TITLE: On the Edge: Dangerous Moments in Navigating Two-ness.

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ABSTRACT

There are moments in the therapeutic encounter where the possibility of transformation turns on a knife-edge. In this clinical paper, I explore responses to the confrontation with otherness, separation and separateness. Tustin exquisitely opened a space for naming and reflecting on the precarious nature of transitioning between the psychic states of oneness and twoness. The transitions between these states for some patients are terrifying, leaving them exposed to falling into an internal state of collapse and catastrophe. I consider through the case illustrations of a small child and an adult woman some destructive strategies that can be employed to avoid this experience; the small child with an abusive and traumatic history attempted to attack the analyst with scissors; and the adult woman who had a long history of serious psychopathology and self-mutilation reaching back into adolescence shifted from self-harm to threatening to harm the analyst. I shall suggest that the analyst's relationship to her own emotional resonances played a significant role in determining the therapeutic action and the outcome of interpretive intervention. Additionally, I consider how the role of the unspoken elements in making an interpretation is crucial to the question of transformation and navigating 'the tantrum of two-ness'

PAPER

Introduction: aggression and psychic states.

There are moments in the therapeutic encounter where the possibility of transformation turns on a knife-edge. Confrontation with otherness, separation and separateness can arouse frightening states of mind; anxieties can be depressive, persecutory or of feeling non-existent. As we know, Tustin exquisitely described the precarious nature of transitioning between the psychic states of oneness and twoness which for some patients can be terrifying, leaving them exposed to falling into an internal state of collapse and catastrophe. The recognition of twoness can arouse violent feelings or the 'tantrum of twoness', and some patients are only able to manage these feelings through concrete modes of functioning, for example through using the body or in action. In the complexity of the consulting room, different types of psychic states can be entangled in the same behaviour in the same temporal moment. Ogden's extension of Klein's framework of paranoid-schizoid and depressive positions (Klein, 1935,

1940, 1946) to include an autistic-contiguous position makes the point that psychic experience is produced in the dynamic interplay of the three different modes (Ogden, 1988, 1989). In developing the autistic-contiguous position, Ogden builds on the work of Tustin, Bick and Meltzer amongst others. The autistic-contiguous mode is a pre-symbolic, sensory-dominated mode, and if a breakdown in the continuity of this experience occurs, the state of 'nameless dread' (Bion, 1962) dominates, leading to imprisonment in the tyranny in sensory-based defences; such as the reliance on autistic objects and shapes (Tustin 1980, 1984); second skin formations (Bick, 1968, 1986) and adhesive identification (Meltzer, 1975). For Ogden (1989), anxieties characteristic of the three modes are linked to experiences of disconnection: disruption of whole object relations due to the fear that one has harmed the loved person leading to loss of love in the depressive position; fear of annihilation from fragmenting attacks on the self and one's objects in the paranoid-schizoid position; and fear of disintegration from the collapse of sensory cohesion and boundedness in the autistic-contiguous position.

In this clinical paper, I plan to share some preliminary thoughts about the nature of the experience for patient and analyst when aggression comes into the consulting room. I suggest that aggressive behaviour that on the surface looks similar can not only reflect different psychic registers and anxieties, but also, following Ogden, these different states can co-exist in the one behaviour. Further I want to suggest: 1. distinguishing the different psychic registers can sometimes only be understood clinically by immersion in the emotional climate of the session and 'learning from experience'; and 2. the anxieties operative at different registers need to be understood before transformation is possible.

To explore these issues, I plan to present two case illustrations; one a small child and the other an adult woman both of whom relied on aggressive strategies to manage the experience of otherness. The small child with an abusive and traumatic history attempted to attack the analyst with scissors; and the adult woman, who had a long history of serious psychopathology and self-mutilation reaching back into adolescence shifted from self-harm to threatening to harm the analyst. The small child illustration is presented to remind us of ordinary communication using projective identification. When his terror is understood he shifts from a disintegrated and paranoid mode of functioning to a more depressive one. This

illustration contrasts with the adult woman whose communications are more complex. Persecuted and persecuting and sado-masochistic elements of her functioning dominate the clinical landscape but folded into these states are more hidden and disguised elemental terrors of death and non-existence. For this woman, as Mitrani puts it, 'protective decoys' are 'encased in the extremes of acting out' (2011).

