The Infantile and its vicissitudes in the therapeutic relationship

Matthew McArdle, Saturday, September 10, 2022

The baby in the cot

Let's begin with a baby. He lies in the cot having woken from a deep sleep. Momentarily he is peaceful. He appears to be 'feeling' his surrounds; the distant sounds, the colours in the room, the sensation of the blanket wrapped snuggly around him. After a few moments, an awareness dawns on him. He is alone. He is without that life-giving presence of his mother. He wriggles, writhes, and becomes quite tense. Then, from his mouth, but in a sense from his whole face and body, a cry erupts.

Sometimes this cry seems like a call 'I'm here. I'm waiting. Please come now.' Other times the cry is much more. It is an expression of deep inner fear and distress. A fear of unbearable 'annihilating,' aloneness . Maybe, we could call this second cry, a scream.

Mum hopefully arrives and attends to her baby's physical needs, feeding, changing, bathing, holding. However, the deep scream of distress also requires the mind of a mother that can hear and take it her babies overwhelming fear. Only then can she make the 'scream' a bearable experience.

Introduction

Bion suggested that "Freud's analogy of archaeological investigation with a psychoanalysis was (useful) if we considered we were exposing evidence not so much of a primitive civilisation as of ***a primitive catastrophe***." This primitive catastrophe is the psychic distress of unmet, unbearable raw experiences. The catastrophe of not having a ***mother-mind*** to ***modify*** and make bearable 'raw experience.' In analysis we deal "not so much with a static situation that permits leisurely study, but of ***a catastrophe*** that remains at one and the same moment ***actively intact*** and yet ***incapable of resolution***."

When these active and present catastrophes emerge, they can be unbearable for both patient and therapist. In this paper I want to explore the difficulties we as therapists have developing our own ***inner workspace*** to bear our patients inner catastrophes. When we are unable to provide the inner space to meet our patient's archaic catastrophes then we will

likely participate in enactments with our patient. If these enactments persist without reflection, then I believe they can lead down the slippery slope to boundary crossings and on some occasion's boundary violations.

I will illustrate this theme with broad examples from my own reflections on clinical experiences and hearing the clinical experiences of colleagues. I will draw selectively on theory that I have found useful and relevant in my own clinical work. This is in no way a systemic review, but a selective discussion. I am particularly drawing upon the thinking of Melanie Klein, Donald Meltzer, Wilfred Bion and Herbert Rosenfeld. Their thinking has been extremely useful to me in grappling with the intense and archaic experiences patients bring into the consulting room.

I will be talking about those patients who have pockets of their personality that seem fixed and stuck in an early catastrophe at the paranoid schizoid level of surviving.
I think that it is likely that within all of us there are these early undeveloped pockets of our personality and experience waiting to be met by an available mind.

Patients inner, undeveloped 'fixed' catastrophes erupt often in unexpected ways and at unforeseen times in therapy. When they do 'emerge' these feelings are often experienced as violently projected into us as therapists. ***It is essential to meet our patients 'where they are at' in the moment .*** When archaic catastrophes erupt, patients are needing to communicate to us in a pre-verbal way.
If we are not open to 'hearing' these communications then these unmet, unheard communications can lead to acting out by the patient, collusion between patient and therapist and enactments by us as therapists.

<u>The Therapeutic Situation</u>

Therapy should be a safe place that prioritizes reflective thought, symbolic meaning through words and experiencing above action. In the therapeutic space a patient has the rare opportunity to explore otherwise hidden, unknown and unthought aspects of themselves. The therapeutic frame, maintained by us as therapists, protects both participants by 'prioritising' reflective thought and refraining from action without thought. When intense, archaic feeling states are present the pressure to 'not think', to act and to expel feelings can

be extremely powerful. Sometimes we as therapists are accused of being 'all talk' and 'no action.' There is truth to this accusation. However, it is untrue that a therapist should never act.

Interpretations are a form of action. Hopefully, our interpretations come from inner 'work' as therapists and not as reactions to intense feelings that we are unable to bear and need to expel. Often, we find ourselves spontaneously responding to our patients. This is not a crime. In fact, it may represent an attuned 'response.' What is essential is that we can reflect on our actions and enactments, including the words we say to our patients.
I give Peter my dates of leave for the coming months. During the session he is withdrawn and seems angry. It is important that I recognise that giving him leave dates is action on my part and that it effects Peter and may have potential significance for him.
If I am open to hearing Peter's response I can explore with him, as he is able to, how he feels when I make these decisions without consulting him that affect him.

