Module 5 - Extended Lectures on Kleinian Theory

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Section 1 - Unconscious Envy: Everything I Would Have Wanted to Learn if I Had Not Already Known It

EVERYDAY EXAMPLES OF UCS ENVY IN ACTION:
1 – Aphorisms and quotes:
– Success: The one unpardonable sin against one's fellows. (Andrew Bierce 1842 – 1904)

– Whenever a friend succeeds, a little something in me dies. (Gore Vidal – 1925 – 2012)

– One likes people much better when they're battered down by a prodigious siege of misfortune than when they triumph. (Virginia Woolf – (1882 -1941)

– If you pick up a starving dog and make him prosperous, he will not bite you. This is the principal difference between a dog and a man. (Mark Twain (1835 – 1910)

– There are many things that we would throw away, if we were not afraid that others might pick them up. (Oscar Wilde !854 – 1900)

– A fool always finds a greater fool to admire him. (Nicholas Boileau-Despreax 1636 – 1711)

– Moral indignation is in most cases 2 % moral, 48 % indignation, and 50 % envy. (Vittorio de Sica 10901 – 1974)

– With someone who holds nothing but trumps, it is impossible to play cards. (Christian Friedrich Hebbel 1813 – 1863)

– Every truth passes through three stages before it is recognized. In the first it is ridiculed, in the second it is opposed, in the third it is regarded as self-evident. (Arthur Schopenhauer 1788 – 1860)

2 – The Story of Snow White and the Seven Dwarfs
– A beautiful, wicked, jealous (sic) Queen fears her stepdaughter will grow up to be more beautiful than she and has her working as a scullery maid.

– Each day the Queen checks with her magic mirror to see who is the fairest of them all. One day, when the girl is an adolescent, the mirror says Snow White is now the fairest.

– In a rage the Queen tells her huntsman to take the girl out into the woods, kill her, and bring back her heart as proof that she is dead. He takes pity on the girl and lets her go off alone into the scary, dark forest.

– She happens onto the house of seven dwarfs, Bashful, Dopey, Doc, Grumpy, Happy, Sleepy, And Sneezy,

– The Queen, upon discovering that she has been tricked by the huntsman returning with a pig's heart, flies into a rage and plots the death of Snow White by giving her a poison apple that will put her into a permanent "sleep of death" from which she can only be revived by "love's first kiss". The wicked Queen assumes the dwarfs will mistakenly bury Snow White alive. The Queen, disguised as a poor, elderly beggar woman, seduces her into biting into the apple by saying it is a magic wishing apple and one bite makes your wish come true.

– After Snow White is poisoned, the dwarfs chase the Queen to the top of a mountain where she falls to her death after being struck by a bolt of lightening. The dwarfs find Snow White so beautiful that they do not have the heart to bury her so they fashion a glass and gold coffin within which they keep her.

– Prince Charming, who had searched far and wide, comes to the dwarf's place, kisses her, and they ride off into the sunset, living happily ever after.

How Might One Interpret Snow White?
1 – The story lays out much of the anatomy of the unconscious inner world:

– an idealized part of self in innocent purity = Snow White

– various good baby parts of self: Bashful = shy baby part of self
Dopey = the silly baby part of self
Happy = the happy baby part of self
Sleepy = the unborn, inside baby part of self
Sneezy = the psychosomatic aspect of the good baby parts of self

– the adult part of self (i.e. the most mature part of self and the one that identifies with the good parents) is represented by Doc

– Grumpy would represent a watered down version of the bad part of self

– the missing biological mother has been replaced by a very bad version of a mother in the form of the envious Queen

– the good, but ineffectual dad/penis is seen as a possession of the bad mother/queen

2 – The story is open to interpretation from a number of different angles but I wish to approach it from the point of view of unconscious envy. The key point is that envy as a raw emotion, when intense, is so

unbearable that maneuvers must be used to protect against it. While there are many options, most involve some form of reduction of the "enviableness" of the object, hence usually some form of destructive attack. One can see that the queens envy must feel to her like it tears at the very core of her being, since tearing out Snow White's heart is felt to be the appropriate attack back for being so beautiful.

I think the part of this story that is so difficult to comprehend is that it began with the infant Snow White's rage and envy of her own missing mother, and that envious hatred had to be "split-off" and evacuated into the outside world, hence a stepmother as an inevitably available container.

DEFINITIONS:
1- ENVY: A two party relationship, at a part object level, more linked to hate than love, in which one compares oneself to another in terms of a quality, a capacity, or a possession and feels a painful discrepancy between self and other. This pain, which we call envy, is instantly defended against by any of several unconscious defensive maneuvers. It is a more primitive emotion than jealousy that begins at an earlier time in infancy.

2- JEALOUSY: A three party relationship, between whole objects, based on love, in which one person wants the love of another and does not want that person to give their love to a third person. The further back in infancy one traces jealousy the more it shades into envy and becomes very difficult to distinguish from envy.

3- GREED: A very primitive emotion, closely linked with envy, in which one experiences an insatiable desire to take from the object more than one needs and/or more than the object has to give.

4- GRATITUDE: The feeling that one has received something good from another and can hold on to it. This leads to a feeling of appreciation for having been given this good thing, etc.

5- ADMIRATION: Essentially the result of making the same comparison as in envy but without the hateful resentment.

UNCONSCIOUS ENVY AND THE DEATH INSTINCT:
1- THE DEATH INSTINCT: Essentially the feeling that when one weighs the pain of being born and out in the world against the pleasure of relationships to mom and dad, the pain is too great to want to stay outside. This results in a wish to be "unborn" back inside mom and an attendant hatred of the pain of being out in the world. This hatred often extends to a hatred of the mental apparatus that can experience the separateness and attendant mental pain.

2- MOTHER'S BODY AS THE PROTOTYPE OF THE ENVIABLE OBJECT:
– breasts which are the source of food and comfort
– the womb which is the source of life

THE ENVIOUS, OMNIPOTENT, KNOW-IT-ALL, DESTRUCTIVE, SELF-SUFFICIENT "BAD" PART OF SELF:
1- THE LUCIFER MYTH: Lucifer (light bearer) was created one of the mightiest of angels but covets the glory and power of God and tries to usurp divine authority thus becoming Satan (adversary). He is expelled from heaven and sets out to disrupt the purposes of God on earth among God's image bearers, humans.

– Thus Lucifer can be seen to embody the essence of envious hatred of goodness, not matter how talented one is oneself. Hence the idea "I would rather rule in hell, than serve in heaven" (and be second in command).

DEFENSES AGAINST THE EXPERIENCE OF ENVY:
1- WHAT A BABY CAN DO TO COPE WITH THE PAIN OF ENVY:
a – Get back inside mom to be unborn = raise yourself up to the object's level

b – Turn away from mom/breast = spoil the object

c – Stop having a mind = deny the comparison

d – Evacuate its experience out into the world = either make someone else contain the envious state of mind or evacuate the part of self that feels the envy

2 – WHAT THESE LOOK LIKE IN LATER LIFE:
a – The person who unconsciously joins up to their objects by getting back in side (#1 above) invariably has fuzzy boundaries while the one who takes possession and control of object (#2 above) is more associated with the more aggressive and controlling approach to relationships as is commonly seen in highly narcissistic personality types.

b – Spoiling the object in order to no longer feel it is enviable, while simultaneously idealizing ones own body and its products, spans the spectrum of external manifestations from absent mindedness to extreme alcoholism and drug usage.

c – Denying any envy usually means denying any desire to compare which typically requires becoming bland and limiting ones ambition.

d – Two choices are available to evacuate the experience of envy. One can evacuate the "envious feeling" by becoming enviable, or one can evacuate the part of self capable of the feeling of envy into someone. This is often a sibling or friend in childhood, while later in life it is usually into one's spouse or child.

CONSEQUENCES FOR LATER DEVELOPMENT OF EXCESSIVE BABY ENVY:
1 – CONFUSIONAL STATES
– About good versus bad, i.e. what is to be valued?

– Sources of food (i.e. originally whether from mother or from one's own bodily products)

2 – IDENTIFICATIONS
– Commonly involve identifying with an object which has been distorted &/or devalued.

– Excessively contaminated with omnipotent and omniscient certainty and grandiosity.

3 – SELF ESTEEM
– Uncertainty over something's goodness undermines feeling good about oneself and ones ability to love or to hold onto goodness.

– Since motives are so often hostile and competitive, it is difficult to feel good about one's achievements.

4 – PERSECUTORY ANXIETY
– Envious competitiveness engenders the expectation of hostility and retaliation.

– Never being able to hold on to the goodness of anything leads to being haunted with doubt about the ongoing goodness or value of any person or thing.

5 – PREMATURE ONSET OF GUILT AND SEXUALITY
– Guilt is result of spoiling attacks on mom and her body, one fertile source of characterological depression.

– Because oral gratification at feeding from mom is spoiled by resentment and grievance, there is a natural tendency to try to comfort oneself with sensations from ones own body and to turn to ones own bodily products. This results in a very early tendency toward genital and anal masturbation.

CIRCUMSTANTIAL EVIDENCE ALERTING FOR ENVY:
1 – APPEARANCE:
– excessive blandness (e.g. fear of stimulating envy)

– excessive ostentation (e.g. urge to provoke envy)

– excessively "counter-culture" (e.g. turning away form ones primary objects and their values)

– excessively sweet (envy "split off") or sour (envy "spoiling" everything)

2 – INDIVIDUAL'S HISTORY;
– drug use

– childhood deprivation

– excessive ambition or failure to succeed

– confusion about goodness

– twins or siblings very close in age

– life/personality slowly or steadily deteriorating

3 – CHARACTER TYPES WHERE ENVY IS A PROMINENT FEATURE:
– narcissistic/arrogant types

– all psychotic/schizophrenic types

– potentially all neurotic types, esp. as severity of disturbance increases

SOME MANIFESTATIONS OF UNCONSCIOUS ENVY IN THERAPY SETTING:
1 – JOINING UP WITH THE OBJECT
– via omniscience (for control and to reduce envy)

– idealize therapist

– own therapy and equate self with it (subtle to overt theft)

– assume or demand equality/parity

– transform intangible qualities into tangible "things" so that it is possessable/controllable

2 – TURNING AWAY FROM THE OBJECT
– idealize ones own body and/or own bodily products

– perversely "twist around" the therapist's productions to spoil them

– put emphasis on the wrong syllable

– drop insights between sessions

– "acting out" to turn away from or spoil/attack therapy

– confuse healthy "dependence" with addictive dependence to justify "omnipotent self-sufficiency"

– stay in bad treatment

3 – "SPLIT OFF" ENVY
– deny its existence

– provoke it in others

– focus on or fear it in others

4 – ATTACK THE OBJECT (THERAPIST)
– negative comments (subtle to vicious)

– provoke spouse, parents, friends, etc. to attack

– hold on to grievances

– debase the quality of something (e.g. so as to deny that it is alive, human, ineffable, etc.)

– backhanded compliments to avoid proper acknowledgement of goodness

– failure to recognize something good that is in evidence

5 – ATTENUATE THE ENTIRE EXPERIENCE OF LIFE
– transform living into dead, inanimate, controllable, mechanical

– stifle love and intensify hate

<u>SOME GENERAL GUIDELINES FOR INTERPRETING ENVY</u>:
1 – ENVY WILL NOT COME UP UNTIL THE THERAPIST MAKES IT AN ACKNOWLEDGED AND EXPECTED EMOTION

2 – SENSITIVITY TO PAIN OF BEING AN ENVIOUS PERSON

3 – DON'T OVER-VALUE YOUR INTERPRETIVE ROLE AT THE PATIENT'S EXPENSE

4 – LOOK AT ENVY AND FEAR OF BEING ENVIED IN CONTEXT OF PATIENT'S TOTAL SITUATION

5 – EMPHASIZE INEVITABILITY OF SOME ENVY IN LIFE

6 – NON TRAUMATIZED, SEVERELY ENVIOUSLY OMNIPOTENT PATIENTS OFTEN SURVIVE INTERPRETATION OF ENVY BETTER

7 – ENVY DIMINISHES IF THE PATIENT FEELS ACCEPTED AND HELPED IN ANALYSIS AND IS GIVEN
TIME AND SPACE TO THINK AND GROW

Section 2 - An Overview of Manic Defenses in Clinical Practice

General Overview:
1 – Dr. Albert Mason says that perhaps as much as 75% of the work of analysis involves the effort to diminish manic defenses. These maneuvers are in almost constant operation in any form of psychotherapeutic situation even if the therapist is not primarily trying to work on them.

– Because they aim to preserve the patient's unconscious sense of self-sufficiency and limit the vulnerability to loss or guilt about how the therapist is treated, virtually any successful form of therapeutic relationship is a potential threat to these unconscious states of mind:

e.g. any state of acknowledging dependence, feeling of need, or feeling of helplessness

e.g. every separation, especially including the 6 days between sessions in once per week therapy

e.g. contact with loving, caring feelings for anyone, but especially the therapist (because love makes one aware of dependence on and need for the other to reciprocate)

e.g. successful interventions by the therapist that make the patient aware of his or her psychic reality (i.e. having an unconscious inner world that he cannot control and therefore hates)

e.g. interventions that give the patient relief from distress but make the patient aware of being dependent on the therapist for getting that relief

e.g. any situation or interpretation that makes the patient aware of their mistreatment or harm done to another person (often friend, family member, or therapist) leading to guilt for hurting someone whom they love (which is may be the most painful feeling of all emotions that humans can have)

e.g. it useful to think of these as specific maneuvers to defend against smallness, need and dependency and their consequences for the pains of the depressive position, analogous to the way narcissism is a global character defense against the same smallness, dependency but additionally and most importantly in the case of narcissism, the potential for feeling envy

2 – Most therapeutic relationships that interrupt prematurely do so as a result to manic defenses

3 – Much of what makes patients difficult or unpleasant to work with is a result of manic defenses – these are usually patients with severe character disorders whose attacks and devaluations as a result of manic defenses combined with unconscious envy make them so unbearable to work with

4 – Manic defensive maneuvers often manifest themselves in much more silent fashion – e.g. living inside the object

– e.g. consciously valuing the therapy but splitting off the hostile part of self into someone else, commonly a spouse, parent or friend who does the undermining or attacking of the therapy

– e.g. respond to interpretations with open agreement but with an unconscious or private feeling that they knew it all along (and therefore don't need you for anything they don't already have)

Definitions of Klein's Developmental Positions:
1 – Paranoid-Schizoid Position: A set of primitive psychic maneuvers that are necessary in earliest infancy for the baby to bring order to its world so that it can internalize a core, good relationship to its mother. This is stored in the form of a good part-object representation of her, the good breast, that will be the foundation of a lifelong sense of emotional stability and sense of being loved and safe.

To achieve this ordering of its world the infant must divide itself and mother (or caregiver) into good and bad (the processes of "splitting-and-idealization") and then hold onto the good and get rid of the bad into the outside world (achieved by the process of "splitting-and-projective identification"). It now feels that both it and its object are all good (actually purified to the point of being "ideal") and that the outside world contains the really bad elements. The "paranoid anxieties" are about the bad stuff returning to attack and ruin the idealized self and object.

This is a value system of self interest with little concern for the other except to the degree it benefits and affects the self.

[Note: If this splitting into good and bad goes too far initially because of difficulties in the mother infant relationship, then the bringing the two versions of mother back together in the depressive position is made much more difficult. The result is potentially significantly problematic for later life.]

2 – Depressive Position: As development continues into the middle of the first year of life, the infant's increasing psychic capacities and organization bring about an ever increasing awareness of its separateness from its mother. As it introjects her as a loved, good figure, it feels itself to contain more goodness and is even more able to tolerate separateness. This creates a positive cycle for development.

It is in contrast to all of the pains of infancy where mother has been felt to have so much and the infant so little and her relationships with others compound the distress. These combine to create very painful states of envy and jealousy, which when combined with grievances about separation, frustration, etc. lead to hateful attacks on mother.

If the splitting-and-idealization of self and mother is not excessive, the increasing awareness of separateness, as positive development proceeds, leads to a painful realization that the ideal mother that the baby loves and the all bad mother that it hates are one and the same person. It then realizes that it is injuring its "good" mom when it attacks the "bad" mom during states of hateful rage. This makes it painfully aware that is has mixed, i.e. ambivalent feelings, for one and the same person. In turn, it wishes to repair and restore the mother that it loves after damaging her in states of rage, etc. This wish to repair is the product of feeling both loss of the good mom and potentially unbearable guilt for hurting and/or damaging her.

3 – Manic Defenses: An organized set of mental maneuvers that are aimed at diminishing the pains of the "depressive position". As awareness of separateness increases in the middle of the first year, anxiety about losing one's good mother and/or guilt about damaging her in moments of hostility becomes greater than the infant can bear. Instead of returning to the primitive earlier mechanisms of the paranoid-schizoid position, the infant uses a new, more organized set of mental postures.

These defenses have, as their primary aim, the diminution of these pains by avoiding any experience of the psychic reality of them. First and foremost, this means evading the essential realities of being a baby who cannot live without its mother. To evade these realities it must do something about (1) its needy dependence on its mother as it increasingly recognizes its separateness from her and (2) its loving concern for her welfare when it mistreats her (i.e. depressive anxieties and guilt).

The infant may also hope to eliminate those situations that generate its envious or jealous hostility, resulting from its increasing awareness of its separateness (due to the progressive diminution of massive states of fusion attendant to projective and introjective processes).

The evasion of these psychic realities is achieved by use of the "manic triad" of "control, contempt, and triumph". These three states of mind eliminate the experience of need for and dependence upon a unique person who is separate. The also make the person no longer worthy of guilty concern for how it is treated.

In many individuals, these attitudes are augmented by a very powerful tendency to replace the need for a separate, living, uncontrollable other with something which is not separate, not alive, and is very controllable. In the infant this means turning to its own body and bodily products for comfort and sustenance (i.e. erogenous zones and excreta). In later life, these maneuvers are unconsciously transformed into more socially acceptable activities but they retain the same infantile significance.

4 – Mania: The state of mind that results from an acute, massive domination of the personality by manic defenses as a result of an extreme depressive situation that is felt to be unbearable. It is more linked to a state of psychotic functioning than neurotic functioning and can easily lead to a more openly psychotic state. When the underlying depressive anxieties break through without being dealt with constructively, an overt clinical depression often results.