Clinical example: using projective identification

James aged two years and eleven months has a very sad history. Just before his second birthday, James was removed from the care of his emotionally damaged and violent mother. His foster care arrangements had not worked out well and he was developing a reputation for behaving aggressively towards his (mostly female) carers; he would attempt to attack them with knives. He is now living for the past few months in the home of his fourth caregiver. He has not seen his mother for about two months but does have some contact with his father, although this is relatively recent arrangement and he does not know his father very well. The following material comes from his second assessment session., It has been chosen because it provides a snapshot of the process of transformation from acting on paranoid phantasy to thinking and symbolic play and of the more ordinary use of projective communications to make interpretations.

When I meet James in the waiting room, he appears to recognize me from the previous occasion but he is not able to separate from his carer Mr Robert S. On entering the room, James goes to the play table directing Mr S to sit close to him. James begins to try to use the scissors to cut at the paper provided but as in the first interview, is not able to manage it himself and seeks my assistance to hold the paper. James starts to cut at the paper with increasing vigour and I must be careful to avoid being "cut". James correctly senses my apprehension about being physically hurt and this leads to an increase in his excitement and to more vigorous cutting actions. This is, perhaps, best thought of as an enactment of a sadomasochistic dynamic. (In "reality", we might ask could I have been frightened of a two-year-old with toy scissors. Surely not, and yet at this moment in the session, I subjectively experience apprehension). Mr S begins to speak saying that James has started nursery school and I ask James about it, but he requires some assistance from Mr S to recall his attendance at the school. I comment that perhaps yesterday at school James missed Mr

S. James replies, “not sad” and returns to cutting in an aggressive fashion, directing his “attacking” actions at me – perhaps, in retaliation for my “piercing” words. I attempt to talk to James about his worry and anger about my presence and talk, but he appears too aroused to take in anything.

He can be, however, distracted with drawing. He can draw an approximation of a circle and make some marks inside and outside the circle. At first, he says it is a face, but it soon changes to a jellyfish. I ask him to name the marks inside and outside the circle and they are randomly assigned parts of the face - nose (outside the circle), mouth (above the eyes) and eyes (below the mouth). We talk about fish and James agrees that he has seen fish but is very confused as to where. Mr S says that James has been to the Aquarium (a visit arranged by the care agency in the recent school holidays) and that, when James was placed on the bus, he cried. I say that James was sad on the bus and cried. James replies, “not sad” and then moments later, he says, “I cried”. James, then, becomes distressed and unsettled and climbs onto Mr S’s knee.

James is now sitting with Mr S and I invite him to return to the table to draw, which he does. He asks me to draw cars and this is repeated about 6 or more times. James seems quite involved in directing me where to draw. At this point, I suggest that Mr S might wait outside like last time. James looks distressed and says “no, not stay” and moves to climb on Mr S’s lap and, then, the arm of the chair. I next attempt to put into words for James his anxieties about me, my strangeness and his worries that I might keep him with me, that is, be yet another carer. He then says to me “who are you?” I ask if he remembers my name and he lists some names, finally settling on Ben (who is a neighbour of Mr S). I again talk about his confusion and anxiety about who he imagines I am. Mr S then asks James to be careful so as not to fall (he is perched precariously on the arm of the chair). James says, “no Robert fall” and then begins a game of blowing at Mr S who pretends to fall and after a moment James includes me in the game, so Mr S and I pretend to fall down repeatedly. James begins laughing very spontaneously and joyously as we play this game. The session continues.

Discussion:

This clinical vignette illustrates the shift from a persecutory frame of mind to one in which some thinking, and separateness is possible, for example as suggested by the "who are you?" It also shows that, with some reduction of his anxiety, he can take in and identify with the analyst's interest to know him. James rightly perceives that the analyst is asking "who he is" and he in turn, now asks "who she is". This is a moment of mutuality. With this shift, James is more able to represent in play his desperate anxieties about his mind and world falling apart as seen in the "falling over" game. In the first part of the session, James is angry and trying to cut off or out his own experience – his play with the scissors and my reaction of apprehension; an example of an evocatory projective identification (Spillius, 1988) or Joseph's "nudging" (1998) whereby the analyst is under pressure to experience James' frightened and threatened feelings about being in the presence of an unknown woman. In the session, the mention of the word "sad" creates a moment of danger for James; his defences are breached by my talk. At first, he denies it saying "not sad" but this is not enough to protect him from overwhelming disintegrating anxiety. He needs to increase the vigour of his cutting and to discharge his feelings in action. In this, he communicates violently his need to cut off any contact with the analyst.

