Response to: The Infantile and its vicissitudes in the therapeutic relationship

I was pleased to be asked to respond to this paper on the challenges for the therapist in dealing with the emergence of the Infantile in therapeutic work. In doing so I will be speaking about some related ideas some of which are from the recently published books of Florence Guignard and Jan Abram both of whom presented to us in our pre-Open Day public seminar series on the Infantile. I hope this will help us to think further about what Matt has raised and stimulate the discussion.

Matt focusses on a particular phenomenon - that of the eruption of periods of time in a therapy when chaos and confusion reign, when thinking and understanding are obliterated and there is enormous pressure to act. He raises the important issue of the therapist's internal capacity to recognise, understand and respond appropriately at these times to the inner distress of a patient who may be communicating in the only way possible, that is by projective identification, a very early catastrophe that has been encapsulated in the mind which is surfacing in the therapeutic setting. Specifically this is the catastrophe of the infant's experience of chaos and confusion in the absence of another mind that is able to receive, modify and make the raw experience more bearable. A relationship over time with a mind which can assist in registering, metabolising and regulating affect is the basis for the establishment of the container-contained relationship necessary for transforming distress to comfort, a projective identification welcoming mind. Without this foundation the further development of the mind is severely compromised. Without containment a fear and hatred of emotion can underlie powerful destructive defences against recognition of one's own experience.

Matt warns us of the slippery slope from impasse, boundary crossings towards serious boundary violations that can occur when a therapist repeatedly fails over an extended period of time, to grow what he calls their own alive, dynamic internal workspace in

response to the demands of a patient and reminds us of our professional, ethical responsibility to undertake the highly personal internal work that is necessary to meet the patient's needs.

Donald Winnicott's concept of the breakdown that a patient fears in the future but which is actually a breakdown that they have been through in the past, but which they have not experienced 'because they were not yet there to experience it' is clearly also describing the infantile catastrophe. Winnicott attributes this to failure of the earliest environment, that is the mother or other, at the stage he calls absolute dependence.

For Winnicott, madness means the infant suffered unthinkable anxiety, a state of mind in which nothing can be comprehended because there is no ego functioning in the infant and deficient ego protection from the m/other. He says this is a fact of the patient's history and it is this fact that has to be lived through in the transference of the analysing situation.

Jan Abram suggests that the terror of returning to this infantile state of mind underlies the intense resistance to psychic change which can be thought of as a negative therapeutic reaction. She goes on to describe how the negative therapeutic reaction can be the patient's unconscious anticipation of the eruption of the early trauma, which alongside the patient's need to remember and bring it into consciousness, is facilitated by the safety of the therapeutic setting. If the therapist can survive the storm and remain reliable this provides the potential for the patient to place the trauma in the past and so liberate them to live creatively in the present.

In his paper today Matt is drawing our attention to those very difficult times in a therapy when we might be overwhelmed by a negative therapeutic reaction or 'blown away' by the nature and the force of projections, or when they might touch too closely on our own unexplored infantile psychic areas. Being thrown by this experience we might not recognise enactments or our own defensiveness, and we may not be able to re-establish our equilibrium or a balanced state of mind without both external

support and internal work. We might not be able to survive the storm.

From her many years of clinical observation Florence Guignard, - offers us a theoretical explication of the operations of the Infantile in the therapeutic relationship which I think may help to further flesh out our understanding of what happens in the therapeutic encounter.

She finds that transference and countertransference appear and are active precisely at the meeting point between the Infantile of the patient and the Infantile of the therapist and gives a metaphor of the analytic space as a shifting constellation of points of impact that generate tensions between the psychic space of the therapist and that of the patient.

She states that

"Like every human being the [] therapist has his own defences against too exciting, conflictual or painful infantile experiences and fantasies. These are moments when the []therapist may either find himself invaded by a representation with which he does not know what to do or in a state of paralysis and representational emptiness. In both cases he risks grasping at an inadequate representation and offering it to his patient or simply to serve as a guide to his own distraught listening".

She names these moments, which are vicissitudes of projective identification, **blind spots** in which the therapist is unconsciously identified with the infantile in the patient or with one of the internal objects of the patient's past. She described how blind spots can lead to what she calls **stopper representations** – which is saying and doing anything rather than concentrating attention on what is hurting – a kind of closing the question before having examined it - and **stopper interpretations** which have the function of denying the absence of representations. The therapist may for example, resort to commenting on the patient's personal history, may turn to theory or revert to blaming the patient.

She proposes that whenever the therapist is unaware of blind spots the drive excitation arising from the encounter of the two Infantile aspects of patient and therapist can only increase. In the treatment of children motor agitation may dominate the clinical picture while with adults an unanalysed negative transference may be masked by an erotization of the transference. We can glimpse here, the connection to issues, which if not dealt with, may lead to the slippery slope of boundary transgressions.

As well as reminding us that Freud contemplated the analyst's need for further periodic personal analysis, perhaps every 5 years, she argues that 'because [the therapist's] [..] main instrument for healing is their own self, it is of utmost importance to update conceptual tools to think about this'.

In addition to the crucial ongoing personal inner psychic work that is required of us as clinicians we are of course also obliged to remain open to and abreast of extensions and elaborations of theory such as those provided by Guignard and Abram which might contribute to our understanding of some patients.

I think we can be blinded not only by our unconscious identifications but also by our adherence to, or privileging of particular familiar aspects of theory. What we hear, what we make of what we hear and how we respond to what we hear in a patient's communication is also a result of the ideas and theories that guide our understandings and our technique.

The interpretation of the destructive aspects of a patient for example may at times be a defensive attacking and blaming of the patient by the therapist which may be justified consciously by recourse to dearly held aspects of theory. It is well known that we seek the safe harbour of the certainty of our theories at times when we feel most at sea.

In this light, I would like to flesh out a little bit more the ideas behind the two different perspectives which were offered by two consultants in the clinical example. In relation to how a clinician might

understand and choose to interpret a patient's destructiveness, Jeffrey Eaton (2005) writes that:

"it is very important to differentiate the consequences of violent projections, which are, indeed, often destructive, from their motivation which may be very different. The intensity and pervasiveness of some forms of violent projection may be part of an unconsciously frantic search for a helping object that can transform pain and distress into comfort".

Understood in this way the behaviour is related to a primal need to seek what is needed to survive and develop, rather than the desire to destroy. These patients may need to internalise a container-contained relationship before they can benefit from insight about their destructive aspects.

Being able to hold and move between paradoxical understandings of our patients rather than collapsing to one dimensional thinking is considered (Bergstein 2015) to facilitate growth and transformation. This is the challenge for us as we endeavour to assimilate new aspects of theory and related technique as the field develops. It is one of the privileges of this demanding work that it requires us to attend to and keep our own dynamic internal workspaces alive, with the consequential benefits to our own deeply personal growth and development.

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