5 – Manic Reparation (to evade experience of guilt): An omnipotent maneuver in which reparation is done quickly without any acknowledgement of guilt about damage done or possible loss of a loved figure. The guilt is therefore completely denied and thus does not register in psychic reality. No real loving feelings for the person are allowed as this would risk true depressive concern for the object.

To avoid concern the repair must be done with special conditions: (1) it is done in relation to objects other than the primary object, (2) the object is not experienced as having been damaged by oneself, (3) the object must spoiled so that it is seen as contemptible, inferior, dependent, etc.

Because proper concern and repair in relation to the originally damaged loved object is avoided, manic reparation is never successful and complete. If it were successful, the restoration would lead to a loved object being re-established toward whom love and depressive concern would be reignited and guilt would result.

Baby Origins of Manic Defenses:
1 – As the infant recognizes mother as a separate, unique individual, it begins to see that mother is her own agent and can leave the infant whenever she wishes, be with someone else, etc.

2 – While recognizing mother as separate, the infant also increasingly recognizes its utter dependence on her for its very survival to meet all the needs it cannot provide for itself. If the infant is of a particularly envious predisposition, it also feels intense resentment and even hatred that mother is the

source of what it needs. In effect, it envies her for "having everything, knowing everything, and being able to do anything".

3 – When the infant feels enraged and destructive, it realizes increasingly that it is damaging a good mom who it needs and loves. It thus wishes to repair her and restore its good, loving relationship with her. This requires the (1) acknowledgement of the damage, (2) toleration of the feeling of guilt about having hurt her, and a (3) willingness to feel sorry and try to make amends. In effect, its tolerance of the feeling of love for the good mother has to outweigh the pain of its guilty feeling of responsibility for damage imagined to have been done.

4 – Repair of the damage and restoration of the good mother is likely to fail:
– where the infant does not feel the damage can be repaired (often because of excessive violence in the reaction of the infant)
– where the infant is excessively intolerant of need and dependence
– where the infant has an excessive tendency toward hurt and grievance that it cannot get past
– where the infant is excessively envious of the mother for being the source of everything good

5 – When the infant feels it cannot bear the psychic realities of dependence, loss, guilt, etc. it will resort to defensive postures to prevent their occurrence or evade their consequences. The goal will be to evade feelings of smallness and need, dependence on a separate person, guilt about damage imagined to have been done, and to deny all psychic realities that relate to these issues. Where the infant has a predisposition to turn to its own body and bodily products to generate a phantasy of self sufficiency, then premature sexualization of the erogenous zones and anal omnipotence may become prominent aspects of the manic denial of needing mother.

<u>Classic Triad of Manic Defenses</u>:
1 – Control: The central problem for the infant is that to survive, it is in need of things that it cannot itself provide. It must therefore depend on mother to provide such needed things as sustenance, care-taking, and love. If one mistreats this needed figure, and it is felt to be separate, then it can go away and the infant will die. The most constructive approach to this problem is to accept these realities and preserve a good, loving relationship to mother, making repairs to the relationship whenever damage to it occurs (in reality or unconscious phantasy).

The main alternative, if one cannot tolerate these realities for whatever reason, requires eliminating the psychic experience of dependence on someone who is separate. One must get these needs met while simultaneously denying the reality of dependence on a source that is separate and can go away. This is in effect making mother an extension of oneself so that all needs are met without any acknowledgement that they are coming from a separate source. This can be done with the use of several different phantasies and maneuvers, the central distinguishing characteristic being whether they are (1) done from the "inside" of mother or (2) from the "outside" mother. Generally speaking, control from the outside is less extreme than control from the inside because the person is allowed to be separate (just not allowed a real life of their own).

– If one stays, in unconscious phantasy, on the "outside" of mother, then an illusion of complete control over her must be maintained while her other relationships are be ignored or hallucinated out of existence. Very disturbed children and borderline adults will often use overt coercion and intrusion which represent the most extreme and violent versions of attempts at control of the needed figure.

A simpler and less dramatic approach is to imagine that mother is in need of or dependent upon the child, in effect a role reversal achieved by projection of ones own baby neediness into the mother while simultaneously taking possession of her desirable traits and capacities through unconscious introjection of them. Varying degrees of actual intrusive and controlling behavior of mother and her activities are used as needed to augment these phantasies.

– Where the infant found separateness from mother particularly difficult to accept in early infancy, and opted to remain an "unborn, inside baby", then it is more likely to resort to this phantasy as a maneuver when it is trying to cope with the depressive anxieties of loss and guilt later in infancy.

In effect, it is resorting to a phantasy that is a normal part of early infancy, but whose use in later infancy and childhood becomes increasingly problematic as its ongoing use undermines the normal procession of development in childhood.

2 – Contempt: Remember that these defenses are usually occurring at a time when the infant or child is angry at mother and imagines she has been damaged and may go away. If one denies that one loves her, cares about her, or needs her, then guilt and loss can be denied and avoided. Since one is already angry at her, it is easiest to just stay angry while devaluing mother so that she is neither needed or worthy of guilt for how she is treated. Since one no longer cares how she is treated, continued attacks are justified.

This contempt for mother and denial of any need for her is commonly augmented in the infant by turning to is own body (especially erogenous zones) and bodily products (especially the anal ones) in order to generate a phantasy of being self-sufficient.

3 – Triumph: This is really an extension of the omnipotent phantasies seen in the contempt, especially when unconscious envy leads to a wish to cruelly reverse roles with the parent. The contempt used to avoid dependence and vulnerability to loss is extended to a triumphant defeat of the parent so that the parent becomes the worthless, helpless, needy baby and the baby becomes the big, fancy parent.

The risk of unconscious guilt for these attacks and a return of even worse depressive anxieties of loss make for a serious potential of a vicious cycle requiring increased omnipotent self sufficiency and ongoing devaluing attacks.

Manic Defenses, Anal Omnipotence, and Masturbation: While control, contempt, and triumph represent the primary components of manic defensive maneuvers, they are all aided, abetted, and augmented by various masturbatory activities that can be used at any moment, in any combination, to increase the sense of self-sufficiency. Whenever a therapist sees either one, i.e. manic states or masturbatory activities, then the therapist should be on the lookout for the other.

1 – Omnipotence: A state of mind generated for the moment to deal with a task at hand. It amounts to an unconscious phantasy that "I can do this". At its deepest underpinnings, it is most commonly a baby wish for magic to deal with a mental pain in relationship to mother. Sexual excitation and obsessional maneuvers are the most common generators of this phantasy as they combine a feeling of self-sufficiency with a sense of control over the object.

2 – Masturbation: The use of any erogenous zone to generate pleasurable or distracting sensations that give one a "magical" sense of control and/or self-sufficiency. The activities are often used to generate or augment a baby level phantasy of getting inside mother to be safe and/or emptying out an unwanted state of mind e.g. getting away from the unvbearable pain of anxiety and frustration.

3 – Anal Omnipotence: A probably inherited tendency that is definitely augmented by deprivation and disturbance in infancy, in which self-sufficiency, intrusion, and at times violent attacks on the object are all augmented by a turning to one's own anus and stools. Odors are commonly used after early infancy to secretly maintain these phantasies because social mores restrict overt turning to ones stools. Manifestations later in life often include an excessive valuation of things one can produce oneself, e.g. speech, writing, painting, money, drug usage, smoking, etc., in preference to people and relationships.

Manic Defenses as Seen in Dreams: Less ill patients usually attempt to consciously treat their therapist decently, so most of the manic maneuvers and attacks on the therapist occur unconsciously and are represented in dreams, often long before they are consciously recognized.
1 – Dreams denying separation

2 – Dreams denying the proper feeding relationship to the therapist/breast
– communist/socialist defense of making everyone the same, i.e. no difference between parents and children

– sexualizing the relationship to the therapist = *erotic transference*

– role reversals with the therapist

– seeing the therapeutic relationship as a commercial exchange

3 – Dreams that overtly devalue the therapist

4 – Dreams of omnipotent self sufficiency and turning to one's own body and bodily products

Manifestations Relevant to the Working Therapist in the Clinical Situation:
1 – Mistreatment of internal and external parents
– spoiling the parent as an individual, often profound with alcoholic, violent, or crazy parents

– splitting the parent's relationship apart

2 – As seen in the transference toward the therapist (often leading to a negative transference)
– living inside the therapist

– denying the therapist as a living being with needs and feelings e.g. a machine just doing its job

– using the therapist exclusively as a "toilet breast" (patient is continually evacuating, not communicating, or feeding)

– being self sufficient and denying need for the therapist as a feeding breast

– reversing roles so that the therapist needs the patient or is seen as the destructive figure

– overtly denigrating and spoiling the therapist's work

– erotic transference to make equal and evade feeding dependency and/or envy

3 – Manic defenses and acting out(side) the therapy:
– financially

– sexually (especially infidelity)

– addictions

4 – Manic defenses often go unrecognized because they are projected into family member, friend, boss, etc.
– often see manic activity aided and abetted in someone else

Consequences of Failure to Address Manic Defenses:

1 – Manic defenses undermine psychic change because these defenses always do harm to the therapist, the patient, and their relationship. Therefore, they are continually generating guilt and paranoid anxieties of retaliation, no matter how unconsciously held or split off. Simultaneously they undermine any capacity for appreciation and gratitude and ultimately the love that would allow the patient to see the value and benefit in the relationship to the therapy and therapist.

– the patient's personality is not developing improved internal figures to give a sense of stability

2 – The therapy is inherently being undermined, progress is thus being undermined, with a result that the therapy stagnates even if the patient stays committed to being "inside" the therapy relationship. With more disturbed, envious, or paranoid patients, there is a chronic risk of interruption of the therapy.

– patients that resist change even though their manic defenses are being analyzed can be thought of as remaining "inside" the "eye of the hurricane" (i.e. the womb) where it is calm, fearing getting separate and into the storm

3 – The manic defenses are self-perpetuating as a vicious cycle, so therapy must stalemate until they are addressed. There is always a danger that this vicious cycle will escalate, resulting in much more serious consequences including destructive mania, depression, and suicide.

Key Treatment Postures for the Therapist:

1 – It is crucial to mobilize guilt in order to stop destructive, negative, spoiling activities

2 – All manic maneuvers used by the patient must be addressed as they are being used. Children will escalate before your eyes until something breaks down, commonly in the form of an accident or a minor injury. Adults will commonly escalate until they break off therapy.

3 – Manic maneuvers should be addressed as they first present themselves This lessens the likelihood of their becoming problematic in the therapy as it allows the patient to begin to develop a concept of the patient's own activities bearing a relationship to baby feelings. Later analysis of them in detail in the transference is then much easier for the patient to recognize and hopefully accept, and there is less damage, paranoia, and guilt that has to be dealt with and repaired.

– anticipation of negative transference and its early analysis greatly diminishes the ultimate destructiveness of negative transferences

4 – With "thin skinned" patients, who are easily persecuted by the feeling that the therapist is "sitting-in-moral-judgment" of them, the infantile anxieties underlying the manic maneuvers need to be spelled out so that the behaviors have a human side to them.

5 – With "thick skinned" patients, who easily deflect any feeling of guilt, it is important to "hold their feet to the fire", examining in great detail the destructiveness, etc. of their maneuvers to mobilize guilt and not allow intellectualization.

– Meltzer: If patient says they kicked somebody, ask the shoe type, power of kick, where it landed, what it did to the recipient, etc., etc.

Section 3 - Concreteness in Infancy, Clinical Practice, and Everyday Life

Basic Assumptions:
1 – To be an infant is to be concrete and psychosomatic!

2 – The geography of phantasy for the infant is the mother's body, inside and outside [Donald Meltzer].

3 – At its origin, the capacity to symbolize has its root in the relationship to a mother. Whenever an infant has an experience that is powerful enough that the infant feels a need to communicate that it is being impacted by something, the mother's response that gives meaning to that experience adds to the capacity to symbolize.

4 – The unconscious internal world and the world of external reality are gradually differentiated by the processes of symbol creation and reality testing (esp. in the depressive position).

5 – The child's interest in the world is determined by a series of displacements of affect and interest from the earliest figures to ever new objects.

6 – As an extension of #5, the psychoanalyst is often faced with the task of understanding and recognizing the meaning not only of a particular symbol but also of the whole process of symbol formation.

7 – To study concreteness is to study the most fundamental underpinnings of the entire evolution of mental life in an individual, both healthy and disordered.

The Relationship Between the Basic Assumptions and Emotional Distress:
1 – Emotional distress in infancy promotes the maintenance of concreteness at the level of the baby core.

– The greater the emotional disturbance, the greater the interference with symbol development.

– At any age of development, when emotional distress becomes too great to bear, there will be a retreat back to psychological maneuvers (especially projective processes) that will erode the quality of symbolic activity, at least temporarily, back to concrete "symbolic equations".

2 – The defensive maneuvers of the baby core of the personality are by nature very concrete.
– e.g. splitting-and-idealization
– e.g. splitting-and-projective (processes) identification
– e.g. denial and the use / misuse of the organ of attention
– e.g. the equation of physical states with emotional states of mind (i.e. somatization)

3 – In infancy, the absence of a good object is experienced as the presence of a bad object.

4 – Of the three primary emotional issues that an infant has with its mother, (i.e.envy, jealousy, and separation) separation is the one that is most inherently concrete in nature to the infant. It will remain so throughout the lifespan even though unconscious envy is also very concrete in its fundamental nature.

5 – Dreaming, in which symbols are used to represent split off (i.e. from consciousness) unconscious phantasies, requires some degree of separateness from objects so that these objects are symbolized. The degree to which separateness is obliterated by massive mental maneuvers, as in psychotics – borderlines – and psychopaths, parallels the degree to which normal use of symbols in dreaming will not occur. In other words, daytime phantasies and nighttime dreams all have the same emotional value and significance.

6 – Concreteness is the starting point for symbol formation and what is left when it fails.

Examples of Baby Concreteness:
1 – Early concreteness can be seen in an infant that is breast feeding vigorously, pushes too hard with its face, has a breast occlusion episode, and then refuses to feed from that breast for the rest of the feeding.

2 – Vestiges of baby concreteness can be seen in later childhood behaviors as:

– kids covering their ears when they are saying degrading things to another kid in a 'put down' contest

– hand gesticulations that accompany speech

– small children being unwilling to eat a broken cookie, as if once inside them, they too would be broken

– needing to keep food rigidly apart on the plate or alternately always mixing it together

– being unwilling at any age to eat something because of its color, texture, smell, flavor, etc.

– compulsive purchasing or hoarding things and unconsciously equating them with bodily products as a substitute for food from mom and a relationship with her

3 – Curiously, somewhere in early childhood, a deep gulf develops. On one hand there is a conscious awareness that it is not possible to move mental states outside the body by physical maneuvers. Simultaneously, the phantasies of doing just that continue with the same frequency throughout the lifespan, especially via unconscious projective processes. It is analyst Jim Grotstein's "in the meantime, on another plane…"

– It may turn out in the future that this gulf is in some way a function of the separation of cerebral cortex pathways of thinking versus limbic system pathways of "proto-mental" thinking.

Definitions:
1 – Concrete [Webster's]: Characterized by or belonging to immediate experience of actual things or events; real, tangible, or literal.

2 – Concreteness: Its origin is found in the state of mind that infants have at the beginning of life. They seem to treat the mental experience of physical states and emotional states of mind as indistinguishable from each other. Both are experienced as happening in the body. Physical states are dealt with by physical maneuvers such as pooping, peeing, spitting up, sneezing, crying, and going to sleep. The crucial point is that the equation of mental states with physical experiences results in states of mind being experienced as if they were the equivalent of concrete physical states and can therefore be dealt with via physical maneuvers in space.

– "Me" and "not me" becomes a physical differentiation equivalent to inside me or outside me. [Quote from a six year old: "Mom, am I yours or am I mine"?]

3 – Symbol [Webster's]: Something that stands for or suggests something else by reason of relationship, association, convention, or accidental resemblance.

4 – Symbolism: a mental activity in which one thing is used to represent another but they are unconsciously and consciously recognized to be different.

5 – Symbol formation starts in earliest infancy, as soon as object relations commence, but ordinarily changes its character and functions with the changes in character of the self and object relations. Thus the quality of the symbols and their usage will parallel the object relations taking place in early development.

– Three parts in symbol formation = Self (ego) – Object being symbolized – Symbol representing the object

– This process of symbolization is a crucial aspect of emotional development and its disruption is evident in all severe mental illnesses.

6 – The geography of phantasy for the infant starts with mother's body, both inside and out. By rapid extension, based in part by genetic "pre-conceptions" [see Wilfred Bion], the infant's own body and that of significant individuals in the surround are also added, but in particular dad's.

– These early, primitive symbols representing parts of mom and dad's bodies, at a "part" and later "whole" object level, become the core of symbolic activity, as seen in dreams. More symbols can be added in the course of development and used in self-expression, communication, discovery, creation, etc.

– The child's interest in the outside world is a result of a series of "displacements" of these affects and interests from the earliest to ever new objects. These displacements are achieved through symbolization.

7 – [Summary by Hanna Segal]: Symbol formation is an activity of the ego attempting to deal with the anxieties stirred up by its relation to the object and is generated primarily by the fear of bad objects and the fear of the loss or inaccessibility of good objects. Disturbances in the ego's relation to objects are reflected in disturbances of symbol formation. In particular, disturbances in differentiation between ego and object lead to disturbances in differentiation between the symbol and the object symbolized and therefore to the concrete thinking characteristic of psychosis.]

– Therefore, problems of symbol formation must always be examined in the context of the ego's relationship with its objects. Such explorations begin in the here and now but extrapolate to their underpinnings in infancy.

8 – Symbolic equation: When one thing is not just felt to represent another, unconsciously and possibly consciously, but is felt to actually be the same as the first thing.

– Symbolic equations are the earliest symbols, "proto-symbols", if you will. In healthy development, as the relationship between self and object gradually evolves, there is a parallel evolutionary change in symbol formation to fully formed symbols.

– Think of a continuum. At one end a symbol is felt to be the thing and at the other end it is felt to represent the thing. In turn there would be a continuum of abstraction in the symbolic representations from portraiture to modern art.