Mary comes to her session and asks to meet by Zoom next week as she plans to travel interstate. How do I respond to Mary and her request? After covid and lockdowns this is a complicated situation. Do I 'defer' to ***'the rules'*** in a **rigid** way and say 'no.' Do I **acquiesce** to Mary's request? Or can Mary and I create the space to do the hard work together of exploring the relevance and potential meaning of both her request and the possible responses to it? Do I need to *please Mary* and without thought, acquiesce to her request? Can I *tolerate Mary's anger* if I delay or decline to offer an alternative method or time of meeting? Do I *experience the request as a demand* and *resent Mary* for making it? Can I develop and under pressure maintain the ***space within myself*** for ***reflective thought*** leading to more ***informed action***? Or do I ***act without thought discharging and expelling difficult feelings***?

If I don't develop space in myself and with my patient for thought, then a pattern of ***action without thought*** can develop. If I do 'hear' and contain Peter's feeling of being belittled and uncared for when I leave him out of my leave-making decisions, then I am unable to respond to his need.

If I cannot tolerate Mary's frustration and anger, then I am incapable of exploring with her the possible meaning of what she is bringing to her session. Containing and exploring difficult feelings is growth promoting and leads to informed decision making. If I cannot do this, I leave Mary and Peter with the idea that ***difficult feelings can only be expelled***. If we as therapists do not recognise our ***thoughtless actions,*** then we are more likely to engage in recurrent enactments.

Some all-too-common situations

Joe

Joe has a lifelong habit of 'getting under other people's skin. He tends to make comments that irritate and annoy those around him, usually resulting in fracturing of his relationships. His therapist sees herself as a kind and caring person. When Joe begins to irritate her, she ignores these feelings. She compensates by being more friendly and agreeable in her interactions with him.

Sally

Sally has a history of early life neglect and childhood sexual abuse. She has been working in intensive therapy with her male therapist for several years. She feels abandoned and neglected when her sessions end. She feels heard by her therapist, but the sessions stir up deeply painful feelings and memories. At the end of each session, she stands and looks at her therapist with tears in her eyes. One day she says to him "I can't leave unless you hug me." Her therapist cannot tolerate the rejecting feelings if he declines her request, so he embraces her. This recurs frequently.

The therapist feels embarrassed and ashamed of what is happening so does not discuss it with colleagues and tries not to think about it himself. The therapist convince himself the 'hugs' are therapeutic. He denies his own feels of comfort derived from the physical contact.

Jane

Jane never felt her parents supported her enough as a child. Her therapist likes to feel she is helpful to her patients. Overtime the therapist begins to feel she is letting Jane down. She begins to feel inadequate as her therapist. In response she offers Jane advice. She makes

recommendations on books to read and cultural events to attend. Jane begins to text her therapist when she attends these events.

Then, in one session the therapist discloses to Jane that she will be attending the same concert that weekend. As both are going alone, they agree to meet and have coffee beforehand.

Discussion

Joe, Sally, and Jane are all bringing common internal distress and difficulties to their therapy. Joe needs a therapist who can tolerate him 'getting under their skin;' a therapist who can tolerate the irritation and anger this engenders and can begin to consider with Joe why he needs to relate in this way. However, Joe's therapist wants to be kind and helpful and, cannot find the inner workspace to be irritated and angry at her patient.

Sally carries within her deep pain, confusion, and neglect. She needs a containing and thoughtful mind for this unresolved pain. Jane needs a therapist with clear boundaries who can tolerate feeling inadequate and disappointing to her.

Jane feels disappointed, let down and angry at her parents. She needs a therapist who can bear being a disappoint to Jane; a therapist whom she can feel angry at and let down by. Unfortunately, Jane's therapist needs to feel helpful and cannot contain these experiences. For their own reasons each of these therapists cannot find the inner workspace to contain and make bearable their patients' distress.
Each end up in enactments with their patients. Some of these enactments cause boundary crossings and others to a violation of the basic trust between patient and therapist.