Next, he draws a face, which turns, into a jellyfish. This seems to express his terrible uncertainty regarding his objects and their constancy - what is a face but a cold fish, perhaps? He appears watchful of me. Again, when I say "sad", he first denies it and then says, "I cried". Perhaps, he can acknowledge to himself and to me his sense of loss and grief because I persist with trying to stay in some emotional contact with him and he feels that someone is interested in knowing about his experience. In this material, there is a movement from the bizarre scattered representation of a human in the drawing to something different, something more poignant, a child who acknowledges his vulnerability.

Following this, he needs to shield himself and he has me drawing cars. He shows a need to control me, which is "you will function as I want." He needs to protect himself by reversing the situation between us. In phantasy and in our interaction, he pushes me around so that I am

not a frightening object who pushes him around. There is another chaotic moment in the session when I introduce a threat to his precarious control by suggesting that the carer leave the room. I talk to James about this and he asks "who are you" which I feel marks a very important moment in the session, as mentioned. The "who are you" question is said not from a paranoid place but rather a curious more separate place. This position allows a space for another, for a "you" and permits this little boy to ask his crucial questions: who are you and implicitly what is the nature of the people in his life? His capacity to ask this question suggests he retains a sense of curiosity and is not a closed system or completely shut down, as there is a place in his mind for another. Again, I talk with him regarding his anxiety about not being able to trust and his fear of losing his caregiver. Then comes the "fall down" game and he demonstrates that he can play a little with enjoyment. He completely alters. The three of us are together as a co-operative threesome, not falling apart or attacking and destroying each other. In this vignette we see a little boy who is enormously anxious regarding the stability and trustworthiness of his objects. His objects are fragile, unpredictable and interchangeable in both reality and phantasy. But when his anxiety is recognized he demonstrates his capacity for real emotional availability and to represent his anxieties in play.

In this vignette, we see a 'straightforward' illustration of Klein's mechanism of projective identification (1946), an object -related process in action where an aspect of the analyst's subjective experience captures the patient's unconscious, nonverbal and unverbalised communications. When the analyst can make some sense of his communication, a movement from a paranoid- schizoid position to a more depressive one is made possible; a movement from a doer-done-to dynamic to a space for 'thirdness'. The triangularity of a symbolising process is facilitated: the symbol (the falling down play); the symbolised (his terror of a violent ripping apart from his mother / other, leaving him in the free-fall of unbearable loss and non-existence; and the mediation through an interpreting self (the 'who are you?' which is enabled by identifying with the other who can reflect upon him).

Second clinical example: representing the unrepresentable

I am now going to contrast the experience of working with James to working with a female patient, Ms D with whom I worked decades ago and whom my interpretive words appeared to fail to reach. Yet, at the same time, I observed changes in her self-harming behaviour. She

had had a long history of self-harm which had occurred in her home. As we worked together this shifted and she began to self-harm in the institution where I saw her and then, eventually in my consulting room. But, with hindsight, I initially misunderstood the nature of her anxieties which involved elemental terrors of non-existence.

The patient, Ms D., is in her late 30's, the mother of two children. She initially presented to a paediatric hospital's psychiatric department threatening to murder her younger son and kill herself. She was treated in the department for five years. I saw her for three and a half years in mostly twice weekly therapy and prior to this she had been seen for 18 months by another therapist. I want to discuss two episodes of acting out in her therapy; the first occurred about six months after I began to work with her and the second 18 months later. Ms D. had a longstanding history of self-mutilation and other issues associated with a borderline personality disorder, especially hypersensitivity to the experience of loss and separateness. In Tustin's terms, she is best seen as belonging to the 'entangled / confusional' category (1981). Her symptoms and disorder had been evident since adolescence. The containment of this self-destructive behaviour was a significant problem during the early months of her therapy, as it had been throughout her adult life, during which she had had several inpatient psychiatric admissions. The self-mutilation comprised either wrist or abdomen slashing with a razor blade. While slashing she fantasised that she was letting out the badness which she felt had either originated from within herself or had been put into her by the other; that is, the mutilation served the medieval purpose of bloodletting. Ms D reported that, after she cut herself, she felt relief. I was left with the question about what needed to be bled out.

On several occasions after her therapy session, Ms D mutilated herself in the hospital toilets, smearing blood over the walls. Later she would recount that her intention had been to attack and humiliate me because she felt I had cruelly abandoned her at the end of the session. The patient appeared not only to be attacking the bad, abandoning analyst inside her mind, but also cutting off the link with the good, caring analyst representation and her own tenuous capacity to think about and feel her experience of pain and loss.