9 – Summary: The movement toward symbol development is a necessary and normal aspect of learning to cope with ordinary mental pains such as those that ensue from separations. This is all taking place in an environment of adequate availability of good objects. Where the developmental environment is more disturbed the infant will resort to more extreme maneuvers involving greater levels of omnipotence (i.e. magic) and psychotic (i.e. massive) levels of projective processes. The consequence of resorting to more extreme maneuvers is the continuation of concrete thinking and the undermining of the development of symbol formation.
[See Case Example of a 7 year old boy at end of outline]

A Working Model of the Composition of the UCS Inner World:
1 – Humans seem to experience their emotions in early life as embedded in relationships, i.e. all emotions

seem to be experienced unconsciously as occurring within an object relationship in which one is doing or feeling something to or about the other (i.e. an unconscious phantasy). This becomes a really useful paradigm for understanding any emotional state of mind. Underlying the emotion is an unconscious phantasy of an object relationship in which one can ask – who is doing what, to whom, and why?

2 – For reasons that I can only make conjectures about (most likely a combination of (1) how the brain stores early experience combined with (2) genetically based pre-conceptions (3) combined with 9 months inside one unique person) it is useful to presume that every person, after infancy, has a handful (maybe 3 to 6) of these core relationships.

The "unconscious phantasies", that dominate these core relationships, in turn form the foundation for that individual's outlook on life, relationships, and what we expect to happen. Each of these relationships usually involves a different 'part of self' locked into a rather permanently fixed relationship with a "good" or "bad" version of mom or dad. They are used as templates to think about the meaning on any life experience.

– Their recreation in the outside world, because they are the 'only game in town', determines how we conduct ourselves in any emotionally intimate relationship (the "repetition compulsion"), especially with family and romantic partners, and with our therapist (transference). Because these relationships can always be found to have the qualities of infantile thinking and seem to resemble and fit the early history of object relations with caregivers for that individual, I think of them as comprising the "baby core of the personality".

3 – It is useful for us to create a working model of how this baby core is created, even if it is also mostly conjecture based on clinically observable data and recent developmental neuro-biological research. It now appears that the earliest memories of life in utero and immediately after birth are stored at a midbrain level in what is referred to as the limbic system comprised of the amygdala, hippocampus, and other nearby areas. These earliest experiences seem to be stored as "memories in feeling" without any thoughts, in the form of phantasies, attached to them.

– Since these stored emotional experiences occur first inside mother's body, and then with key caregivers after birth, they seem to always accrue to the relationship with mother first and foremost. These experiences are then worked on at a "thinking" level in the cerebral cortex, and ultimately the frontal lobes of the cortex. While this process of the cortex coming on board is starting in utero, it accelerates its development very rapidly in the first days, weeks and months after birth. Since the infant is relating with its own body to mother's body, most of the developing phantasies are very concretely about one's own body and mother's body, at what Klein calls a "part object level".

<u>"Limbic Leakage", Cortical Development, and Unconscious Phantasy</u>:
1 – If we assume that memory can be stored in the brain before it can be thought about, and that experiences get recorded mostly because they are particularly emotionally evocative or are less evocative but repeated regularly, then these stored experiences as 'memories in feeling' will have an impact on the developing psyche of the infant.

Because the human brain seems to work by pattern recognition and association, rather than storing a digitized snapshot of a whole experience, it is clear that current experience can evoke the recall of emotions linked to similar experiences from archaic midbrain levels of memory. Furthermore, if those earliest experiences were unusually powerful, then associations to them are evoked by a wide range of things in current life.

Premature birth, adoption, severe colic, and very short spacing between siblings (e.g. less than 18 months apart) are examples of some very powerfully evocative early experiences.

2 – So if we have these early events stored as “memories in feeling”, and we are having new ongoing experiences, both of these sets of emotional experiences are becoming part of what the cerebral cortex is trying to organize and give them a sensible meaning. As the ultimate significance of the emotion is organized, it becomes the center of the meaning ascribed to an object relationship – the aforementioned “who is doing what to whom and why”.

The object relationship could then be described as being between a part of self and a version of mom or dad, with the “unconscious phantasy” representing what they are imagined to be doing to each other for some reason.

3 – Limbic leakage is a concept representing the consequence of anything evoking the “release” of archaic memories in feeling because something in the current environment is stimulating an association to those earliest experiences. Since these memories are so deeply unconscious and literally “unthinkable”, they can powerfully evoke a mood or emotional reaction that one cannot consciously fathom. If such emotional states are being chronically evoked and were originally very disturbing, as in someone who is chronically seriously depressed or anxious, then they have no hope of getting past it without professional help.

– Since so many of these earliest experiences have phantasies formed about their meaning during infancy, and reworked as to their significance for years, then the likelihood of the phantasy being distorted is very high if not guaranteed. Again, the more powerful the emotional issue around which the phantasy is being formed, the more likely that it will be a problem in life that cannot be dealt with constructively without outside help.

4 – Summary: What will become the earliest phantasies, at a cortical level, are probably felt to be the same as the initial raw experiences of early infancy. Because these earliest experiences are so central to the infant, they become the basis for most if not all of the earliest explorations of life in the world outside the womb. As development proceeds via these explorations, new objects will be added to the earliest objects. In turn this will lead to self-expression, communication, discovery and creativity.

Much of these latter activities represent a displacement into the outside world of feelings and phantasies, as well as sublimations of those, via a process of “symbolic representation”. This means that interests in the earliest objects, will move to new objects that come to represent the early ones. Much if not all of this activity is manifested by a child’s play. If the earliest relationships have too much mental distress linked to them, then that pain will put a strain on the smooth transition of expansion of these processes of displacement and sublimation and expansion of the use of symbols. What is likely to remain is a tendency to concreteness and diminished imagination.

<u>Concreteness, Children’s Play, and Dreaming</u>:
1 – It is useful to conceptualize the play of children as their physically concrete way of thinking including testing hypotheses about life and the difference between the inside and outside worlds in which they live.

2 – Similarly, it is useful to conceptualize “dreaming as thinking” done by the baby core of the personality while asleep. Dreams think about whatever emotional issue is dominating the baby core of the personality at that moment and depict how the baby core is choosing to deal with that issue.

– Dreams require the depiction of parts of self, good and bad versions of mom and dad at part and whole object levels, and various states of mind and concomitant activities in those states of mind that make up the baby core of the personality. As a result, one can see the evolution of symbolic representation and one’s relationship to those symbols in a stark fashion in dreams.

– The bad part of self may evolve in the course of a successful analysis from a monster from outer space, to a prehistoric tyrannosaurus, to a vicious wolf, to foreign assassin, to a bad figure in the news, to the equivalent of one’s sibling in a perturbed state of mind. A similar evolution might occur for a parental figure.

3 – The greater the emotional disturbance in thinking, the less dreams will employ symbolism and the more they will represent "symbolic equations". It leads to the interesting question as to whether or not psychotic individuals dream in any proper sense of the word, or whether they are just moving dream furniture around in mental space.

Klein's Models for Early Development, Creation of Symbols, and the Experience of Separateness:
1 – Klein's Paranoid-Schizoid Position: The infant needs to bring order to its world and does so by dividing and separating good (i.e. pleasurable) experiences and the objects linked to them, from bad (i.e. unpleasant) experiences and the objects linked to them. This process of splitting-and-idealization leads to a natural desire to have a union with the now ideal object and get rid of and totally annihilate the bad object as well as bad parts of self (linked to the experience of the bad object). Along the model of alimentary tract's function, the bad tends to be evacuated into some container in the outside world. At this time omnipotent thinking is paramount and reality sense intermittent and precarious. The concept of absence hardly exists so that when the union with the ideal object is not fulfilled, what is experienced is a feeling of being assailed by the presence of the bad object or objects.

– This period of development corresponds to Freud's period of hallucinatory wish-fulfillment. Projective processes are the major defensive maneuvers, i.e. splitting-and-projective identification, whereby large parts of self are projected into the object and the object then becomes equated, i.e. identified, with the projected parts that it is felt to contain. Similarly, internal (figures) objects are projected outside and identified with parts of the external world felt to contain them. These first projections and identifications are the beginning of the process of symbol formation.

– However, these early symbols are not felt to be symbols or substitutes but the original object itself thus forming a symbolic equation between the original object and the symbol in the internal world and the outside world. (This equals the basis of the schizophrenic's concrete thinking.)
[Note: – The fact that most of the first alimentary evacuations occur in relation to mother and her body, where the infant had been living for many months, may contribute to the fact that most "projections" throughout the life span are imagined to be "into the body of someone" even though mental health professionals persist in saying "onto". Since projections always entail a "content" that is to be moved in physical space for some "motive" in the projector's unconscious inner world, the "consequence" that is expected in unconscious phantasy to result from the projection will follow logically. All projective processes can be made into an algebraic equation where: content + motive = consequence. Knowing any two of the components will usually allow one to deduce the likely composition of the third element.]

2 – Klein's Depressive Position: As development takes the infant into the middle of its first year of life, the quality of its object relationships change. Instead of imagining two mom's, i.e. an all good one and an all bad one, its brain development leads it to recognize that the mom that it at times loves is the same mom that it hates at other times. This unites the two part objects, i.e. a good version of mom and a bad version of mom, into one whole object. This means that it can have both loving and hating feelings for the same person, i.e. ambivalence. In turn, it can now feel guilt for harming, during hateful periods, the person that it also loves. This loving, guilty concern (what Klein calls depressive anxiety and depressive guilt) is a healthy, necessary step in the development of caring object relations and the whole package is referred to as the depressive position.

[Note: Despite the confusion in nomenclature, all of the above is part of normal development and not to be confused with clinical depression.]

– We now have an object relationship that has evolved to one in which guilt, fear of loss, or actual experience of loss and mourning, lead to a striving to repair, restore and re-create the object. Successful repeated experiences of this sequence lead to a good object being securely established in the inner world of the infant.

– With a gradual lessening of projective processes and a relative strengthening of introjective processes, a change in the reality sense occurs and a gradual differentiation of internal and external reality develops. The infant increases its desire to spare and save the object from its possessiveness and aggression.

– This situation is a powerful stimulus for the creation of symbols, which in turn acquire new functions, which in turn change their character. The symbol is, for example, a means for displacing aggressive impulses from the original object, lessening both guilt and fear of loss. Those symbols residing in the inner world also operate as a means of restoring, re-creating, recapturing, and owning again the original object. But they are no longer fully equated with the object.

3 – A symbol is created by the self to represent an object (i.e. person) that is felt at some level to be separate from the self, literally physically and probably emotionally. As development proceeds through infancy, the symbol can be used to remember the object during its absence. All of this is a precondition for a successful uniting of good and bad versions of mom in the "depressive position".

4 – What happens to symbol creation and its consequences when there is an excessive reliance on projective processes to get back inside mom and rid oneself of the experience of separateness? The result is an erosion of separateness and an increase in confusion as to whether or not the symbol is the same as the object. In other words, the symbol and the object symbolized become "fused and confused".

– Becoming an "unborn inside baby" once again is a common temporary state of mind for many people as they go about their daily life. For some, it is a way of life, and thus becomes significantly problematic.

– As Segal puts it "only when separation and separateness are accepted and worked through does the symbol become a representation of the object, rather than being equated with the object". Where there is a disturbance in the relationship between the self and the object, it will be reflected in a disturbance in the relationship between the self, the object symbolized, and the symbol.

5 – Full symbolization can be thought of as an achievement that requires full tolerance of separateness and therefore adequate tolerance of mourning of the lost object that is represented by the symbol.

Bion's Model for the "Mother – Infant Relationship" and a "Theory of Thinking":
1 – The Mother – Infant Relationship: Taking off from the models of Melanie Klein, Wilfred Bion elaborated a model of the infant's relationship with the mother in earliest infancy that gives the mother a crucial and indispensable role in the infant's development of a capacity to think. His idea was that infants have raw, unthinkable, unusable states of mind and body that can only be emptied out of the infant's mind (i.e. evacuated), as if they we chunks of mental concrete. He arbitrarily called these raw mental experiences "beta elements". These evacuations are imagined to go into the mother where she performs several functions (Bion's reverie). It is necessary for the mother to (1) take in these raw states of mind/body, (2) tolerate contact with them, (3) organize them into a meaningful idea regarding what they are and why they are being experienced, and then (4) behave back toward the infant in a fashion that is appropriate to dealing with that specific raw, unusable and unthinkable state of mind.

2 – The Theory of Thinking: The above process gives "meaning" to an otherwise meaningless and unusable piece of concrete mental furniture. Bion gave a name to the state of mind that the infant re-introjected in a more usable, thinkable form from the mother's emotional and behavioral response. He called it an "alpha element". This new processed version of the original raw experience was now something that could potentially be thought or dreamed about. The gradual development of a capacity to perform this "alpha function" on one's own is a prerequisite for moving from psychotic modes of functioning to healthier modes of actual thinking and symbolizing.

– Beta elements are concrete, suitable only for evacuation, while alpha elements are moving in the direction of symbolization and potentially suitable for thinking and use in dreaming. Practically speaking, alpha elements could be seen on a continuum from the very earliest movement toward primitive symbolization

(e.g. labeling an emotion) to very sophisticated and highly elaborated symbolization (e.g. poetry, contemporary art, etc.).

3 – In normal circumstances, according to Bion, an infant will develop a capacity to cope with separation and its attendant anxieties. If these anxieties are not excessive, the infant gradually learns that the parent will return and it begins to develop a capacity to create and hold on to the memory of the temporarily lost good object. Thus it learns to remember the absent object by creating an image representation of that object in its mind. This internal mental representation (called a "thought" by Bion) is used to bridge the painful gap of loneliness until the object returns and is thus the prototype of a developing capacity for symbolization.

– The success of the above process is linked to a combination of the infant's capacity to bear frustration and the environment's capacity to keep this frustration within bearable limits.

4 – As disturbance increases (linked to environmental failures and the infant's predispositions), a greater degree of omnipotent maneuvers are resorted to in order to cope with such mental pains. These maneuvers invariably aim to evade the experience of separation (both psychic and external reality). In that process they undermine the maintenance of a healthy relationship to good objects by creating a relationship to omnipotent maneuvers as a substitute for object relations. These omnipotent maneuvers include:

– turning to one's own body and bodily products (to deny that the object's absence matters)

– resorting to a phantasy of getting back inside the object (i.e. to become an "unborn inside baby")

– going to the extreme of / explosively evacuating/annihilating hallucinating the object out of existence. [See Case Example at end of outline: An infant whose mother got German measles at 3 months of pregnancy.]

<u>Concreteness in Severe Emotional Disturbance</u>:
1 – To be psychotic is to sink into a global state of baby concreteness and resultant massive confusion between the mind, body, and outside world.

2 – The hallmark of psychosis, according to Donald Meltzer, is to resort to "massive states of projective identification" with a complete blurring of boundaries between self and object (internal or external). This is at the root of the confusional states seen in acute psychotic illness.3 –Consider some of the hallmarks of schizophrenia:
– Hallucinations including auditory, visual, olfactory, tactile, etc.
– Delusions of grandiosity, persecution, and reference
– Disordered associations including loose, clang, tangential, and circumstantiality
– Disordered affect including manic, depressed and flattened
– Disordered physical movement including psychomotor retardation and catatonia

<u>Concreteness, the Learning Process in Childhood, and its Disruption</u>: [See Ravel's libretto from Klein at end of outline]
1 – Example of inhibited symbol formation summarized by Segal of Klein's Case in 1930:
"She described an autistic little boy of four, Dick, who could not talk or play; he showed no affection or anxiety and took no interest in his surroundings apart from doorknobs, stations, and trains, which seemed to fascinate him. Analysis revealed that the child was terrified of his aggression toward his mother's body and of her body itself, because he felt it had turned bad through his attacks on it. Because of the strength of his anxieties, he had erected powerful defenses against his phantasies about her. There resulted a paralysis of his phantasy life and symbol formation. He had not endowed the world around him with any symbolic meaning and therefore took no interest in it. Melanie Klein came to the conclusion that if symbolization does not occur the whole development of the ego is arrested."

2 – Consider these ‘What ifs?”:

– What if the first grade child who was best at coloring between the lines was so concrete as to imagine that to draw on the line would break the drawing, and she would have her first schizophrenic break at 17.

– What if 6 year old boy’s mother was always threatening to go live away from the family and he was terrified of learning subtraction (‘takeaways’).

– What if a third grade girl felt she was keeping her mother and dad split apart out of jealous possessiveness of mom and had an unusually strong preference for printing when doing writing exercises in school and seemed to struggle to learn to do cursive, i.e. “joined up” writing.

– What if a four year old projects his violent biting phantasies, linked to his experience of colic in infancy, into a neighbor’s boisterous red haired golden retriever that snapped at him for trying to take a bone away, and then as a 8 year old seems unusually negative and uncooperative with a rather stern older teacher, Miss Order, who happens to have bushy red hair.

3 – Where infancy is disturbed there is the potential for numerous symbolic equations in the outside world which then carry the full anxiety experienced in relation to the original persecutory or guilt-producing object. This will inevitable disturb if not derail the child’s relationship to the object that has become persecutory.

4 – Infancy has many tasks that simultaneously involve the modulation of emotional distress while learning about life and how to realistically think about and manage it. Feeding is an example, par excellence, where one sees reasonable behaviors and irrational phantasies all mixed together, at times reinforcing something constructive, at others completely interfering with development. One need only consider the following to picture the positive and negative fedback loops:

– a breast feeding “occlusion” episode

– the sequelae of severe colic in infancy

5 – In ordinary development, all children have pockets of concrete thinking that interfere with normal life and development but are accepted by the parents as the price of admission to learning about life:

– Try convincing a child of four that the “monster in the closet” is just in their imagination.

6 –As an example, early separation from the biological mother as seen in normal adoption seems to universally leave issues unresolved that regularly concretely interfere with development.

<u>Attention Deficit and Hyperactivity Disorders</u>:
1 – To keep one’s attention focused on a task at hand for a sustained period, it is necessary to keep internal distractions at bay. But if almost anything leads by association to an emotionally charged early experience, then it is really difficult to not be constantly distracted.

– By extension, if one has very emotionally charged early experiences that one wishes to annihilate from existence, then one cannot allow any thought in any area that might undo the obliteration lest the unwanted experience return. This makes it difficult to think something through at any depth, risk learning new ideas, etc.

– e.g. If having a bad thought is indistinguishable from an act, then you don’t dare think any bad thoughts (see the movie “Jesus Camp”).

– e.g. If in phantasy you murdered mother's unborn inside babies, then thinking about the inside of anything is dangerous.