The infantile in the analytic process

In the analytic process both participants are engaged in the intensity of early infantile experiences in the transference relationship. The analytic setting fosters these infantile experiences in patients. Strong transference feelings develop towards the analyst. Equally strong are countertransference feelings form in the analyst. Intense infantile experiences are also stirred up within the analyst. As therapists our capacity to bear and manage these

strong feelings is central to the therapeutic process. If we are unable to tolerate these feelings, we will need to expel them through some form of enactment or boundary transgression.

In managing pre-verbal, 'part object,' non-separate relations we as therapists are often left floundering in the area of experience that is ***before and beyond words***.

Underlying enactments there is often a loss of distinction and separation between self and other, internal phantasy and external reality, and a failure to recognise the most primitive infantile relations in the transference/countertransference dynamic. In this dynamic it is essential for us as therapists to determine those aspects of the 'counter-transference' that relate to ***the therapist's own unresolved difficulties***, which are at least partly, ***mobilised by the patient's projections***.

This difficult work highlights our obligation as therapists for our own personal therapy, supervision, adequate training, and ongoing participation in clinical groups. I believe that institutional and educational supports are not enough. As therapists we must develop our own internal workspace through personal therapy and then ongoing self-analysis. I believe it is essential that we all establish and maintain ***alive internal workspace*** that can act as a container for the patient's earliest contents of raw experience.

Patients come to therapy with both developed/mature aspects and underdeveloped/immature aspects of their personalities. As therapists we are familiar with and often comfortable working with the verbal, 'neurotic' aspects of the personality. Yet, in intensive psychotherapy non-verbal, undeveloped aspects of personality, eventually, emerge. These early, un-worded pockets of the mind must be communicated like a baby to a mother, not in words, but in a different and archaic way. These communications are not worded but felt.

They need to be felt by us as therapists in the same way a mother 'feels her way into knowing' and understanding her baby. These early, non-verbal experiences need a containing therapist who can 'take in' raw emotional contents. This container/contained relationship transforms the earliest experiences, making them bearable and understandable. This earliest form of communication happens beyond words. We as therapists like parents

have to be containers for early un-worded experiences to hear and see beyond words to inner distress, to the scream and the unresolved catastrophe of patient's early lives. As attuned therapists we respond, not just to words, but to underlying fears and emotions communicated by ***projective identification*** (I will return to discuss projective identification further).

Clinical Vignette

To begin with I want to thank a colleague who shared the following situation with me and has given permission for me to include it in this discussion. The case has been de-identified so that it cannot be recognised. The patient had been attending regular sessions for several months and had developed a good rapport. He seemed open and willing to explore his interior life. He was open to interpretations about the here and now relationship between him and the therapist. He acknowledged connections between here and now events and the past. The therapist was aware that the patient had experienced deprivation and loss in their early life which he minimised. All seemed to be going well.

Then, after about 6 months the patient became irritable and distressed. He came to sessions speaking rapidly and creating an enormous urgency for the therapist to relieve his distress immediately. The patient alluded to suicidal thoughts, creating even more pressure. The thoughtful therapist considered her inner responses. She felt that enormous and unreasonable demands being placed on her. The intensity escalated over many weeks, so she sought advice from a colleague.

She presented detailed accounts of several sessions to her colleague who suggests that the patient was unconsciously attacking the therapist and the therapy.
The colleague suggested that by Projective Identification the patient was expelling unwanted aspects of themself and trying to control and limit the therapist's capacity to think. This made sense to the therapist as she felt constantly under attack and unable to think. The colleague suggested that she interpret the attacks and that whilst the patient may not immediately accept the interpretations, the interpretations would eventually 'get through' to the patient and the 'attacks' would likely reduce. Once the patient became aware of the

destructive part of their personality, then a more collaborative working together could be re-established.

The therapist returned to sessions and when she felt attacked, she interpreted that the patient was trying to expel unwanted feelings and attack the functioning of the therapy and the therapist's mind. The intensity of the 'violently' and 'desperately' projected contents increased. The therapist felt under increasing, unbearable pressure and was unable to maintain her mind in the sessions. As she persisted the situation went from bad to worse. She decided to seek advice from another colleague.