In sessions, Ms D. often sat with the back of her chair towards me. I frequently interpreted this behaviour but did not set any limits. Then about six months after the commencement of therapy, she slashed the back of her chair with a razor blade. I was not aware of this until after the patient had left my room. During subsequent sessions, I made interpretations about her murderous rage and how when she felt enraged, she was not only cut off the good, caring aspect of our relationship, but also from that good, caring part of herself. I also confronted her with her lack of control and my alarm about her behaviour. The slashing of the chair continued in some more sessions over the next few weeks, but the self-mutilating behaviour outside of the sessions ceased. During these sessions, whilst I was feeling incompetent about my capacity to contain my patient's behaviour, I was curious about the transition from slashing skin to slashing the covering of the chair; from outside the consulting room to inside the consulting room; from the patient's skin to what might be seen to stand for the analyst's skin; from self to possibly a transitional object. I did not feel personally frightened at this stage.

The secret slashing of the chair covering continued for several sessions. Until in one session a significant change occurred. Ms D. remained silent for the entire session, again sitting with the back of the chair towards me. From time to time I made some interpretive comment, perhaps going through the motion of trying to make contact as I (passively) despaired about the possibility of contact. About halfway through the session I felt acutely overwhelmed with almost unbearable feelings of futility, desolation and non-existence. I began to doubt whether I could endure this patient until the end of the session. I had an urge to act; to shout at her to leave. After some moments reflecting on my state of mind, I realised I was being required to feel cut off, dead, empty perhaps in concordance with the patient's experience. But also, as I began to reflect on my experience, another experience began to take shape in my mind, an experience of a limit, of agency, of wanting to live – a recovery of a split off aspect of my own identity. Once I emotionally understood my own identification with death and non-existence, I spoke again. Although the content of my subsequent interpretations remained relatively unchanged, the way I spoke I assume was different – I suggest that, in an out of awareness way, I changed my tone, rhythm and intensity of my speech. I imagine that my voice conveyed the recognition that I had emotionally received her message, but also that I was still alive and different from her - that there were other possible psychic registers. After this session there was no further chair slashing or self-mutilation for another 18 months. We were then able to return to work together in the more usual way.

There was a recurrence of this acting out behaviour, 18 months later, following a summer break. Again Ms D. slashed the chair, initially without my awareness. At the same time, she made numerous menacing threats about slitting my throat with a knife. As during the previous episode of acting out, this behaviour continued until, during one session, I felt frightened for my own safety and not prepared to tolerate this behaviour further. Again, after reflecting on my feelings, the content of my interpretations did not significantly change, but the way I spoke did, once more creating a moment of embodied speech. The patient's acting out settled. At this time, she left with me numerous knives and blades to hold for 'safe keeping'. Eventually this patient was able to pay for the hospital's chair to be repaired.

Discussion: The limits of imagination

Ms D used perverse and addictive self-harming behaviour to manage the distress and rage aroused in her by the experience of separation and, in her therapy, the ending of sessions acutely signalled a deadly and dangerous moment for her – she cuts her skin, but we can ask in her mind whose body is she attacking in her mind? In her confusional state, at the register of the paranoid- schizoid states of mind, a very concrete phantasy is enacted – she attacks the bad absent maternal object. At the same time, the sequence of displacements involved in cutting her skin at home, in the hospital toilets and finally the upholstery of the consulting room chair suggests on another level a form of transformation is occurring, that is, the creation of a transitional object (the chair), a me /not me object. In the movement from the patient's addictive use of her skin to the 'as if-ness' of the chair upholstery, we see the possibility of an 'in between' space; a me /not me space; The 'rhythm of the safety' of the therapy offers this possibility (Tustin, 1986), even if the interpretive gestures, framed along the lines of paranoid-schizoid phantasies, anxieties and defences, appeared to fail to make any adequate emotional contact with the patient.

It was not until I was able to empathically 'stomach' the patient's communication through projective identification (Tustin, 1986) that Ms Ds deeper elemental terrors were sufficiently recognised by me. I had to experience the crisis and an impending sense of catastrophe to be able to get at Ms D's terrors. Ms D's dramatic way of being, of self-mutilating and cutting,

both disguised and expressed an encapsulated part of her experience. Terrors of spilling and liquefying, of there being no skin boundary, no containment, and of dying were captured in the cutting. The cutting and the ripped and punctured skin which resulted in the warm flow of blood was her auto-sensuous way of mopping up 'the experience of woundedness' (Tustin, 1986, p. 282) brought about when she felt ejected and cruelly forced to face the 'not-me' experience. The hard blades which she carried with her functioned as autistic objects to provide some experience of sensory definition. The oppressive hold of these sensory protective manoeuvres to obliterate the experience of separation and separateness gradually shifted so that she was able to use the chair as a transitional object.