– e.g. If in unconscious phantasy you have stopped your mom and dad from getting together, then you may have difficulty putting anything together, as it would tend to undo your control over your parents [Ron Britton's patient shouted "stop that fucking thinking".]

Concreteness and Sexuality in Adolescence:
1 – Whose body and sexuality is it?
– If sexuality is stolen, then sex is a crime

2 –One cannot have a boyfriend or girlfriend if it is confused with possessing mom or dad
– This is so concretely frightening that boys will fight when told "go f… your mother".

3 – Pregnancy and abortion require an investigation of: (1) Whether in psychic reality a pregnancy has occurred yet?; (2) In psychic reality, whose baby is it, mother's or the adolescent's?

The Baby Core of the Personality, Concreteness and Psychosomatic Illness:
1 – Definition: Psycho-somatic refers to the interaction of the mind (psyche) and the body (soma). Therefore, psychosomatic illness would imply that this interaction is leading to a symptomatic difficulty. This is not to be confused with hypochondriasis wherein the psyche is imagining an illness.

2 – As stated at the beginning of this talk, to be an infant is to be psychosomatic. If the caregivers have a preference for conceptualizing bodily states as a source of all distress, as opposed to seeing emotions as the source of distress, then the infant will not develop "psychological mindedness".

– In the beginning of life, infants respond to both physical and emotional experiences with a response that has a physical component. If only the physical aspect is recognized by the caregiver on a continuous basis, then the emotional component will not be given recognition and meaning. If the infant's target zone for physical expression of emotional states is one that the caregiver's attitudes reinforce, then somatization may take preference over mentalization. The groundwork is laid for a concrete displacement via unconscious projection of emotional states, and phantasies about, them into the body.

3 – A strong preference for making mental states a bodily issue is almost always completely intractable to mental therapy. Even if convinced that one bodily zone of difficulty is "mental/emotional" in origin, the patient is at high risk to unconsciously just find a new zone that couldn't possibly be "all in their head".

4 – Definition: A "folie a deux" is the presence of the same or similar delusional ideas in two persons closely associated with one another. It represents one of the most difficult if not impossible situations to treat in mental illness.

– One finds some degree of this intractability almost universally in psychosomatic illness. This is in great part a result of a desire to not see the issue at hand as mental or emotional, which in turn is commonly a result of a parental preference for the same attitude. Where one or both remained bound together by this attitude about the illness, creating a secondary gain, that area of life will likely remain immune to outside influence that might alter how the illness is perceived and used.

Concreteness in the Therapist:
1 – Patients are usually consciously aware of wanting to talk about something although they may not know why that particular something has come into their consciousness. The patient's communication usually has a subject and an object who exist in the patient's actual current life and are outside the relationship to the therapist. It takes significant training to see:

– In that outside situation, the patient is likely recreating something that exists as a relationship in their UCS inner world, very likely with origins in preverbal experiences of infancy.

– The patient may be talking about something in their life outside therapy that has a parallel with their feelings about the relationship to the therapist (i.e. transference).

– At times the content of the communication is less important than the process taking place at that moment. In turn, the process may represent some very early emotional issue.

2 – In all of the situations just described above, concreteness in the therapist will naturally predispose him or her toward behavioral approaches and away from thinking about the unconscious inner world. If the patient is also very concrete, then both will tend to feel driven to action in response to a problem instead of thought about issue at hand. A fix or cure becomes the goal rather than understanding the phantasies and emotions at hand.

– Never assume that because a therapist says they "believe in the unconscious" that they actually do. There is a lot of "unconscious lite" in the ranks of the mental health profession, including psychoanalysis.

3 – A strong need, at a baby level in the therapist, to be seen as good, smart, clever, funny, likable, etc. will interfere with staying separate from the material to think about it and will predispose the therapist to concretely act in response to countertransference feelings. Insight into this can allow a repair by going back to the missed interpretation.

4 – The level of "imagination" that a therapist brings to the work of analysis is highly variable and to some degree contributes to the "talent" that some have for the work. This is perhaps analogous to competitive figure skating where one has to learn the compulsory maneuvers (at which the Eastern Block always excelled) and then do free style skating (at which the freer thinking West excelled).

– Dream interpretation is typically the arena in which the freedom to imagine is most necessary.

5 – When patients are unconsciously putting pressure on the therapist to "act rather than think", all therapists must remind themselves of the need to represent with symbols (alpha function) for the patient rather than take action in the form of giving advice, etc. This is more common when one cannot "think" of an understanding of the situation at hand, or when the patient is feeling especially helpless and needy, or at the end of sessions when "ideas" don't seem to "fix" the situation so that patient/baby can be sent away guilt and anxiety free.

Two Reference Texts You Must Own:
Donald Meltzer. "Sexual States of Mind", Clunie Press, 1973

Hanna Segal. "The Work of Hanna Segal: A Kleinian Approach to Clinical Practice", Jason Aronson, 1981

Two Classic Papers:
Wilfred Bion. "A Theory of Thinking", Int. Jour. Psychoanal., 1962, Vol 43, Parts 4-5.

Donald Meltzer. "The Klein – Bion Expansion of Freud's Metapsychology", Int. Jour. Psychoanal.,

EXAMPLES

Case Example of 7 Year Old Boy:
1 – A patient is brought by his mother at seven years of age. Her first pained but earnest comment was that she had been completely uncertain about how to deal with a baby or understand the needs and feeling states of her first born child. As she summarized it "no one taught me how to be a mother". He is very odd,

uncoordinated, teased at school, and has clearly inherited both his scientist parent's intelligence and their lack of understanding of ordinary social cues.

2 – The boy, who seems chronically frustrated, ineffectually angry, confused about how life is supposed to work, seems to have summarized all of those emotional states with a decision that he is not going to engage in any more life at a given moment than he feels like doing. This quasi 'sit down strike' about life seems to benefit him by evading that which he doesn't understand or at which is incompetent (i.e. sports and assorted school subjects). It has a secondary benefit of exporting his frustration and feeling of inadequacy into his mother. Beneath this level of acting out, I suspected he was dominated by a deeper despair about whether or not life is worth living at all.

3 – Now thirty two years of age, this man has been my patient off and on through every epoch of his life. I have watched him try to become a competent student who could tolerate doing what was demanded of him, learn about dating, struggle to find an identity, and ultimately a career as an accountant. I have seen his struggles to "think about" his feeling reactions to life rather than simply literally turn away from anything he didn't immediately understand or feel good about. He has developed a gradual capacity to tolerate frustration, delay gratification, have a longer time line for plans in life, and recognize the primacy of his and other's emotions when attempting to navigate life on a daily, monthly, or yearly time frame.

4 – He and I have come to have an appreciation of his limitations and his strengths, the greatest of which seems to be, his considerable intelligence notwithstanding, that he is a genuinely kind, sweet person (much like his "lost" but kindly mother).

5 – Along the way we uncovered that he had difficulty learning Spanish, which had lots of competition in classes, but had a talent for Japanese and Konji, where he was the only non-Asian student in most of the classes. After gaining a Master's degree in Asian studies, but realizing his thinking was ill suited to being a teacher at the level of a college professor, he discovered by happenstance that he had a gift for accounting.

Case Example of Mom with German Measles:
1 – A woman contracted German Measles at the beginning of her second trimester of pregnancy and lived in terror for the rest of the pregnancy that the child would be born with birth defects. The baby came out of the womb screaming and almost literally did not stop for his first year of life. The woman did not attempt a second pregnancy.

2 – The boy was brought to me for therapy at eleven as he was becoming disruptive at school and difficult at home. After an extended evaluation of family therapy lasting several months, the parents felt it was best that the child have a five day a week analysis with me and they would check in occasionally with me as issues arose. The analysis lasted at a 5 day a week frequency until it ended when he was 18 and no longer wished to continue. During the seven year treatment he complained about attending but never missed a session with the exception of a week when he was about fourteen and had a brief psychotic episode.

3 – In the first few weeks of individual play therapy he would not allow me to speak, covering his ears, drowning out my words with la-la-la…, and finally threatening me with physical violence. He brought his lunch sack to his 7 AM sessions and on about the third week pulled out a book of matches proclaiming "Look what my mom put in today!" He then proceeded to light a match and throw it at me whenever I attempted to make an utterance. My supervisor, Susanna Isaacs Elmhirst remarked matter of factly: "He needs to play with fire". For the next year or so he would set paper on fire in the sink of my child playroom and I would limit it to the number of sheets that produced the maximum amount of smoke I could tolerate in the room.

4 – At age 13 he tried to organize a chapter of the Ku Klux Klan in his elementary school. By fourteen it was clear that he had inherited the capacity to be an alcoholic like his grandfather.

5 – At sixteen he was in a single vehicle auto accident in which he and his drunk friend who was driving a jeep at a high speed were both ejected from the vehicle since neither were wearing seat belts. The crash was so violent that both of his tennis shoes were thrown off his feet yet miraculously he was uninjured save for assorted scrapes and bruises.

6 – During his entire childhood his father remained patient and close to his son, ever hopeful, and his mother struggled with feeling guilty and despairing that he would ever be "normal". We all agreed from the beginning of treatment that our primary goal was to get him through the maelstrom of adolescence, alive at the other end of the storm.

7 – When encouraged by the family to consider enrolling in the military, he refused saying accurately that it was the "largest baby sitter" on the planet. At age 24, coming in for an incidental follow-up he remarked spontaneously that "I am the most envious person I know".

8 – He became a construction worker and later a handyman, never able to set his sights on goals that were not grandiose, and forever struggling to take orders from people who were less intelligent than he but more reasonable and predictable.

Klein's Example:
From Klein's "Infantile Anxiety-Situations Reflected in a Work of Art and in the Creative Impulse, 1929:

"A child of six years old is sitting with his homework before him, but he is not doing any work. He bites his pen-holder and displays that final stage of laziness, in which ennui has passed into cafard. 'Don't want to do the stupid lessons,' her cries in sweet soprano. 'Want to go for a walk in the park! I'd like best of all to eat up all the cake in the world, or pull the cat's tail or pull out all the parrot's feathers! I'd like to scold every one! Most of all I'd like to put mama in the corner!'

The door now opens. Everything on the stage is shown very large – in order to emphasize the smallness of the child – so all that we see of his mother is a skirt, an apron and a hand. A finger points and a voice asks affectionately whether the child has done his work. He shuffles rebelliously on his chair and puts out his tongue at his mother. She goes away. All that we hear is the rustle of her skirts and the words: 'You shall have dry bread and no sugar in your tea!'

The child flies into a rage. He jumps up, drums on the door, sweeps the tea-pot and cup from the table, so that they are broken into a thousand pieces. He climbs on to the window-seat, opens the cage and tries to stab the squirrel with his pen. The squirrel escapes through the open window. The child jumps down from the window and seizes the cat. He yells and swings the tongs, pokes the fire furiously in the open grate, and with his hands and feet hurls the kettle into the room. A cloud of ashes and steam escapes. He swings the tongs like a sword and begins to tear the wallpaper. Then he opens the case of the grandfather-clock and snatches out the copper pendulum. He pours the ink over the table. Exercise-books and other books fly through the air. Hurrah!…

The things he has maltreated come to life. An armchair refuses to let him sit in it or have the cushions to sleep on. Table, chair, bench and sofa suddenly lift up their arms and cry: 'Away with the dirty little creature!" The clock has a dreadful stomach-ache and begins to strike the hours like mad. The tea-pot leans over the cup, and they begin to talk Chinese. Everything undergoes a terrifying change. The child falls back against the wall and shudders with fear and desolation. The stove spits out a shower of sparks at him. He hides behind the furniture. The shreds of the torn wallpaper begin to sway and stand up, showing shepherdesses and sheep. The shepherd's pipe sounds a heartbreaking lament; the rent in the paper, which separates Corydon from his Amaryllis, has become a rent in the fabric of the world! But the doleful tale dies away.

From under the cover of a book, as though out of a dog's kennel, there emerges a little old man. His clothes are made of numbers, and his hat is like a pi. He holds a ruler and clatters about with little dancing steps.

He is the spirit of mathematics, and begins to put the child through an examination: millimeter, centimeter, barometer, trillion –eight and eight are forty. Three times nine is twice six. The child falls down in a faint!

Half suffocated he takes refuge in the park round the house. But there again the air is full of terror, insects, frogs (lamenting in muted thirds), a wounded tree trunk, which oozes resin in the long-drawn-out bass notes, dragon-flies and oleander flies all attack the newcomer. Owls, cats and squirrels come along in hosts. The dispute as to who is to bite the child becomes a hand-to-hand fight.

A squirrel which has been bitten falls to the ground, screaming beside him. He instinctively takes off his scarf and binds the little creature's paw. There is great amazement amongst the animals, who gather together hesitatingly in the background. The child has whispered: 'Mama!' He is restored to the human world of helping, 'being good'. 'That's a good child, a very well behaved child', sing the animals very seriously in a soft march – the finale of the piece – as they leave the stage. Some of them cannot refrain from themselves calling out 'Mama'."

Case Example of Woman Getting a Ticket:
1 – A middle aged woman drives past a parked police car in a small business district and parks. As she unhooks her seat belt and starts to roll up the window the officer walks up and states declaratively "you were not wearing your seatbelt". She says yes I was and he says no you weren't and a brief back and forth argument ensues during which she lamely states "I know I was wearing it because it would have gone ding-ding-ding if I wasn't wearing it". He ends the 30 second argument by going back to his patrol car to write her a ticket.

2 – She gets out of her car in a quiet fury and mindlessly continues the argument that she was wearing it. He tells her to get back into her car and when she refuses he grabs her and puts her in an "arm bar" with her left arm behind her back. She manages to get out of the arm bar and demands that he call his supervisor. At that point a second patrol car drives up, a male officer gets out and walks up, and a small crowd has begun to gather watching the spectacle.

3 – "I don't know how, but I could see in the second officer's eyes that he was a man who was going to listen to me and I calmed down and started to be able to think." The supervising officer also arrived within a few minutes and the woman was convinced to get back in her car with all now talking calmly and rationally.

4 – Once back in her car the woman remembered that she always tucks the shoulder harness under her left armpit so that it does not hurt her breasts thus explaining why the officer was so certain that he did not see her wearing a seat belt/shoulder harness. That fact, which might have diffused the entire situation right from the beginning, was unavailable to her consciously until the entire altercation had transpired.

5 – Consciously, the emotionally crucial feeling had been that the officer did not believe her and would not listen, mirroring much of her childhood feelings about her anxious mother and absentee father. The event, which occurred on a Friday morning left her in a deep depression all weekend, even after hunting down the same officer on Saturday and apologizing to him, apparently making him further perturbed.

6 – At her Monday session with me, having refused her husband's urging to call me on Saturday, she said that what was so surprising to her was that she was so vehement in pursuing the officer and that she was utterly incapable of coherently explaining the situation except to keep reiterating that it would have gone ding-ding-ding if she had not been wearing it. She could not remember the word "alarm" or that she had tucked the harness under her armpit.

7 – Historically, this woman had spent her entire childhood trying to be her anxious, narcissistic mother's perfect daughter, always with the goal to never be a problem or burden. She completely denied feeling any resentment that her mother favored her emotionally handicapped younger brother or that her mostly absent, traveling salesman father never came to her rescue.

8 – This patient complained of a lifelong feeling that she did not have a good memory and was intellectually inferior to the rest of her family. This idea has held in spite of the fact that she was a competent, self-taught auto mechanic. My experience was that she was in fact quite intelligent and quick to catch on to things that were of interest to her and did not evoke an excess of anxiety.

Assorted Clinical Examples:
1 – A woman who comes to analysis five times per week. She had an inadequate, infantile mother who left her feeling chronically deprived. The patient is forever asking for make-up sessions, double sessions, etc. to make up for perceived losses of contact with the analyst.

Section 4 - The Clinical Relevance of the Organ of Attention

General Introduction:
– This course is about things that we observe everyday, both at home and in our consulting rooms. We take most of the phenomena for granted and do not give them any more thought than a barely conscious acknowledgement unless we are pained by something specific at that moment.
– Some aspects of seminar may be upsetting as you apply the models to your own life, professional or private.
– I'll offer models for thinking about these issues in early development, daily life, and the clinical setting.
– Psychoanalysis is very much a combination of content (e.g. UCS phantasy, dreams, etc.) and process (e.g. how one manages the content in the context of human relationships). This course is mostly about the "process" side of things.

Why Does How One Focuses Attention Matter?
1 – Little has been written about the Organ of Attention. This seems to be a function of it being in everything mental and developmental, like H2O is are part of almost everything that is alive, and thus we take it for granted while failing to notice its relationship to mental and development issues. Furthermore, while some disorders have it in their name, they are not really caused by it so much as they are mediated by and expressed symptomatically via the use of attention behaviors.

2 – Psychoanalysts study how and why people think, feel, and behave. This takes Kleinian analysts back to infancy to study the origin in the baby's relationship to its mother. In turn this leads to a detailed study of the baby's methods of coping with the inevitable mental and physical pains of infancy, especially since in the beginning of life after birth, the methods for coping with mental pains are essentially the same as the methods for coping with physical pains. It even appears that the mental pains are for the most part experienced as bound up with and thus indistinguishable from physical pain.

3 – In recent decades, mental health professionals and educators have found a huge overlap in their interests as studies of childhood development, both ordinary and problematic, have led to an awareness that emotional development and cognitive functioning are very intertwined. This can be seen in the increasing focus on issues like dyslexia, attention deficit, Asperger's syndrome, every other expression of a "learning disability", and most extremely infantile autism.

4 – All of the above examples have in common how an individual "focuses" their mental apparatus in life situations. Some of these situations would appear to the casual observer to be predominantly "just a cognitive" situation, like learning math or a language, while other contexts make it easier to see that emotions are recognizably a part of the mix.

5 – I would like to suggest that it is worth playing the 'devil's advocate' with oneself and assume that all primary coping methods originate in infancy, even if they are modified stylistically over the years. At rock bottom, these methods of directing one's focus are all about coping with mental pain, even if there is no obvious direct link to mental pain any longer. In other words, every learning disability, every consistent failure to understand what should be understandable, every style of attending to or avoiding focusing on anything in life, has some link to an early mode of regulating and coping with emotions and mental pain.

6 – The most graphic example of this link between the focus of attention, mental pain, infancy, and the difficulty of seeing how they are linked, is the tragic situation of infantile autism, which now shockingly affects in varying degrees an estimated one percent of our young children in the U.S. It may also be the most useful example, in its severity, for how the organ of attention, at the extremes of the bell shaped curve of development, is crucial to think about if one is to create models that may help us understand this illness in particular and mental functioning in general.