The second colleague had a very different perspective. This colleague proferred that the patient was using Projective Identification in a desperate effort to communicate with the therapist. The therapy had brought to the surface the patients early life pain and overwhelming, unprocessed experiences. These experiences could only be communicated by Projective Identification and the therapist needed to create the 'inner workspace' to bear and understand these desperate communications. The therapist needed to ***listen deeply*** to hear the pain, hurt and desperation of her patient's experience. Only when the therapist developed an inner space for these experiences could she really hear and speak to the patient's infantile catastrophes.

She returned to the sessions and listened. She noted in herself how unbearable the experience was. She began to hear the patient's intense pain. She began to feel the patient's desperation and urgency. She heard her patient's pleas. She felt his painful and frightening aloneness; the inner catastrophe that could not be put into words. She heard his inner scream. After tolerating these feelings for many weeks, she discovered words to express to her patient her new-found understanding.

The patient felt heard, seen, and understood. The intensity of Projective Identification diminished. Therapist was more able to bear being with her patient. As this continued over many months the picture of a baby whose parents could physically provide, but not hear and see the baby's desperate fear and distress emerged. The work for this patient and therapist

is intense and painful. The feelings are very meaningful. There still remains so much that is not yet put into words.

Discussion of the vignette

This is not an example of gross acting out or a persistent and damaging collusion, but an illustration of the difficulties of ordinary, everyday work in psychotherapy. When difficulties emerged, this therapist was able to reflect on them. She sought an outside (third) perspective from a colleague. Even then, she remained reflective and when difficulties continued, she sought input from another colleague. It was only then that she was able to see and hear the potentially meaningful communications of her patient. The therapist needed to develop within herself new and different 'workspace' to 'hear' and 'see' these communications.

It was only when this new space within the therapist formed that she could hear and respond to her patient's 'beyond words' communications. In doing this she had become a welcoming object for her patient's projective identifications. Patient and therapist formed a container/contained relationship that the patient had not previously experienced. This container/contained relationship became a new experience that the patient could internalise to assist with further unbearable experiences (past, present, and future).

This therapist was ultimately able to create the ***internal workspace*** needed to receive her patient's projections and make sense of them. The theme of this conference is 'too close, too far.' To begin with this therapist was ***too close*** to the patient and his projections. In the sessions the therapist was feeling confused and knocked about, unable to maintain her mind. She recognised this and by seeking an outside opinion, began the process of creating adequate distance for reflection. Unfortunately, the initial opinion she received was too narrow and too distant from the patient's infantile experience. Whilst there may have been aggression in the patient's projections, this first opinion left the therapist ***too far*** from her patient. It is only with the input of her second colleague that this therapist could find an appropriate distance with her patient.

If this therapist hadn't been able to find appropriate distance and form new internal workspace, I suggest three likely outcomes. Firstly, she may have continued to interpret the

patient's 'attacks on her.' The patient may have responded to this by masochistically complying or by withdrawing, even leaving therapy. Secondly, the therapist may have given up on her patient and ended the treatment, rejecting her patient. Thirdly, due to the unbearable nature of these intense projections, the therapist may have found ways to avoid the difficult and painful experiences. This would have recreated a more comfortable setting, but likely led to repeated enactments.

Early states of mind

As we may all know, "in Kleinian theory, the paranoid schizoid and depressive positions are, and remain throughout, the two elemental structures of emotional life." In recent years, many analysts have been exploring both pre-Paranoid Schizoid positions and post-Depressive positions. For the purpose of this discussion, I will focus on the two early positions described by Klein. Most particularly I am focusing on those aspects of our patients that are stuck in an early Paranoid Schizoid state.

In health the Paranoid Schizoid position charts the "journey from the chaos and confusion of (the baby's) first moments, to a way he could think about, organise and relate to his world and the people in it." Roth has noted that problems in the Paranoid Schizoid position can emerge in two ways. Firstly, an inability to adequately split good and bad experience in the first instance, leaves the patient with terrifying feelings of confusion, disintegration, chaos, and depersonalisation. Secondly, the establishment of rigid splits that cannot be integrated, leaves patients with a rigid personality that is brittle and inflexible.

In the earlier case the patient was likely projecting areas of confusion and chaos related to inadequate splitting in early life. However, the therapist's response following the first discussion with a colleague was likely to re-enforce rigid splits within the patient and the therapy. Yes, the patient's aggression might need to be recognised, yet below and behind this was a desperate need for the unmet aspects of the patient's infant self to be contained.

