now regarded as echoistic, but who had left after just seven sessions. She recalled the crushing feeling she had experienced in long and painful silences, and described how her attempts to stay attuned to the patient resulted in feelings of inadequacy and incompetence, as the echoist asked her what she should do and threatened to leave as each session drew to a close, stating that she felt she was not being helped. The therapy had ended, somewhat to Serena's relief, after her supervisor had felt that the patient was not yet ready to engage in the work of therapy. What was so interesting, in the context of the work in this book, was that Serena shared with the group the circumstances under which the therapy actually came to an end. She explained that her supervisor had suggested to her that the next time the patient spoke in the way that had become routine, Serena might say that she understood the patient may not be ready. She said she simply had echoed the words of her supervisor at the very next session, and this had brought the therapy to an end.

Analysis

The discussion which took place following this raised important questions about the suitability of the practice of echoing back the patient's words when working with echoistic or narcissistic patients. Actions used to convey 'unconditional positive regard', when expressed to a destructive narcissist, or a patient with a destructive narcissistic object, proved to be both problematic and contentious, and led to further discussions about how supervisors might help therapists to deal with the specific and difficult demands of working with narcissistic and echoistic patients. Serena concluded that she had been made aware that she was practising a method which felt very natural to her, but which may have largely been based on a defensive organisation of her mind, one that until then she had been unable to acknowledge, and which her supervisor had not detected.

Acting through the therapist

I have found that the self-destructive echoist has a narcissistic object from whom they cannot always differentiate themselves. The presence of such an object, when the therapist herself is echoistic to a significant degree, makes understanding the transference and countertransference in the clinical situation incredibly complex. The following short vignette depicts an experience shared by one therapist, who attended a training course. She identified in herself a largely narcissistic object, and she shared a clinical experience in which she was able to understand something of the role this object played in her own mind, and its impact in the sessions with a self-destructive echoistic patient.

Vignette

Catherine had been practising as a therapist for many years and had decided to attend a training on echoism because she thought she recognised aspects of herself in the description provided for the workshop. Throughout the day the concept of a critical voice resonated so strongly with her that she expressed some relief in the workshop at being able to share it, and to feel that others had experienced something similar. She expressed a secret fear that if she had mentioned this on her training or to a supervisor, they might think she was schizophrenic. This turned out to be a common fear, and could be seen as a barrier to being able to talk about the work openly and transparently, with further consequences for the patient. In a clinical seminar later on in the workshop Catherine presented her work with a patient whom she now believed to be echoistic. She described a situation in which something led her to be defensive in supervision, and protective of the patient whenever the supervisor detected hostility in the transference. She described repeating the patient's own words to the supervisor, and reported that these were often delivered with some force and judgement that the supervisor detected, but that Catherine could not see.

Analysis

The group had powerful reactions to Catherine's clinical descriptions and were able to recognise the presence of a particular feeling of *certainty*, both of the patient – who Catherine described as echoistic and unconfident – and of the therapist. This resounding *certainty* present in the atmosphere seemed, on discussion of the case, not to belong to the patient, nor to the therapist - who was

generally felt to be tentative and halting in her communications - but seemed instead to be the property of a narcissistic object in the patient, one which *operated and projected through* Catherine.

When the therapist's own object, which was less malignant yet more critical than the patient's, had the chance to impose judgement on Catherine, she experienced crushing feelings and thought herself incompetent as well as arrogant, and feared that she herself was a narcissist. The group felt that they were able to help Catherine understand something of what might be taking place in the sessions, based on their own countertransference reactions to the material and to Catherine's session with her supervisor. This relationship in which the self-destructive echoistic patient's narcissistic object is projecting through a defensive echoistic therapist with a critical object of her own, revealed a highly complex process which required a good degree of understanding of echoism.

Conclusion

This chapter raises further questions as to whether specific clinical approaches may be more appropriate than others for working with echoism and narcissism. It not only indicates but confirms the need for training in echoistic phenomena and relating, for all therapists and supervisors.

The next chapter takes this further in considering how the concept might be developed both theoretically and clinically, and how the balance of attention given to narcissism over echoism might begin to be redressed.