Observing Some Sample Human Situations, Both Ordinary and Extreme:
1 – In the course of a day, when is your focus on the important point and when is it distracted away from the point?

2 – What is commonly observed when someone is first madly in love?

3 – What commonly happens when a person getting a divorce looks at themselves in the mirror?

4 – What is happening when a four week old infant consistently looks past its mother's face rather than "into it"?

5 – What has happened to a woman's capacity for self awareness when she gives birth unexpectedly in a toilet?

The Phylogenetic History of Attention:
1 – The brain was used historically primarily as the body's alarm system. It needed a method to go on alert when a stimulus suggested that danger was afoot. It developed the 'reticular activating system' [RAS] that releases a rush of adrenaline that closes down all unnecessary activity, e.g. the heart rate slows, breathing becomes shallow, and the brain becomes quiet. Meanwhile, activity goes on in the superior colliculus, the lateral pulvinar (a part of the thalamus), and the parietal cortex, all of which are concerned with orienting and focusing. When the organism recognizes the cue, the appropriate area of the brain springs into activity and shows a greater level of activity than would have occurred in a brain that had not been put on alert.

2 – Attention is a largely automatic mechanism performed in the brainstem that constantly scans the environment for stimuli. It is necessary for thinking and possibly for consciousness. It involves these three components:

– Arousal: Stems from a group of nuclei in the midbrain (at the top on the brainstem) which make up the RAS, some of which are responsible for the overall level of activity of the brain as a result of releasing a flood of neurotransmitters when stimulated. Dopamine and noradrenaline (norepinephrine) particularly activate the prefrontal lobe. Alpha brainwaves, which are particularly associated with alertness, are also created by this group of RAS neurons.

– Orientation: This is primarily a result of activity of neurons in the superior colliculus, which turns the eyes toward the stimulus, and parietal cortex which disengages from the previous stimulus.

– Focus: This is brought on by the lateral pulvinar, a part of the thalamus, and operates like a spotlight, turning to shine on a stimulus, and shunting information to the frontal lobes which can lock on and maintain attention.

Coping Methods Used by Infants to Deal with Emotions:
1 – Brazelton's depiction of an infant's coping repertoire:
– cry, poop, pee, spit up, sneeze, stare fixedly, go to sleep

2 – Klein's depiction of an infant's primary psychological coping maneuvers/defenses:
– denial (i.e. of an aspect of external reality)
– splitting-and-idealization
– splitting- and-projective identification
– manic defenses (i.e. denial of an aspect of psychic reality)

Early Patterns for an Infant Relating to Mom:
1 – It is useful to start with an assumption that an infant is preoccupied with its mother and that the geography of phantasy for the infant is mother's body, both inside and outside.

2 – The infant's early patterns of relating to mother often form the underpinning for lifelong ways of relating to all human beings, both in love and hate, as well as lifelong patterns for dealing with various mental pains.

– e.g. turn toward an object to make contact; or go inside the object in phantasy to obliterate separateness

– e.g. turn away from an object; focus elsewhere; go to sleep

– e.g. turn to its own body and bodily products to generate sensations and substances to feed on; remain in motion to hold itself together and bind anxiety with kinesthetic/proprioceptive experience

– e.g. turn to inanimate things as a substitute for and in preference to human contact

The Overarching Models and Concepts for This Course:
1 – I wish to arbitrarily divide a human brain/mind into several component entities:

– a neuroanatomical/neurologic substrate composed of a brain, a peripheral nervous system, chemical neurotransmitters, etc.)

– a "sensory-perceptual apparatus" that is composed primarily the five senses (i.e. sight, hearing, smell, taste, and touch) used to apprehend external reality. I will refer to these collectively as the "organs of perception".

[Note: It is not uncommon to hear people refer to having a "sixth sense" about something. This does not seem to be a sense in the proper use of the word but instead usually refers to knowledge acquired, stored and applied unconsciously, what we ordinarily think of as "intuition". A more proper sixth sense would be the "kinesthetic-proprioceptive" sense of our limbs and body in space and their movement and mediated to a considerable extent by the cerebellum and the vestibular apparatus of the middle ear. There is arguably a seventh sense that is also worth noting, the sense of what is happening inside our body to our organs which might be descriptively referred to as an "enteric sense".]

– a mind/mental apparatus that can be consciously and unconsciously self aware, perform mental functions, and direct the "mind's focus" either: (1) internally to any aspect of psychic reality; or (2) externally to any aspect of external reality (using the sensory-perceptual apparatus). It would seem probable that a part of self is directing this capacity when the focus of the mental apparatus is to internal states of mind or mental functions. The direction of focus to external reality would seem to be divided between an internally derived choice, combined at times with a reflexive demand made of the perceptual apparatus by external reality.

[Note: This mind/mental apparatus area of description may in fact be an attempt to differentiate frontal lobe cortical functioning from other cortical areas. For example, it may be that primitive emotions coming from midbrain structures (e.g. the limbic system including the amygdala, hippocampus, caudate nucleus, etc.) have different responses when they reach different areas of the cerebral cortex. Perhaps when they reach the frontal lobes they can be "focused upon" in a fashion that allows for more "thinking" about them than if they were primarily channeled to the motor cortex for expulsion via action.]

– a personality which originates in infancy and therefore has a "baby core" made up from early experiences. It can be modeled as having rather permanently fixed relationships between "parts of self" and various "versions of mom and dad". These internal relationships can be grown with experience and thus develop to more advanced, mature qualities of interaction (both thinking and relating). However, they often retain many of their primitive components.

– an aspect of self, at any given moment, that is in control of the focus of the mind's attention, both the capacity to feel internal states (emotional or physical) and the capacity to use the perceptual apparatus to experience the outside world.

[Definition: The organ of attention is that part of the mind/mental apparatus that can be "focused" in order to attend to something that is sensory, cognitive, or emotional. When it attends to the outside world, it does so via the sensory/perceptual apparatus. I propose that it is usually under the control of a part of self.]

2 – Human beings seem to have a very wide range of ways in which they use their "sensory-perceptual apparatus". They may be very observant, or alternately, rather unobservant of the world around them. They may choose to focus their attention on important, or alternately, seemingly trivial elements of their surround. They may be able to shift their focus as seems sensible, or unable to change their focus even when they consciously wish to. And perhaps most surprising of all, humans seem readily to distort their perceptions or even hallucinate the perception out of existence.

3 – When we add the internally directed focus of the mind (i.e. "mind's eye" via the organ of attention) to the variations in human use of the sensory perceptual apparatus as outlined above in #2, it seems very likely that emotions are central to the choices made regarding on what to focus. In particular, the regulation of mental pain may be at the root of much of the variation, from individual to individual, in use of the organ of attention and the sensory-perceptual apparatus. At the most general level, as Bion put it, this amounts to a decision to face mental pain in order to modify it, versus a decision to try to evade contact with it.

4 – The next question is who or what is making the decisions that direct the "focus" of the organ of attention? Is it merely a mechanical product of the central nervous system doing its job of orienting to stimuli? Is it a conscious choice made by the "self", or can it have unconscious components controlling it without conscious awareness? We commonly do not know what topics will be central to our dreams on a given night so that is an example of unconscious choice of focus. If the choice of focus involves "self" at a conscious or unconscious level, are there different parts of self involved that might be described or modeled. [Note that the answers to these questions, some of which may well be unanswerable, are likely to be started with the two words – "it depends".

5 – I would like to propose that this focus of attention of the mind toward or away from something is a function of both learned tendencies and inherited predispositions. I suspect that the learned ones have a very large, although probably not exclusive, derivation from coping mechanisms designed to regulate mental pain, with a very large weighting toward maneuvers and attitudes developed in early infancy. The nature of the choices for direction of attention and the types of maneuvers involved often gives clues as to the underlying motivation for these choices as well as hinting at which parts of self may be involved.

6 – It is important at this point to observe that the part of the personality focusing attention can choose to direct the attention toward psychic/emotional areas, external realty areas, or both simultaneously. This expansion of flexibility and range is precisely that psychoanalysis (and most psychotherapy) is designed to

accomplish. Put in other words, a primary task with which all individuals struggle from birth onward is to grow the capacity to have the adult part of self in control of their organ of attention in a mature, constructive, mindful manner that attends to everything that matters. In contrast, immature parts of self (and especially the destructive part of self) expend great gobs of mental energy avoiding mental pain and thus failing to deal with what matters at the moment. Unfortunately, in most individuals of any age, baby parts of self, both good and bad, rather than the adult part of self, tend to dominate control of the organ of attention whenever that individual has to cope with "baby level emotions".

Language, Pursuit of the Truth, and Some Early Uses of the Organ of Attention in Infancy:
1 – It seems likely that curiosity and coping with mental pain are two key states of mind that compete in the infant. Curiosity has the potential to look for the truth. Coping with mental pain, when the infant has so little capacity to understand and think through an issue or conflict, must by necessity force an infant to evasion of the pain, usually by evacuation. Hopefully this leads to quick relief from a noxious state by the ministrations of a receptive figure in the surrounding environment.

2 – Infant's who learn to cope with mental pain, without the aid of someone else to help modify the pain, will often hypertrophy their organ of attention into its reverse, an organ for evacuation. As that infant grows up, pursuit of the truth, in the form of understanding what was painful, will be replaced with a hypertrophied sense of already knowing that what is needed is a quick way to evade the potentially distressing experience. In the long run, this is likely to lead to an omnipotent brand of omniscience in which "what I know is all I need to know". It is worth noting that, as Bion observed, that the organ of speech was better suited to telling lies that pursuing the truth.

[As an aside,we might also note at this point that we are unable at this time to explain where and how the "self" resides, neuro-anatomically speaking. Furthermore, we do not really understand how we "feel" our emotions nor how we perceive the various more subtle psychic qualities of experience. We can say that the organ of attention looking internally or externally has the potential, if allowed by honest parts of the self, to make observations that are meant to accurately represent both psychic and external reality in an honest, truthful, accurate fashion.]

3 – Later in life, even in healthy circumstances, language will have developed, as Bion said, "..as much for the achievement of deception and evasion as for the truth." Thus any perception, expressed as an observation, must be evaluated both in terms of what is being communicated, and to what use is it being put (illumination or deception). Furthermore, where on the developmental spectrum does it belong, i.e. is it primitive or sophisticated.

Meltzer's Dismantling of the Organ of Attention and Infantile Autism:
1 – It is useful to start by picturing a mother with an infant. From the infant's point of view, mother is a composite of a number of "unisensual" experiences: her odor, the sound of her voice, the sight of all the parts of her body, the feel of her skin and hair, the senses stimulated by her touch of the infant, etc. Combined and integrated, they make up a total or complete experience of mom, in all her qualities and aspects, i.e. a whole mom to have emotions about.

2 – Now imagine the infant choosing to only use one sense at a time, with a purposeful denial of the existence at that moment, of any of the infant's other senses and their potential perceptions. The infant would be having a "unisensual" experience of mother that lacked, maybe even precluded, any awareness of the whole. It would be like the fable of the blind men holding on to various parts of an elephant. But unlike the fable, the infant would not be trying to piece together and imagine what the whole object might be. In fact, the primary purpose of this dismantling of the sensory apparatus would be to avoid any awareness of the whole object so as to avoid any feelings about the whole object.

3 – This is Meltzer's model of an infant, particularly of a very sensitive, sensuous nature, who feels its mother is very easily damaged by its needs (e.g. because she is depressed), and by whom it perhaps feels painfully dropped. Such an infant may adopt an approach to the mother that is meant to spare them both

mental pain and physical harm. The infant simply “dismantles” its sensory apparatus into the component parts, and only uses one at a given moment, to relate only to a part of mother. Functionally, this disassembles mother into component parts. It then allows for a denial of such emotional pains as separation, envy, jealousy, depressive concern that one has damaged mom, etc.

[Note: These highly intelligent, sensitive infants/toddlers, do this in such a gently manner seemingly precisely to spare a mom (who already is felt to be distressed, depressed, and/or damaged) from any further harm. When this dismantling is done to an extreme extent, the evasion of a whole relationship to mom precludes any feelings in the relationship, i.e love, hate, etc.]

4 – When an infant/toddler has adopted this approach to a very extensive degree, all development of a mental apparatus that can grow “mindfully” is prevented. The developmental consequences are catastrophic because brain development is literally physiologically arrested, personality growth stops, and relational skills are nonexistent. In highly intelligent infants who preserve a “focus” in one area and proceed with cognitive development in that one area, one has the potential for a “savant” capacity in that area, but fails to get past the “idiot” level in most other areas.

5 – In less severe autistic development, one can follow the logical consequences of the infant having disassembled its mental apparatus into component parts, and mother into component parts as well. Let us focus first on the infant’s sensory experience where it might equate one sensory experience with another, while ignoring the actual origin of the experience. Here are a couple of examples:

-The sensation of one’s buttocks against mother legs when sitting on her lap, can be equated with the pressure and sensation of sitting on anything, especially where the emphasis of mental focus is on the sensation of one’s own butt cheeks and not on the object creating the sensation. This denies mom’s existence yet keeps one fused with her.

– The sensation of one’s cheek against her breast can be equated with the sensations of one’s cheek against one’s favorite stuffed animal can create the same fusion without awareness of mother or any need of her.

– The familiar smell of mothers body equated with the familiar and consistent smell of one’s own blanket, toes, or butt crack generates a sense of not needing anyone else while being joined up via the odor.

6 – Now let’s focus on the object half of the experience. The dismantled component of the original object can be equated readily with an inanimate object, often one that is a part of the original object or bears some sensory relationship to it. For example, a brassiere could be equated with the breasts, a shoe or sock with a foot, underwear with a genital or anus, etc. The subject can then focus in an obsessional manner to this part of the original object, and it has the potential to become what Meltzer describes as a “fetishistic plaything” as seen in perversions.

7 – We then need to make a distinction between the following:

– A dismantled object can in theory be reassembled, without harm, if the perceptual apparatus is once again used in a more integrated manner

– A part object as an experience of early development before the whole mother, etc., was integrated into experience.

– A part object created by splitting processes that inherently includes some violence and damage in proportion to the degree of sadistic impulse contained in the original motives at the time that the splitting occurs (envy as part of the motivation greatly increasing the likelihood of damage in the splitting process).

Misuses and Miscarriages of the Organ of Attention:
1 – In emotional disturbance, where coping with mental pain by evasion or omnipotent maneuver is the overriding motive, then the activities of the organs of perception and the organ of attention are at high risk to be misused in a manner that leads to:
– misperception,

– a refusal to take in a perception or phobic avoidance

– evacuation of the perception (i.e. projection)

– evacuation of a component perceptual apparatus (i.e. leading to a paranoid hallucination)

– a delusional reversal of the use of the perceptual component (i.e. so that it becomes an organ of projection)

– denial of the perceptual reality of being separate from the object (e.g. as Rosenfeld said, when an infant approaches an object, in love or hate, the urge is to get inside the object)

2 – Erik Erickson had in his stages of development the idea that an infant must decide in the beginning of life if things are predominantly good or predominantly painful (i.e. basic trust or mistrust). The former leads to a fundamentally optimistic outlook on life and the latter leads to a pessimistic one. I can readily imagine that this can be conceptualized, neuro-anatomically, as beginning with powerfully distressing early experiences being stored at an unthinkable midbrain level of the limbic system, especially perhaps the hippocampus and amygdala. As these primordial, primitive memories in feeling are sent to the cortex throughout the first year of life, they must generate a very hopeless feeling that pain cannot be escaped and dominates the emotional landscape of infancy.

An interesting question is whether these primitive pains cause the organ of attention to develop an excessive expectation of pain and lead to excessive attention to the painful or potentially painful side of life, while simultaneously failing to look for what is good in life. Is this an organ of attention gone bad? In contrast, some people always see things through rose colored glasses and idealistically fail to observe negative possibilities so we call them idealists. The middle ground might be represented by someone with a confidence that life will be both good and bad but the negative events are tempered by a realistic awareness of the full range of possibilities and their relative likelihood.

In all of these examples emotional choices related to coping with mental pain are made early in life and impact how the parts of the personality will direct the five senses for the rest of the life

3 – Misuse of the organ of attention can be seen in simple acts of procrastination where something that should be attended to is avoided. An opposite type of misuse occurs when there is an obsessional focus on one element of a situation or issue at the neglect of another of equal or greater importance. These activities should always be considered circumstantial evidence that a baby part of the personality is having its way at that moment, not an adult part of self.

This is not to say that there aren't genetic predispositions involved when someone is "big picture" oriented versus "detail oriented" or "concrete" versus "abstract" in their thinking preferences. Such contrasts can be seen in comparing an accountant to a philosopher.

4 – Attention Deficit Hyperactivity Disorder:
– Neuro-anatomically speaking, the lack of concentration, short attention span, and physical restlessness can be correlated with a limbic system that is working at full steam in these children while the cortical areas that would focus attention, control impulses, and integrate stimuli have yet to become fully active. This lack of activity in the right hemisphere regions of the anterior cingulate (an area that fixes attention on a

giving stimulus), the prefrontal cortex (an area concerned with controlling impulses and planning actions), and the upper auditory cortex (an area concerned with integrating stimuli from several different sources, probably contributes to the reacting in a fragmentary fashion to stimuli rather than integrating them into a 'big picture'. It may be that stimulant drugs activate these areas with the resultant cortical activity inhibiting limbic system inputs and the anxiety driven activity.

[Note: There is a close relationship between moral attitudes and action, as contrasted with thought and meditation.

5 – Tics can be thought of as projections into the body of a state of mind or a part of self that demands that the organ of attention be directed toward it even when other parts of self are trying to resist that focus. The underlying phantasies are typically felt to be unacceptable to self or object because they contain an element that is imagined to be destructive in some way.

6 – Grudges and grievances, which amount to holding onto negative states of mind, represent a particular part of self holding onto a particular negative focus toward a specific object. Where the state of mind is found later in life, there is invariably an underlying prototypic situation that needs to be uncovered if the current external focus is to be diminished.

7 – It is useful to recognize the origin of "pop-up" ads from various parts of self, especially destructive parts of self, that distract the good parts of self with propaganda. This is commonly a product of conflict between an urge to generate a narcissistic personality organization where good baby parts of self enslaved to the bad self (i.e the envious, omnipotent, know-it-all, destructive self sufficient part of self) versus an urge to enter into a loving, good relationship to a good object.