Projective Identification

When I was a medical student, I followed a psychiatrist on his daily ward rounds for several weeks. One day he reviewed a patient who had been admitted to hospital the previous day having attempted suicide following a breakup with her boyfriend. As they talked, she looked over at me and said 'well, of course, we all know what you're thinking! You clearly hate me and blame me for everything. I know you're laughing at me. I know what you think about me.' She continued to talk in this way becoming more and more agitated and angry. The psychiatrist, to my enormous relief, ended the meeting. I felt attacked and confused. I wondered what I'd done.

The psychiatrist later said, 'don't worry, it was just Projective Identification!' I think this was supposed to provide some explanation and relief for what had occurred. It didn't. The patient had projected unwanted and intolerable 'rejecting feelings' into me. I had identified with the 'rejecting' and felt that I had 'done something wrong.'

Projective identification was first identified by Melanie Klein as central to the defensive functioning in the Paranoid Schizoid stage of development. A baby, in phantasy, can split off the painful, distressing, overwhelming inner parts of themselves and locate them in their mother.

At first, projective identification was seen solely as a defensive means of expelling unwanted and unbearable experiences. However, Bion and others came to see that projective identification was also a means of communication between patient and therapist, as it had first been between baby and mother. The baby unable to speak and unable to make sense of what they are experiencing can through projective identification locate their fear, distress, and pain in their caregiver who, if they have the inner space to contain these overwhelming contents, can then understand and make sense of their baby's experience.

Rosenfeld said that "*some patients, however, live in such a permanent state of projective identification that I think one has to consider that in these cases we may be dealing with a different and more primitive … process.*" These patients communicate their inner catastrophes by projective identification. Rosenfeld notes that "*Projective Identification is*

often confusing to the analyst and may prevent him from thinking and interferes with his capacity for judgement and assessment of the patient."

Further Rosenfeld said *"I find it useful to think of projective identification in two simultaneous ways. On the one hand, in all projective processes of this kind there is an expulsive quality. The individual, sometimes very violently indeed, is trying to rid himself of unbearable thoughts and feelings and to do so forcibly by imaginatively taking over and controlling others. On the other hand, the process of projective identification can also be considered as* ***an attempt to communicate****.* ***If the unbearable and often chaotic thoughts and feelings which are expelled can be contained (Bion 1962b), it is possible that what is happening can be understood and considered, paving the way for the thoughts and feelings to be tolerated and to become less unbearable****."*

In order to contain and understand the projected contents we as therapists must be aware of the communicative potential of Projective Identification. If we only ask the question 'what is this patient doing to me?' we will fail to be a welcoming mind for the question '**what is this patient trying to get through to me?**'

<u>Further discussion</u>

Patients who are stuck in an early Paranoid Schizoid, survival position need to constantly project their unbearable experience into others to survive. These inner catastrophes must be expelled . However, there is also an archaic part of the patient constantly searching for a container for their 'unbearable' catastrophes. Projective identification as a communication relies on the presence of another person who can create the space within themselves to become a ***projective identification welcoming object*** (Eaton).

"A ***projective identification welcoming object*** promotes the recognition of psychical experience and a space for thinking, while a ***projective identification rejecting object*** leads to a denial, even hatred of psychic reality. A projective identification welcoming object is the basis for the establishment of the evolving relationship between container and contained that promotes the transformation of distress to comfort."

If a patient's projections are not recognised and received as potentially meaningful, the patient's distress and intensity of projection will likely increase. Often, we as therapists experience these 'violent' projections as attacks.
Often the aggressive and controlling aspects of the projections are interpreted and the patient is seen as expelling and attacking. When we fail to be projective identification welcoming objects, recognising the communicative potential of projections, patients become increasingly distressed and frantic. The situation can escalate. Eventually patients withdraw into a form of narcissistic isolation or into numbness and deadening.

If this escalation proceeds without reflection enactments are likely to occur. The patient's 'contents' are expelled and are not seen as full of possible meaning.
Action through enactment replaces reflective thought. These enactments can lead to ever-increasing boundary crossings and sometimes lead down Glen Gabbard's slippery slope to boundary violations.