Following Ms D's use of the chair as a transitional object and my real recognition on an emotional level of her terrors, I arrived at being able to link in my mind her elemental anxieties of dissolution and non-existence with my depressive concerns for life and living, Ms D appeared to be able to imitate or identify with my sense of concern and the need for reflection. Words per se (or sematic content of words) for this woman were insufficient, and, of course, it was not the meaning of the words alone that made contact with her. Specifically, it was the quality in my voice which showed her I had received a real message from her about her terror, confusion and rage, that I knew about my own hatred and fears, and that I could deal with it and contain it. In the end, Ms D was able to internalise another perspective after a period of a sustained, intense encounter; a limit that said something like: 'enough of this, destructiveness is real; and your protective strategies do destroy the present and future'. A symbolic space is created or co-created to represent her anxieties about twoness and separateness in thought

Resonance

Betty Joseph suggests that analysts are to 'give understanding that will resonate in them [analysands] emotionally' (1993, p.311). She describes that resonance can fail due to the analyst's failure or the patient's pathology. She goes on to discuss problems located in patients related to psychic disaster and confusional states coupled with rigid defensive structures vividly portrayed by the image of a metal / impermeable jacket. In these states, according to Joseph, interpretations do not impinge in any emotional sense on analysands as they have no real conception of being understood. Joseph does not connect these ideas to those of Tustin (1986) and Sidney Klein (1980) who wrote of hidden, encapsulated autistic

phenomena in persons not diagnosed with autism, but I think that the states being described are similar. But, my experience with Ms D suggests that it is very understandably human for analysts to want to erect 'impermeable jackets' to defend against exposure to elemental terrors. We bring to these types of clinical encounters our own need to protect ourselves psychically but, additionally we are also 'nudged' by our patients to join with them in finding ways to hide and evade such horrors. My work with Ms D went to the brink of miscarrying. I was being provoked by cruel sadistic elements of the patient's presentation to get rid of her. If I had decided to 'cut' off treatment, it would have been in accord with a version of the patient's mode of expulsion as the only means to manage her collapsed state of 'going on being'.

In these states, the analyst can lose a sense of a working third – simply put, the triadic relationship between the analysand, the analyst and psychoanalysis (referring to the setting, technique and theories) described by Britton (2015) is derailed. I would argue that what was initially constructed or co-constructed with Ms D was an 'objectified' thirdness. What I mean here is that I, the analyst unconsciously joined too tightly to psychoanalysis - I knew intellectually the verbally 'correct' interpretation (more or less) at the level of the paranoid-schizoid position but I was in an empathic/relational sense out of touch with an earlier more traumatised and helplessly encapsulated aspect of the patient. In one aspect of the countertransference, I enacted the turning away to the 'other' (the other of psychoanalytic technique) and, thus, left the patient feeling abandoned. By this, I mean that I believed that I could evade something like the horror of non-existence and nothingness and that I hoped unconsciously that I could get by with her without going to that catastrophic place of death and survival. At the same time, on another level, I was unconsciously processing the patient's anxieties. I suggest this allowed the movements from skin to chair covering to representation in thought of the meaning of her terrors and her protective need to evade them.

To conclude:

In these two case vignettes, both patients initially struggled with the recognition of otherness and separation. The small child's inner world appeared populated by persecutory and fragmented representation of self and objects but, when met with a containing other, he could use this experience to create a symbolic way to communicate the fragility and instability of his

world. In contrast, the woman who appears trapped in a world of violence and self-harm, when, after a prolonged time, her elemental terrors of emptiness and blackness are apprehended, she can manage her inner anxieties without needing to enact her sense of woundedness and spilling out. In both vignettes, the 'working through' of catastrophic anxieties was supported by some understanding of the mechanism of projective identification that enabled a more empathic stance with embodied speech. The work with Ms D lends support to the idea that speech needs to carry the experience of the patient's inner catastrophe, this being often expressed unconsciously through the tone and rhythm of speech. Also, the analyst's relationship to her own emotional resonances played a significant role in determining the therapeutic action and the outcome of interpretive intervention. I shared momentarily with James and in a more protracted way with Ms D something of their catastrophic experience and gave it meaning in my mind. After this moment with Ms D, although my verbalised interpretations were relatively unmodified, my patient's acting out behaviour ceased. The unvoiced but represented thought appeared to function 'in' and 'alongside' the spoken words and this appeared to bring about a transformation. This transformative experience for both patient and analyst speaks to the role of non-verbal elements in psychic change.