Migraine Headaches as a Model of Mental Evasion:
1 – A useful model to have when dealing with a migraine headache sufferer is to think of the headache as a failure to convert a distressing emotional state into a thinkable, mentalized state of mind. Instead, the distressing emotional state is converted into an unthinkable pain in the head, quite literally at a neuro-vascular level. The development of a capacity to think consciously about these previously unconscious states of emotional distress can lessen or even eradicate the migraine headaches.

2 – I suspect that the original failure to be able to mentalize these emotional situations was a composite result of parenting that did not offer the requisite psychological mindedness to think about them, and an organ of attention preference for not trying to focus on the emotionally distressing situation. I derive the latter assumption from many years of analyzing patients who had severe migraines where I was particularly impressed at how insensitive the patient seemed to be about recognizing obvious (at least to me) triggering emotional situations.

Counter-transference and The Organ of Attention:
1 – Does the analyst's emotional state (consciously/unconsciously) take him/her toward perception of emotions and mental pain or toward reason, understanding, and flight from confusion, not knowing or understanding, etc.

– This difficulty is likely to have its greatest impact where the patient's predisposition to lie to self about certain issues or emotions joins to a similar predisposition in the therapist. This is often concealed in a capacity to reason which may be simply a rationalization that takes the organ of perception away from pursuit of the truth.

Brain Structure, Attention, and Constructive Implications:
1 – Working hard on 'non-emotional' mental tasks inhibits the amygdala which is why keeping busy is often said to be the source of happiness.

2 – To create a pervasive sense of well being, the ventromedial area of the prefrontal cortex needs to be involved by creating a feeling of cohesiveness. When this area is inactive, as seen in depressed patients, the world seems pointless and fragmentary. Interestingly, over activity in this area is associated with mania.

Also, the right hemisphere seems to be more sensitive to negative emotion, while high activity in the left is associated with happiness. All of these findings seem to correlate well with the observable fact that people that are busy with purposeful work on which to direct their organ of attention usually have greater internal harmony and a sense of well being.

3 – The anterior cingulated gyrus helps focus attention and 'tune in' to our own thoughts.

4 – Awareness, perception, self-awareness, attention, reflection are all separate components of consciousness and can be integrated or disintegrated. Physical activities and mental activities that bring these together are commonly helpful and can range from talking in an emotionally meaningful manner to someone, to going for a walk or run, to doing yoga and other forms of exercise, to meditation. All have potential to bring mind and body into greater harmony.

Clinical Implications Derived from the Concept of the Organ of Attention:
1 – Healthy use of the organ of attention in problem solving or dealing with a conflict.
– Focus attention on the area of distress as fully and for as long as is needed to find an understanding of the issue and create a game plan for dealing with it. Then force the focus of attention away from the issue, keep it simmering on very low heat of a very back burner with a calendar awareness for when it will be brought back to a front burner.

2 – Helping a patient to differentiate midbrain experience of emotions (? unthinkable) from cortical experience of emotions (with goal of thinking about them) and then move the focus constructively toward or away from the feelings as is appropriate in a given context. Unreasonable baby phantasies around the primitive emotion almost always need to be recognized and brought out into the light of day as part of the process of learning to consciously choose to orient away from the primitive emotional association or eruption.

3 – Patients, or fo that matter therapists, need to learn to keep baby distress out of their marriage so that they don't overwhelm their partner with continual organ of attention focus on the negative, "chicken little the sky is falling" side of their thinking.

4 – In trying to go to sleep, or avoid waking up fully during the night, one must learn to use the organ of attention's focus to avoid getting or keeping the brain "in gear". This commonly means recognizing baby states of mind that have emotionally alarming potential and trying to bore oneself back to mindlessness as a prerequisite for going back to sleep.

EXAMPLES

1 – Examples from daily life:
– The mother of a 5 week old infant tried briefly to breast feed it then switched to the bottle, ostensibly because her baby had lost some weight. She was observed to feed the infant on her lap, holding its head in her right hand and the bottle in her left. She did not make much effort to talk and the baby's head was held at an angle from which it could not gaze directly into her eyes. When then held by a stranger, the baby was calm but would look over the stranger's head. Despite very enthusiastic staring into its face and holding it in a comfortable position, it took ten minutes before the baby would finally look into the eyes of the person and smile. The parents had feared that the baby was difficult, but the observer felt that it was actually a very compliant, calm baby.

– A nine month old is dropped off at the day care, cries briefly, then goes off and stops crying after the parent leaves. When the parent returns at the end of the day, the infant in the arms of the daycare person

won't look at the returning parent, finally does turn to the out stretched arms of the parent, allows itself to be held closely, buries its face in the parent's neck and begins to sob.

– A 4 year old goes to nursery school but won't go in and starts crying. The principal comes up and enthusiastically asks him to help her go run a fun errand, and he takes her hand, stops crying, and goes off with her and has a nice day.

– A six year old (or a forty six year old} goes off to his room to get something, gets distracted, goes back to the kitchen where mom (or wife) says did you bring the thing, and the response is "oh I forgot".

– A preteen boy is yelled at by his dad for leaving his bike outside in the rain and is told to go to his room. He immediately turns on a video game, and an hour later comes out to have dinner and is all smiles as if nothing had happened.

– A teenage girl goes upstairs to do her homework, but looks at her Facebook page first, and two hours later still has not started her homework.

– A man gets up, eats breakfast, and goes out to his car to drive to work and notices that he has a flat tire. He says to himself "thank heavens it didn't happen while I was driving on the freeway".

– A woman reported that while having sexual intercourse with her father around the age of twelve, she would stare at a ceiling light fixture and make her mind go blank.

– Every day around the world, millions of people say to themselves that they are going to leave something difficult in their life" in God's hands" and they proceed to stop giving the issue any further thought.

– Politicians in the United States make a conscious daily choice to avoid facing various issues because they know their constituents don't want to face the issues. Historically, when a person with genuine leadership skills comes along and presents the problem with its potential consequences if ignored and offers a thoughtful, constructive, if painful, solution, the sane and realistic adult part of people will rise to the occasion and constructively address the problem.

2 – Examples from the consulting room:
– A severely autistic 4 year old boy is sitting in the middle of the therapist's consulting room carpeted floor. As the therapist tries to engage the child by talking to him at eye level the child vaguely averts the therapist's gaze. As the therapist begins to slightly more actively try to get the goys attention, the child begins to flap his hands repetively for several minutes.

– Whenever the therapist makes an interpretation about a patient's mother, as if he had narcolepsy, the patient becomes overwhelmed with sleepiness, cannot listen intently, and regularly falls asleep before the thirty second interpretation is completed.

– A therapist, in a Monday session, hears a rather disturbed patient make a rambling description of his weekend activities laced with several references to feeling "it isn't worth it", "what's the point of life", "if I just end it all it's not like anyone would care", and so forth. About 15 minutes into the patient's meanderings, the therapist interjects with a shift of the discussion over to how the patient's antidepressant medication is doing and adds an additional drug. The following day the patient commits suicide by hanging himself.

– A patient, who regularly brings in dreams that are rather opaque to the therapist's understanding, announces a few minutes into the session that she had a dream. As she begins to describe it, the therapist finds himself daydreaming about lunchtime, and virtually misses hearing the entire dream. He has to ask to have it repeated, ostensibly to think about it in more detail sense he now knows how it is going to end.

Section 6 - The Bad Self: The Envious, Omnipotent, Know-it-all, Destructive, Self-Sufficient "Bad" Part of Self

Disclaimer:

1 – The goal of this course is to make the side of human existence, represented by severe emotional disturbance and destructiveness, recognizable as an extension of all of us. This can only be done by linking it to infancy and ordinary healthy development. If we just call this aspect of self "bad" or "evil" then none of us will want to see it in ourselves when in fact, as the saying goes, "there but for the grace of god could go I".

If instead we see it as having component elements that are an inevitable part of infancy, then perhaps we will be able to see its influence in ourselves, particularly since in the beginning of life it a necessary aspect of development and survival. The five features I have highlighted are arbitrary but seem to encompass what is most useful to abstract out about this element of the personality, often referred to in a shorthand fashion as the "bad part of self".

2 – This course is designed to give the practitioner a means for thinking about the components of disturbed thinking and behavior, but it is not a catalogue of such behaviors. There is not the time or space to go into every category of life in which a hypertrophy of the influence of the bad self has led to severe disturbance as for example seen in psychosis, addictions, perversions, and criminal behavior. This course is designed to prepare one for a more in depth exploration of such in the literature.

Axiomatic Basic Assumptions

Axiom #1:The bad self by definition exists outside the sphere and influence of the "good family", internally and externally.

Axiom #2: The virulence of the bad part of self is always a product of a combination of factors including genetic constitution, parental and environmental influence both good and bad, and serendipitous events in infancy, childhood, and adolescence.

Axiom #3: The influence of the bad self potentially increases in proportion to the quantity of, and attitude toward, mental pain. This attitude may be a function of the moment or a broader characterological relationship to psychic pain. This broader approach to pain is typically based on (1) the level of trust, originating in infancy, in the availability of good objects, and (2) a characterological loss of a capacity for love by the good parts of self (i.e. because love makes one susceptible to all sorts of mental pains).

Axiom #4: An intense predisposition to envious hatred, combined with sadistic internal parental figures, can usually be found to underlay the most destructive types of behavior stemming from the bad part of self.

Axiom #5: The death instinct most commonly operates at an unconscious level in the form of behaviors that amount to 'Russian Roulette', with a lethal consequence as a distinct, even if remote, possible outcome.

Axiom #6: The most common cause of patient's acting out under the influence of the bad part of self is an insufficient frequency of therapy sessions per week in the treatment setting.

Overview of the Origin of the Bad Part of Self and Its Component Qualities:

1 – Every baby has periods in each day when it is in mental/physical pain and must find a way to cope. As Barry Brazelton describes, it can cry, poop, pee, spit up, sneeze, go to sleep, stare mindlessly at something, etc. Since the infant is totally concrete in its thinking, and because mother seems to be the source of all that is needed, if the pain is too regular and too intense, the baby will associate the pain with the caregiver. The result is that infants naturally assume that "the absence of a good parent is the presence of a bad one", one of Melanie Klein's great insights.

It is at this point (i.e. the unavailable parent who does not respond to the infant's cries for help) that the infant will inevitably try to deal with the pain using whatever methods are available to it. These methods will have two key features:

– They will involve turning away from the caregiver.
– They will involve turning to one's own body and its products for comfort and reassurance.

2 – This process of turning away from one's caregivers to oneself is inevitable and creates a part of self that is universal and necessary for survival. If the pain of infancy is not overly intense or constant, then the sphere of influence of the part of self that "turns away" can be readily counterbalanced by good external parental figures (or other caregivers standing in their place) whenever those good figures come to the rescue during the state of pain. This relief of distress allows the infant to turn back to these good figures.

3 – For all infants the is a painful regular experience that begins with the experience of a painful need like hunger or any other distress and the time it takes for that painful situation to be relieved. The repeated experience of this time gap that is characterized by physical pain or emotional distress, while awaiting relief from this distress, creates a part of self and an attendant array of mental maneuvers (with physical manifestations) that become a permanent structure in the personality. These are initially simply a means to survive physical pain and the frustration of now being separate from mom and helpless. They inevitable create a part of self that exists when it is necessary to cope without the help of anyone else.

The strength and sphere of influence of this part of the self in a given personality is a function of many factors including:

e.g. – the availability and consistency of 'good' external parental figures

e.g.- the relative strength of constitutional factors, in particular (1) tolerance of psychic pain and (2) a predisposition to unconscious envious reactions to what one does not have or cannot produce oneself

e.g. – serendipity: including sibling spacing, trauma and illness, divorce, and other "luck of the draw" elements in infancy and early life

e.g. – how adolescence influences these previous issues and adds additional wrinkles e.g. divorce, death, etc.

4 – This part of self that is attempting to cope begins with a desirable quality of trying to get along without needing someone to fix every little thing. In other words, the infant is trying to be "self-sufficient", a useful capacity to develop in life when it is necessary to bridge the distress of a war zone while awaiting the arrival of the cavalry. It is key that this relying on oneself needs to continue only until help and relief appears. In other words, this self-reliance is temporary and should not prevent the infant from turning to good figures and making proper use of them when they are finally available.

– This is exemplified in later life in a quote attributed to English analyst Hanna Segal who said at a case conference something like "This is a patient who is utterly incapable of making good use of a bad analysis".

5 – It is a universal truism that the pains of infancy are embodied in the infant's smallness and helplessness which will takes years of growth to get past. All infants have some awareness that if they could harness the size and competence of the grownups, it could fix this problem instantly. Enter, stage right, the phantasy of having MAGIC.

Note: I find it useful to think of "magic" as approximately equivalent to "omnipotence".

The belief in magic, and the use of it as an augmentation of defensive maneuvers to cope with the pain of infancy, is highly variable from one baby to the next. Observing infants and their parents suggests that some of this is inherited constitutionally, some is learned from the parents, and some is developed in an ad hoc manner during an infant's attempts to hold itself together and sooth itself.

Whatever an infant's natural predisposition to turn to magic for relief, it is clear that a difficult environmental experience in infancy can greatly hypertrophy this "wish for and belief in" magical coping maneuvers. [One need only to have a conversation with very deprived older children or teenagers to see how much their thinking is permeated with magic and limited appreciation of external reality.]

The earliest versions of magic are likely embedded in the concrete experience that pooping and peeing do bring nearly instant relief from distress. Likewise, feeding brings quick, concrete relief to hunger. These repeated experiences will later evolve into an attachment to unconscious projective and introjective processes as concrete extensions of ways to bring rapid relief to distress.

6 – It is the totality of these "magical" maneuvers, i.e. the strength of belief in them and attachment to their use, that I am referring to as "omnipotence". This use of omnipotent maneuvers is not a constant but rather a state of mind whipped up in the moment [see Donald Meltzer's The Psychoanalytical Process]. This state of mind is created in response to a task at hand that is felt to be a sufficient threat to necessitate resorting to magic, rather like a pep talk before a big game. In other words, the greater the felt problem at hand, which also means the more inadequate one may feel, the greater the need for omnipotence.

e.g. the gunslinger having a shot of whiskey before the big gunfight
e.g. the single adult smoking a cigarette before going into a party or an important meeting
e.g. the teenage boy masturbating before calling a girl for a date, studying for a test, etc.
e.g. the housewife going shopping before a weekend with the kids while her husband travels, etc.
e.g. the infant or small child who sucks a finger as mom leaves the room or sticks a hand down to touch its lower parts as it becomes anxious

7 – The infant's wish for magic is also seen in the degree to which it attributes magic to its parents. This attribution is probably universal as seen in the early phantasy that the parents "have everything, know everything, and can do anything". One ordinarily expects this phantasy to diminish with increasing reality testing during childhood and adolescence.

Where idealization of the parents is excessive, it is useful to consider that the parents are being seen as having magic (i.e. it is being projected into them) and thus magic remains available to the projector to be inherited at a later date. This excessive attribution of magic to the parents effectively makes them into Gods. Their perfection makes them demanding and terrifying and potentially promotes fear and fealty, with a potential to for them to become a "harsh super-ego". By contrast, getting inside such a figure would immediately confer the same power to oneself.

8 – During one's sojourn as an infant, one of the more painful elements of life is not understanding what is going on, why it happening, and how to think about it. This state of ignorance of life leads to a wish that it were possible to have an explanation for each situation that is not understood. This would diminish the feeling of helplessness attendant to not understanding, so often expressed in early childhood with the question "But why?"

For some more than others, this pain is answered with their own ideas, no matter how inadequate or illogical. It seems like the greater the pains of infancy, the more this "know-it-all" function becomes an inevitable buttress to the need for magic. Because the small child's fund of knowledge is so obviously limited, this brand of being a 'know-it-all' is usually bent into a particular brand of omniscience in which a key substitution is made. It does not claim to "know all that there is to know" but rather that it "knows all that it needs to know".

It is because of this distinction that I chose not to call it the 'omniscient part of self'. I wanted it to have an a more limited and inherently pejorative, mildly obnoxious ring to it. I want it to bring arrogance to mind, which is its natural extension, when it is strongly influential in a given personality make-up.

9 – While self-sufficiency, omnipotence, and being a know-it-all are all broad attitudes that an infant can have about its existence out in the world and toward mental pain in general, there is still the question of what actual impact these elements will have on relationships and development. To answer this question we now have to address two issues, the relative impact of nature on one hand as compared to nurture on the other.

To look at 'nature' we have to address the really intense, specific emotions related to infancy. These primarily include reactions to separation, envy, jealousy, paranoid anxieties related to projective processes (i.e. 'persecutory anxiety'), guilt and other 'depressive anxieties' attendant to feeling one has done harm to loved ones, and in some – shame and humiliation about having been small and helpless. These are significantly a product of the constitutional predispositions the infant brings to the dance.

To evaluate the influence of the environmental component of infancy, i.e. 'nurture', we have to look at the people making up the infant's universe in terms of their availability, emotional states, life circumstance, etc. It is key that this appraisal not be done in a "sitting in judgment manner". The net question is are they "good enough" parents, in Donald Winnicott's sense, and is the child making the best or worst out of them.

10 – Of all the above mentioned variables, the one that will impact the influence of the bad part of self the most in relation to overall personality function is unconscious envy. It will substantially determine the capacity of the infant to make use of good figures, who it must be remembered, can be hated for the fact of their goodness!

Most importantly, vis a vis the development of the bad part of self, envious hatred will ultimately be the primary cause of an infant's internal destructiveness and later recreation of that destructiveness in the outside world. Actual deprivation will exacerbate that envious hatred as well as promote and justify action on it.

Where is Jealousy and Why Isn't It Included in the Characteristics of the Bad Self?

1 – Definition of jealousy: A triangular (three person) situation involving whole objects, and based primarily on love, in which one person wants the love of another and does not want that person to give their love to a third person.

One caveat to remember is that the further back toward infancy jealously is traced, the more it shades into envy and becomes difficult to distinguish from envy. This is a result of the infant's earliest feeling/phantasy that mother's two breasts are going off to have a party to feed each other when the mother leaves the infant. Hence the deeply unconscious phantasy seen with some patients that whenever the therapist is unavailable on the weekend, etc. he or she is having a continuous orgy with their spouse while the patient feels abandoned and in pain.