The Container/Contained relationship

Bion said that in the beginning of life (and therapy) two minds are required to think. Babies need their parents to assist them in the development their minds. Patients need their therapists to transform raw somatic elements of experience into thoughts. If we as therapists have adequate internal space, we can be containers for these contents, utilising our reverie and capacity for dream-thought to do psychological work that transforms distress to comfort and understanding. What was previously unthinkable can then become meaningful.

Bion talked of an 'emotionally rewarding experience' where the patient could '*put bad feelings in me and leave them there long enough for them to be* ***modified by their sojourn in my psyche***.' In health the container and contained are not static, but in dynamic relationship with one another. This leads to growth. This causes '*the expansion of the range and depth of thoughts and feelings that one is able to derive from one's emotional experience*' (Ogden, 2004). A dynamic container/contained relationship increases the patient and therapist's

tolerance '*for being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason*' (Keats, 1817).

The therapist's inner workspace

Psychoanalytic psychotherapy is a ***deeply personal experience***. As therapists we need to ***hear***, ***receive,*** and ***respond*** to our patients' unique and personal communications. When early, archaic, undeveloped aspects of patients emerge they are communicated to us by ***projective identification***. The projected 'contents' need an adequate 'container' to receive them. The nature of these yet to be fully felt raw contents requires a robust, alive, and responsive mind from us as therapists. Bion stated that "*an analyst should leave room for the growth of ideas that are being germinated in the analytic experience, even though the germ of an idea is going to displace him and his theories*" (Bion, Tavistock Seminar, 1978).

Germinating 'new ideas' requires ''new space.' We need new inner workspace within us to form to contain the unique and specific personal contents that each patient brings. We may not already have the necessary internal space required by each new patient. To be a projective identification welcoming object as therapists we need to do ongoing psychological work to ensure we have the dynamic internal workspace our patient needs.

Supervision, peer review and further learning are all important for our ongoing professional development. However, the inner workspace required to contain previously uncontained raw contents is a uniquely personal space within each of us. Theory and ideas can be static. This, I think, is the difficult point of this discussion. We have an obligation as therapists to ensure that we have adequate personal therapy and healthy internal objects, creativity, and external relationships to draw upon in our minds.

Ultimately, I think this personal inner space can only truly and fully develop through our own ***personal analysis*** and ***self-analysis***. It is only with the assistance of ongoing self-reflection, self-analysis and analysis of our own dreams (according to Bion, the basis of all meaningful thought) that we can develop and maintain alive, creative, and dynamic inner workspace. This lifelong self-reflection enables us to learn from experience and grow new internal space.

Internal workspace comes from reflection on the meaning and significance of our ***experiences*** and ***dreamlife***.

Summary

Patient's usually attend therapy with developed, verbal aspects of their personalities and undeveloped, non-verbal aspects of their personalities. These undeveloped, archaic aspects of personality communicate by projective identification. Patients who have not had an adequate experience of a containing presence for the raw experience in their early life are accustomed to expelling raw elements of experience as unbearable, 'inner catastrophes.' These patients unburden their minds by projective identification. However, unconsciously the search for a projective identification welcoming object that will container and transform their un-worded contents.

If we do not have the inner workspace to provide a container for these contents, we will likely participate in recurring enactments expelling the contents. However, if we as therapists can develop the inner space needed then we can receive previously unfelt, unmet, and unthinkable contents and in time return them to the patient in a modified, 'thinkable' way. Recurring enactments that are not reflected upon can lead down the slippery slope towards boundary violations. Creative and dynamic inner workspace in us as therapists enables a container/contained which leads to growth. It is this internal workspace that is the foundation of working with our patients' earliest communications and is protective against unrestrained enactments. This space is deeply personal within each of us.

It is from this personal space that we can meet our patients in a unique personal, and meaningful way. This space develops primarily through the therapist's own analysis and self-analysis, relying particularly on their dream life, which is the basis of symbolic thought, and the foundation of learning from experience. This inner space is not 'theoretical' or 'professional.' This space develops primarily through our own analysis and later self-analysis. This internal workspace requires us to reflect on our experiences and dreamlife. This is the basis of symbolic thought, and the foundation of learning from experience.

I would like to finish with a quote from one of my patients. He said "I used to have a small bucket that was always spilling out everywhere. Now I have a bigger bucket and most of my stuff can stay inside."

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