2 – Because jealousy is linked predominantly to love, it implies the predominance of a loving capacity for a "good object". The essence of the bad self is its desire to not be bound by the realities of the world of loving human relationships, the passage of time, caring feelings, and needs that one cannot meet oneself.

Jealousy is much too firmly a part of the sphere of caring relationships to be a key feature of a part of self which is dedicated by definition to avoiding precisely that sphere of feelings and relations.

3 – So while jealousy is a hugely important part of development, at the core of the oedipal situation, and a central part of sibling rivalry (along with envy), it is not ordinarily a part of the bad self.

In fact historically, its link to pain of love has conferred it an element of goodness that has previously allowed societies to forgive murder when done out of extreme jealousy rage, for example a man killing his wife's lover when caught in the act.

On the other hand, "pathological jealousy" is often more linked to unconscious envy and very disturbed projective processes and cannot be thought of as a part of the ordinary development of jealousy.

The Structure of the Unconscious Inner World:

1 – Overview: We need a schematic model of the structure of the unconscious inner world to usefully describe the influence of the bad self in human functioning. I find that a model of paired relationships, between parts of self and versions of mom and dad, formed in infancy (and rather permanently locked together by the brain's phylogenetic predisposition to create such structures for survival value), to be both useful and hold up well to most all of human experience.

This handful of paired relationships can be seen in the transferences of every patient and can be arbitrarily reduced, in a schematic fashion, to several broad categories as seen in item 2 below. While both concrete and somewhat reductionistic, these categories fit well with how humans experience themselves. I offer Disney's Snow White and the Seven Dwarfs as a case in point.

– Doc = adult self; Happy = good, loving baby self; Dopey and Sleepy = good, babyish parts of self; Bashful = a good, but slightly anxious baby self; Sneezy = the psychosomatic baby self; Grumpy = a watered down version of the 'turning away' bad self.

– Snow White and the Prince = idealized parents; the envious Queen/Wicked Witch = a bad mom; the hapless Woodsman and King = inadequate if not bad father figures.

2 – Definitions of parts of self and internal parental figures (= Internal Objects = Superego):

– good baby parts of self that have all the various characteristics of babies with a key determinative quality of being willing to "turn toward" the good parents and family if any exist and thus enter into caring relationships

– an adult part of self that is by definition the (1) most developed and mature part of self at any age and has the characteristic of (2) wishing to model itself after good parental figures wherever and whenever available

– one or more versions of a good mom and dad, and likewise one or more versions of a bad mom or dad

Therefore, the net result in all human personalities is that one can expect a small core of fixed relationships to exist that will remain the template throughout life for what to expect in all relationships. These fixed relationships will be essentially between a part of self and a version of mom or dad. They will always, by definition, be manifested in all emotionally intimate relationships, their externalization representing what is called the repetition compulsion, and will be recreated in various ways in the transferences of therapy .

3 – Highly idealized objects represent evidence of the width of the split between good objects and self and bad objects and bad self. The wider the gap, the more it is evidence of anxiety about being able to keep the

bad from messing up the good. This anxiety may in turn be a result of inadequate differentiation in infancy or it may relate to fear of the strength of one's own destructive urges.

4 – Bad Objects versus Good Objects Behaving Badly (Britton): A bad version of mom or dad is bad by definition to the good baby parts and is seen permanently that way. For example, an alcoholic, violent, or cruel version of a mom or dad is a consistently bad version of that parent.

By contrast, a person who is normally seen as a good parental figure, but is temporarily felt to be doing something bad, for example having an affair, is still primarily seen as a good figure and will not be turned away from so easily as a bad figure.

5 – Turning away versus turning toward good objects: The good baby parts are always longing for a good parental object and can be readily won back around to the sphere of influence of the good family when the baby is in less pain and good figures are available. By contrast, the bad self never allows itself to actually be drawn into the sphere of influence of good objects, even when pretending to do so.

– Throwing a temper tantrum (i.e. behaving badly) versus <="" u=""> (i.e. being bad as a momentary or fixed identity): It is always necessary to look at motive when trying to adjudicate whether or not a piece of behavior is coming from the bad self or a good baby part when in a rage. Good baby parts usually feel guilt after doing something destructive while in a peek of rage. By contrast, the bad self is usually so outside the influence of caring that while it may feel persecutory anxiety or blame, it is not so likely to be feeling guilt in any proper, caring sense of the word.

Overview of the "Envious, Omnipotent, Know-it-all, Destructive, Self-Sufficient" Part of Self:

l – Definition of envy: A two party relationship, based on part-objects, more linked to hatred than love, in which one compares oneself to another in terms of a quality, a capacity, or a possession. The felt discrepancy between oneself and the object of comparison is the pain of envy. This pain is often intolerably great so that it must be immediately defended against by some maneuver. It is these defensive maneuvers that result in the destructiveness of unconscious envy because it they inevitably spoil the object's goodness, render it unavailable, and do indirect harm to one's own development to evade the pain of envy.

The primary maneuvers to cope with envy include: (1) spoil the object so that it is no longer enviable; (2) reverse roles with the object by projecting one's own feeling of envious smallness, etc. into the object; (3) split off one's capacity for envy into someone else, usually while avoiding being enviable oneself; (4) deny envy as a variable in life by completely splitting off any capacity for envy or any comparison which usually impoverishes ones capacity for success i.e. the traditional success phobia; or (5) take the road least traveled and tolerate envy while slowly growing oneself to the level of the object (note: this is healthy and not a defense).

I have put unconscious envy as the first component of the bad part of self because it is the most crucial is determining how destructive the activities of this part of self will be! If attempting to survive mental pain is all the bad self is doing, then one could in theory have an infant who has worked to grow its capacity for self-sufficiency when good objects are unavailable but can willingly turn back to them when they return. On the other hand, if the good objects are hated, precisely for their goodness and possession of what is needed by the infant, then that envious attitude will severely interfere with turning back to them when they are available.

2 – Omnipotence: If the bad self is developed in the context of an infant trying desperately to cope with mental pain, then the infant's reliance on magical maneuvers to cope with states of mind becomes central to that infant's development. In turn, this reliance on magic will ultimately undermine its capacity to face reality. Instead of making the choice, crucial to healthy development, to learn to face and modify mental pain, it will have effectively made a choice to instead consistently try to evade mental pain and the realities within which it originates.

Because this is of extreme importance to the development of a robust mental apparatus, I made omnipotence the second of the characteristics of the bad self. One essential problem with relying on magic is that having good magic, when you are in a loving state of mind, also means that you will have bad magic when in a hostile or negative state of mind. This becomes crucial to healthy development because what you did to your early objects in an omnipotent state of mind, in infancy, lays the foundation for what they are expected to do back to you and how you will feel about life.

If you continue to rely on omnipotence to get through life, you limit your capacity to ever get past these early difficulties and effectively create a vicious cycle where omnipotence that evades mental pain begets more mental pain that is never successfully worked through. One sees this with adults who are usually composed but when they get frustrated in some situation they explode unexpectedly and inappropriately.

At this point we need to highlight two potential components or qualities that link to omnipotence that are particularly useful to understand: envious omnipotence and anal omnipotence.
These often provide a larger background quality to the omnipotence, that as I mentioned earlier, is whipped up in the moment to cope with a task at hand that is felt to activate baby level anxieties and issues.

– Anal omnipotence: All infants have moments of emotional and/or physical distress during which they try to comfort themselves. They explore their own bodies and discover sensations and physical movements that they gradually learn to associate with bringing relief or comfort (e.g. thumb sucking and rocking). If they trust in the availability of their good objects when needed, then they will not rely excessively on these self-soothing, comforting maneuvers.

On the other hand, if parental figures are regularly unavailable or inadequate in their responses to the infant's needs, then a hypertrophy of the use of turning to one's own body and bodily products for self-sufficiency will typically occur. This is exemplified by seriously deprived toddlers who will regularly have one hand down the front of their pants and the other down the rear, touching themselves when anxious.

Excessive reliance on anal omnipotence can be seen as a bolster to manic maneuvers. Turning to things, as a substitute for relationships with people, can be seen as existing on a continuum in terms of quality and quantity, both in infancy and later childhood. The small child who will entertain themselves for hours in a sandbox without seeming to seek human contact is indeed turning away in the extreme. Not surprisingly, this is a relatively common feature in the early history of a child destined to be schizophrenic.

In adult life these elemental forms of self-sufficiency will evolve into such behaviors as: wine or shoe collections, cigarette or cigar smoking, hoarding of money, exciting cars or jewelry, chatchkies, books, etc. At the more debased end of the spectrum one sees the hoarding of useless things like old newspapers, magazines, containers and bags, garage sale items, etc.

– Envious omnipotence and omniscience: The wish for magic, when combined with envious hatred of the goodness of others, is a particularly noxious combination. It is a standard underlying element in all perversions and many psychoses. It leads to envious competition in which a sadistic triumph is often the desired goal so as to feel superior and ruin the others enviable qualities or capacities.

This is wonderfully embodied again in the Snow White and the Seven Dwarfs in the evil, envious queen who wants Snow Whites heart cut out. Envious omnipotence can be seen in everyday life in those who are arrogant and take sadistic pleasure in others failures. Take, for example, Donald Trump who apparently sees himself as the one person on the planet who should have the right to say to anyone, you're fired, and is too arrogant to see how objectionable a behavior that represents .

The urge toward, or unconscious fear of, enviously omnipotent competition often goes unappreciated for its potential to interfere with human development and relations. This is especially true in the realm of test taking and intellectual achievement .

3 – Know-it-all (omniscience): This is commonly included implicitly under the broader rubric of 'omnipotence' but it needs to be separated out as it is so influential in characterological patterns, especially in the arena of arrogance. This component is so beautifully highlighted by Wilfred Bion in his paper "On Arrogance". His idea is that "pride in one's achievement under the sway of the 'life instinct' leads to self-respect". In contrast, "pride in one's achievement under the sway of the death instinct (i.e. unconscious envious hatred) leads to arrogance", that is a feeling of triumph over others.

This influence of omniscience is central to the rigid narrow mindedness of most prejudices and essential to the failure to think through possibilities before embarking on some endeavor. The assumption undermining a more realistic assessment of the situation at hand, is that one already knows what one needs to know embodied in the joke, "my mind is made up, don't confuse me with the facts".

4 – Destructive: I made this the fourth item in the description of the qualities of the bad self because while it is hugely important when operative. It is always either a direct goal of or an indirect byproduct of the first three components. In particular, where unconscious envy and envious omnipotence are prominent features of a personality, destructiveness in some form is never far behind.

Hints at the potential for destructive attitudes and behavior can be seen in childhood but cannot be reliably predicted until after puberty. The constitutional predisposition to rage and action, combined with strong omnipotence of attitude, may be in evidence during early childhood but often goes underground during middle childhood. Seriously harming pets is one ominous harbinger of a destructive aspect to come later.

If it resurfaces shortly after puberty, and the child is not yet in therapy, it may be too late to contain it. This is especially true where the environmental influences (i.e. parents, caregivers, or authorities) have a tendency to respond with aggressive action and too little insight and verbal expression. This leads to the unfortunate fact, so common in the juvenile justice system, that severely emotionally disturbed early teenagers, if physically diminutive, go to the mental health system and physically large but disturbed and immature teenagers go to the criminal justice system.

5 – Self-sufficient: I made this the last variable because it has the quality of being potentially both constructive and/or problematic. In theory, it could be purely constructive, especially if it were always a reversible state of mind that could be undone to allow turning back to good figures when available. Unfortunately, it usually is developed so that one can permanently be beyond ever needing anyone. This limits one's capacity to enter into a healthy sharing, mutually interdependent, adult relationship.

At its worst, the goal of self-sufficiency aims to use omnipotence and omniscience to live outside the sphere of caring, human relationships and as such is terribly problematic for development and life.

Common Possible Configurations of the Bad Self Characteristics:

1- Plain Self-Sufficiency: This would in theory be purely healthy if it was only meant to temporarily bridge the time period during which the good parental figure was gone and then returned.

2 – Omnipotent and Omniscient Self Sufficiency: This would be adding more firepower to the first mechanism and would thus risk being more harmful to development. Omnipotence and omniscience tend to go together although one or the other might be more prominent in the character style based on what particularly works in that individual's childhood. These would be elements that bolstered manic maneuvers used to deny of various aspects of psychic reality.

3 – Envious Omnipotence and the Likelihood of Destructiveness: As soon as envy enters prominently into the picture, attacks on goodness are never far behind and thus harm to self and object are inevitable to varying degrees. The spectrum of destructiveness ranges from interference with development on one hand, to outright physical and emotional violence at the other extreme.

4 – Full on E-O-KIA-D-SS: The combination of envy and a desire to be completely self-sufficient, in order to live completely outside the sphere of time bound, caring human relationships, is qualitative state of virtually all severe emotional disturbance.

Adolescence and the Crystallization of Character:

1 – The basic emotional tenor of the unconscious inner world and the primary tendencies of defensive postures in a given personality are all predominantly developed as a result of the total quality of experiences in infancy and reactions to them. In other words, infancy has everything to do with basic attitudes and approaches to life. On the other hand, none of the final personality traits and qualities that will be lifelong are fully expressed and crystallized until after puberty.

It is only when the future holds up the eminent prospect of growing up and leaving home that one sees the final development of methods for coping that were still latent possibilities before puberty. Thus, one's predisposition to turn away from good objects, one's attachment to omnipotent maneuvers including manic denial of the unconscious inner world and projective processes, one's tendency to envious hatred, etc. will all greatly influence development from puberty through entrance to college and leaving home.

Consider some of the common constellations of development after puberty:
– mood or thought disorders
– confusional states and gender identity issues
– turning away to omnipotent self-sufficiency as seen in substance abuse
– conduct/behavior/antisocial disorders linked to concreteness and omnipotence
– obsessional states and regression back to the safety of latency types of defenses and rigid splitting
– psychosomatic illness
2 – Primarily because of the great dependence of the good baby parts of self on external objects during childhood, the influence of the bad self is not obvious during childhood except in extreme situations. One sees only hints at future possibilities for the bad self until the rebirth of baby states of mind after puberty finally demands taking a stand vis a vis life and relationships. If adolescence contains adequate good figures sufficient to counter act the negative pressures of baby emotional pain, then the good parts of self may retain a dominating link to good objects.

If good objects are inadequate to override the resurging infantile pains of adolescence, then the door is open to turning away to the bad self and the influence of objects in the outside world supporting its approaches. This amounts to a battle for influence that pits the bad self, bolstered by serendipitous events, the pain of infancy, and constitutional predispositions, against the qualities and availability of good objects (i.e. parents, relatives, teachers, therapists, etc.), and environmental influences like poverty, divorce, etc.

3 – Recognizing the presence and influence of the bad self in a child's or adolescent's personality requires an awareness of the influence of projective processes. Most children and adolescents project their bad self, because it is not seen a desirable to own, into someone in the outside world. In childhood this is often an older sibling, a cold, mean, or rejecting relative or parent, or a suitable child from the neighborhood or school.

In adolescence, the various parts of self tend to be dispersed into a gang of friends or associates, some of whom are more rebellious or destructive, and lend themselves to leadership roles and as containers for the bad part of self. No adolescent who performs or supports some destructive behavior is an innocent victim of bad influence. They are expressing an aspect of themselves and need to be held accountable, in an ownership sense, for the act.

4 – It is important to note that during infancy, childhood, and adolescence, a destructive or violent component of the bad part of self may become, functionally speaking, permanently projected into and lodged in an internal version of a parent. While the parent often has earned this to some variable extent, sometimes the projection represents a nearly psychotic distortion. This is not uncommonly seen, for

example, in a divorce where the child colludes with one parent, in a folie a deux, to make the other parent "all bad and to blame".

The Influence of the Death Instinct:

1 – The death instinct is not about death, it is about a hatred of life and all of the pains to which one can be subjected when "living in the world of caring relationships". In effect, the death instinct links to both a hatred of all of the pains of living in the outside world and a hatred of the mental apparatus that can pained by their apprehension. Thus, in the extreme, this can mean hatred of everything mental and mindful as is seen in the worst drug addictions and psychoses.

It seems very doubtful that death itself can be comprehended or even conceptualized accurately in early childhood. It seems more likely that for infants and small children, the opposite of life is seen as being "unborn" back to the inside of mom.

2 – The death instinct is usually among the most controversial of topics, I think largely because it is approached from a vantage point of adult logic. I find it more useful to approach it from a vantage point of baby logic. I prefer to start with an assumption, developed from clinical experience with babies and small children, that when every baby is born it must decide if being out in the world has sufficient goodness/pleasure to make it worth it.

Virtually all infants request being held and seem comforted by a return to the constant contact with mother's body, heartbeat, etc. Some babies will refuse anything other than being on their mother's chest continuously in a "snuggly" type wrap. Later in childhood, they will make all manner of womb equivalents, loving to crawl under blanket wrapped tables, beds, inside cabinets, forts, virtually any nook or cranny.

Unfortunately, some babies decide there is more distress in life after birth than they are willing to tolerate and so they remain significantly ambivalent about being outside the womb. These are the individuals in life who have many and varied versions of undoing this pain by becoming an "unborn, inside baby".

3 – The death instinct is probably an attitude about being born that in earliest life could be thought of as belonging to what we will come to call "good baby parts of self". This ambivalence about life in the outside world will later be used by the bad part of self to bolster its hegemony within the personality.

4 – Living a life as a separate individual in the outside world can be seen as existing on a large continuum. To frame this continuum in stark images, every infant has a dilemma: "how alive to be, how much life to live".

An infant can choose between passionately exploring life and relationships in the outside world at one extreme, or it can retreat to being an "unborn, inside baby" at the other extreme. It can also make a compromise, choosing something in between like accounting or library science.

Those who unconsciously wish regularly to return to the passive state of being completely without effort or responsibility as an "unborn, inside baby" exist in the ranks of every mental health practice, often without being recognized as such.

5 – In adult life, if being born is not ever been fully embraced in infancy and childhood, the death instinct will remain meaningfully influential. The manifestations of this state can be seen in various forms of delays or arrests of development. At the least problematic end of the spectrum one sees some restriction in the scope or sphere of the individual's existence. While common in career development, it is most significant in the realm of relationships, where a lack of risk taking, commitment, or spontaneity, lead to a rigidity of emotional experience or expression, etc. and thus preclude a full relationship, even if married.

6 – At the other extreme, the individual tries to completely obliterate all of the pains of life which then requires attacking caring, external reality, the passage of time, or even the mental apparatus that could be available to experience any of these psychic realities.

While this is more obviously the realm of serious addiction, perversion, and psychosis, it often exists as encapsulated, walled off pockets in an otherwise relatively ordinary appearing individual (see Fifty Shades of Grey!). This walled or split off element may be seen in one's fixed, chronic projections into spouse or family of origin. During times of great emotional pain, it may manifest when the person becomes abruptly suicidal, seemingly "out of the blue".

7 – It is useful to recall the Lucifer Myth in which the best angel in heaven is so filled with envious hatred of God (i.e. mom or her symbolic representation, the "good breast") that he would rather rule in hell than be second in command and serve in heaven. This myth encapsulates the influence of unconscious envy as a major contributor to the pains that the death instinct aims to avoid. At its most extreme, It is manifested as major risk taking in which murdering oneself to cause mother the pain of the loss of her creative product is a component of unconscious suicidal ideation.

The Sphere of Influence of the Bad Self:

1 – Because the bad part of self originates in infancy as a method of coping when good caregivers are unavailable, it always has an aim, at minimum, of getting along without needing anyone else. It will always exploit whatever resources are available including co-opting whichever personality characteristics or traits are the most useful. This almost always means, first and foremost hijacking the intelligence of the person for its own purposes.

This is usually particularly evident in the realm of verbal capacities for symbol manipulation, including propaganda, lying, exploiting confusion, logical fallacy, etc. Remember it can always assert anything as fact and the good objects will by definition be slow to judge while they try to think through the facts of the situation. This will be seen as weakness or uncertainity by the 'bad' part of self.

Where beauty, muscularity, sensuality, musicality have been inherited as desirable attributes, they will invariably be seized by the bad self for its own use and motives. The more the parents are vulnerable to seduction in any of the areas, the greater the likelihood of that area becoming an arena for unconscious, secret, destructive activities under the influence of the bad part of self.

2 – The influence of the bad part of self is highly variable from person to person, and from one period of time to the next even in the same person. What is constant is that the bad self will always aim to lure the good but pained baby parts of self away from the good family whenever possible. It will always propagandize that they should follow its lead and methods for coping, and only then will they be free of mental pain.

3 – Whenever a mental pain becomes too extreme, and is not relieved by good external parental figures, then the bad self will always offer solutions to magically evade the pain. The vulnerability of the good parts at that moment will usually be a function of the nature of the pain and its intensity, and the quality of the relationship to good objects at that moment.

4 – The bad part of self can be seen to follow a sequence of seduction of the good baby parts away from the sphere of influence of good objects and the good family externally and internally:

– It will try to loosen the trust in the good objects by stirring up depressive anxieties, especially via jealousy, so that the good parts become confused and uncertain about their good objects.

– Sensuality is offered up in the name of self-comforting and omnipotent self-sufficiency, usually by masturbation in some form.

– Projective processes are then used to get away from the confines of time and identity with a confusion of inside and outside commonly resulting.

– Manic denial of psychic reality is then asserted.

– Ultimately, the differentiation of good and bad is attacked and the result is a loss of capacity for maintaining sanity as evidenced in the common statement "Man this is some good shit!".

– The bad part of self, as seen in gangs, cults, pimps, drug pushers, etc. always starts by offering itself as a protector from pain. It then exploits sensuality and vanity, and only resorts to brute force when the good baby parts try to turn back to the realm of good objects.

– The good baby parts of self, as development proceeds, can be seen to vary from person to person in how much they are embarrassed, ashamed, or humiliated by the realities of being or having been a small, helpless, dependent, soiled baby. For some these painful states are dealt with, when present, by making constructive use of their own developing capacities and requesting help as needed from good figures in the environment.

For others, these states are felt to be so toxic that they are avoided like the plague. This then requires denying normal healthy dependence and necessitates an hypertrophic reliance on omnipotence, omniscience, and self sufficiency. Invariably, this results in a narcissistic, arrogant approach to life, overvaluing one's own capacities, and diminishing what others have to offer.

If a person hated being a baby, then anything that reminds them of those feelings is likely to be hated and defended against stridently.

7 – The question of who controls manic defenses offers an interesting dilemma. By definition, manic defenses come on board later in the first year of life as the infant is developing a capacity to have a more complete view of mother as a separate figure. The infant then has a new painful realization that person toward whom it has loving feelings is the very same person it at times hates.

This brings to the fore a new class of feelings which Kleinian's call depressive anxieties. They represent the evolution of a movement from a value system of largely exclusive interest in the self to a developing new, more mature value system of concern for the welfare of the other. In turn this creates a new class of defenses referred to collectively as manic defenses. They are not as primitive or concrete as the early maneuvers.

The primary aim of these manic defenses against depressive anxieties is to remain in the sphere of caring relationships with the good family but limit the pain experienced. To do this they focus primarily on denying the psychic reality of having done harm to one's good objects. Because they are trying to remain in the sphere of influence of the good family, I am suggesting that manic defenses are part of the armamentarium of the good parts of self.

This attempt at a clear differentiation of control of manic defenses breaks down as the severity of the mental pain which the manic defenses aim to avoid increases. The good baby parts are then subject to the propagandizing influence of the bad self that will offer up its approaches as a solution as the increasing pain becomes intolerably overwhelming to the good baby parts. At that point the manic maneuvers begin to shade into the realm of more severe disturbance and psychosis.

<u>Narcissistic Personality Organization and the Bad Part of Self</u>:

1 – Rosenfeld/Meltzer definition: A configuration of the personality in the unconscious inner world in which the good, but pained, baby parts of the self have turned away from the good family, internally and externally, to give themselves over to the influence and control of the bad part of self. This can be seen in external reality in gangs, cults, drug pushers and pimps in relation to addicts and prostitutes, etc. It is the personality configuration that predominates in addictions and perversions, most psychoses and borderline personality disorders, narcissists and psychopaths.

To a much milder extent it can be seen as the configuration of many personalities during times of stress but is usually less destructive and more easily reversed with a lessening of pain of arrival of good objects. Every practitioner must deal with this type of emotional configuration in response to every significant separation including weekends, vacations, etc.

2 – The bad self offers an array of means for coping with pain that are a function of some combination of an illusion of omnipotent self-sufficiency bolstered usually by turning to one's own body and bodily products in some form of masturbatory activities. Later, in adolescence, this will be augmented by substance use to alter one's state of mind.

3- For someone to develop a functionally permanent dominance of a narcissistic personality organization, several things usually have to exist:

– The sheer strength constitutionally of the envious omnipotent attitude can overwhelm the good baby parts when their relationship to good objects is impaired in infancy. There is always a knife edge balance between the influence of good objects and hatred of them for their goodness.

– Significantly inadequate or unavailable good figures during infancy and childhood combined with the unfortunate distressing events to undermine a trust in it being safe to love, care, and hope.

– Genuinely bad, sadistic external figures, usually parents or grandparents, sometimes older siblings, whose behavior is a template for destructive, cruel behavior and functionally leads to a fusion of sadistic impulses from oneself with the sadistic behavior of the object to create a "sadistic super-ego". The most virulent, evil personality configurations tend to stem from this sort of personality developmental situation.

4 – It is useful to remember that in the clinical setting this narcissistic personality organization is the configuration that underlays most if not all negative transferences. This awareness adds to the therapist's potential ability to anticipate it in advance of it becoming full blown is situation of separation from or envy of the therapist.

Creation of a Really Harmful Bad Self by Its Fusion with a Bad Internal Figure:

1 – How does a sadistic super-go come into existence? Is it purely a product of cruel behavior from caregivers in infancy and childhood? Can it come into being in someone who was never mistreated in any way by caregivers? What role does an innate sadistic predisposition play in its development?

– Nature and nurture influence all development, positively or negatively. The strength of either environment or constitution, when extreme, can override opposite tendencies in the other. In other words, good parents can have bad kids, and bad parents can have good children, in the sense of seeking loving caring relationships.

2 – What is clear is that the teasing out of each of these components is essential for a patient to be able to see their own contribution, in the hope of modifying it. The greater the disturbance in the caregivers, the easier it is to project one's own tendencies into them and not be able to take back one's own destructiveness.

3 – Where self and object fuse, in a folie au deux, the chance to undo the resultant difficulties is extremely limited.

The Bad Self in Dreams:

1 – With the exception of a patient acting out destructively, it is often easiest to demonstrate the existence of and the activities surrounding the bad part of self by how it manifests in the patient's dreams. Not only are the activities depicted graphically, but the patient cannot deny that they wrote the dream, not that it is just the therapist's attribution to them of something potentially problematic.

A clear reference to suicidal behavior, anal omnipotence, turning away from the treatment, cruel treatment of a child or pet, etc. will commonly show up in a dream before a patient can or will consciously take ownership of such things.

2 – Since the bad part of self is usually seen consciously as undesirable, it is usually estranged from one's sense of self and projected, starting in early childhood, into something scary outside oneself. Picture anything or anyone that a small child could be afraid of and you have a potential container for the bad part of self. A common example would involve one's own sadistic oral, biting impulses, which can be easily projected into a snarling dog or a toothy shark.

3 – Because of the wish to project, disown, and deny one's own destructive side and urges, the bad self usually appears in dreams in a manner that is alien to one's view of oneself. For this reason, the bad part of self as depicted in dreams usually follows an evolution over the course of the therapy as the patient increasingly recognizes and takes ownership of it. This evolution can be typically characterized as follows:

– Alien from outer space or prehistoric monster – to – frightening wild animal – to – scary foreign human – to- human behaving badly but recognizable as one's own age and race. While there is great variety in these manifestations, one can see the evolution of a diminishing width of split in ownership of one's bad part of self.

4 – In a similar fashion, one can see the activities of the bad part of self graphically in dreams. It is in fact common for more perverse, secret masturbatory activities to show up in dreams before a patient will openly and honestly acknowledge their existence to the therapist and at times, even to themselves. I recommend Donald Meltzer's books "Sexual States of Mind" and "Dream Life" for an in depth exploration of these issues.

5 – It in occasionally only through a patient's dreams that their omnipotent approach to reality can convincingly be depicted. It is common to have patient's portray the act of getting inside and taking possession of another person's identity in a dream when they consciously avoid sharing any awareness of such an act in the therapy. I have regularly had patients associate to an aspect of their appearance or behavior in a dream that makes it clear they are taking possession of an attribute they see as belonging to me.

6 – Similarly, omnipotent masturbatory activities show up commonly in dreams as repetitive activities, going in and out of buildings, etc. The often eventuate in a shift in the dream demonstrating that the masturbatory activity has altered the person's sense of identity or relationship to reality. This in turn is likely to have a grandiose, unrealistic quality that is evident by the dream's content or the patient's associations.

Significance in Everyday Life:

1 – The more immature and neurotic aspects of everyone's personality have activities that are microcosms of activity emanating from their "E to SS" part of self. Much of it originates in the childhood pain of "being

small" and thus not getting to do what older siblings or grown-ups get to do. This envy of others fosters all manner of omnipotent over-estimations of one's own capacities and simultaneous denial of those of others.

2 – All manic activities to evade mental pain and psychic reality are in part manifestations of the influence of the bad self to varying degrees, combined with the intolerance of depressive pains by the good baby parts.

– "When the going gets tough the tough go shopping".
– "Don't get mad, get even".
– "Out of sight equals out of mind" and "What I don't know won't hurt me".

3 – Every little emotional slight or disappointment can lead to a momentary shift to control of the bad self.

Activities of the Bad Self in the Therapist:

1 – Because our work is potentially stressful and difficult, it will regularly activate the influence of our own urge to escape that anxiety and distress. This will happen more acutely and forcefully when patients are projecting violently into us and more subtly and insidiously when patients are getting to us unconsciously with their chronic characterological maneuvers.

– e.g. patient is chronically late and you start to use the time to get other tasks done

– e.g. patient consistently hammers you to take action of some sort and ridicules your attempts to think about the meaning of the requests

2 – Strongly envious patients pose a particular problem for a number of reasons. Their direct attacks on our own sense of worth, competence, intelligence, goodness, etc. often result in an urge to defensiveness or counter-attack in the form of an interpretation. The more subtle influence of envy in a "failure to thrive" often pushes therapist's to a progressively more omnipotent, action oriented posture and away from the arduous work of patient, interpretive understanding as therapist.

3 – More severely disturbed therapists who use a lot of omnipotent, omniscient postures and maneuvers that involve unconscious projective processes, especially in relation to unrecognized baby aspects of self, are always at risk to get into situations of serious boundary confusion as a result to these projections.

Implications for the Consulting Room:

1 – It is important to keep in mind that everyone starts out as an infant and has essentially the same modest array of maneuvers for coping with emotional distress. Therefore, all of the configurations of personality organization mentioned in this course exist on a continuum of mild to extreme. Every human personality evidences these maneuvers to varying degrees when under extreme duress and mental pain but they are reversible when things calm down and do not represent that persons ordinary, everyday coping pattern.

In infancys and childhoods in which distress, deprivation, etc. is excessive, for whatever reason, then these configurations of defensive maneuvers become ingrained 'pathological organizations'. [see John Steiner]

2 – The most common expression of these coping maneuvers occurs in therapy provoked by a patient's difficulty of dealing with separation. For this reason the frequency of sessions is the primary tool in the therapist's arsenal for modulating the influence of the bad self while the 'good baby parts' are trying to learn how to understand their painful feelings and irrational unconscious phantasies.

– This is the backdrop to axiom #6 that the most common cause of patients acting out is insufficient frequency of sessions.

3 – In the narcissistic personality organization of every patient, progress will ultimately lead the 'bad self' to feel that it is fighting for its life and that the therapist wishes to murder it. The more disturbed the individual, the more intense this reaction will be as a consequence of progress. The good baby parts are turning back to the good parents, internally and externally, and the bad self is threatened with being put out of business, permanently.

As a result, every significant separation will lead to a barrage of propaganda from the bad self, often leading to significant confusion on the part of the patient's good baby parts. This resulting doubt and confusion is often more that the patient's adult self, acting as an intermediary for the good parents internally and the therapist, has adequate tools and insight to manage until well along in therapy.

4 – Where envy is a major influence on the activities of the 'bad self', the therapeutic work will require a slow but steady acknowledgement of its influence in daily life. The patient needs to see that the therapist sees unconscious envy and its defensive maneuvers as human, inevitable, and problematic, but understandable and modifiable.

Since the word envy easily becomes an intellectual and emotionally meaningless concept, it is often best to simply refer to the emotion of 'hatred' in its place. This places attention on the pain of envy rather than making it a destructive act for which the patient is being blamed. The therapist capacity to be empathic about how painful it is to face one's envy, especially when it is spoiling goodness, makes it easier to tolerate exploring.

– e.g. I imagine that a part of you hates me for having this understanding and wants to deny …

– e.g. I think you turned away because you hated feeling you needed me to be able to cope …

5 – In patients in which the bad self has played a prominent role in their development their treatment will be long and arduous. This is logical when you consider their likely intolerance of mental pain and strong attachment to magic and action to evade it. A higher frequency of sessions, with very steady consistent work over a period of many years is virtually always necessary to make any real substantive changes in personality structure and function.

While one doesn't suggest to patients that it will be a long treatment, it will usually become an implicit underpinning to the therapeutic relationship over time. For the masses, this fact demonstrates why 'Alcoholics Anonymous' is one of the few programs to have consistent success as it offers a way of life with a family/home in every neighborhood.

Section 7 - Embarrassment, Shame, and Humiliation: Their Clinical Relevance

Disclaimer:
1 – This seminar represents Dr. Minnick's personal experience with patients using Kleinian models of development in early infancy.

– A Kleinian orientation leads a therapist to nearly always look for the most intense emotional state that is having the greatest impact on the patient at that moment. The most intense emotions are usually emanating from the baby core of the personality unless the external reality situation is realistically intensely upsetting. Even then, such an upsetting situation will activate the most intense and profound baby level feelings and

phantasies that parallel the external situation. If the external situation cannot be dealt with in a constructive manner, baby level issues will always be found at the root of the failure to cope constructively.

2 – With this orientation toward primitive mental states, shame will not be a primary emotional state that will be a center piece of the therapy. That is not to say that it doesn't play a very pivotal role in the psychology of some patients.

3 – Self Psychology uses a fairly different set of assumptions and models about development in infancy which make "shame dynamics" considerably more prominent. [See Melvin R. Lansky, M.D. for 20+ years on shame.]

Overview:
1 – These emotions all have their origins later in infancy, probably somewhere in the second year of life.

2 – These emotions require a sense of separateness from mom, an awareness of a developing capacity for independent function, a desire to no longer be a baby, and a wish to keep some things private, i.e. hidden from the view of others.

3 – The definitions of these words are to a certain degree arbitrary. Common usage has some tendency to substitute a word which is unconsciously undesirable for one that is more acceptable, in a manner analogous to the substitution of jealousy, which is linked to love, in place of envy which is more linked to the less desirable emotion of hatred.

With this unconscious reaction in mind, my observation of common usage is that embarrassment is often experienced as less "bad" than shame, which in turn is less "bad" than humiliation. When the more undesirable word would have been applicable, people will add a modifier like "totally" to increase the severity of the more desirable word, as in "He was totally embarrassed by the opponent.." when they might have said "He was humiliated by the opponent."

4 – Throughout this course, all states of mind which are described as being in response to an interaction with someone in the outside world can potentially take place in an analogous fashion completely within the unconscious inner world. That is to say that they would take place between a part of self and an internal version of mom or dad, etc.

Axiomatic Ideas:
Axiom #1: The degree to which infancy, and any qualities linked to it, is disliked or even hated, the more susceptible the individual will potentially be to having embarrassment, shame, and/or humiliation.

Axiom #2: In childhoods in which caregivers and/or siblings/peers were hostile, mocking, or cruel in any consistent manner regarding being small, helpless, dependent, etc., the susceptibility to feeling humiliated significantly increases.

Axiom #3: While cruel behavior from the environment will commonly intensify these emotions, it is possible for a person to generate these feelings on their own without any significant mistreatment in early childhood. All that is required is a feeling that being small or dependent is undesirable, followed by a projection of that attitude into the environment.

Axiom #4: The unconscious use of grandiosity and omnipotence, to defend against feeling small or dependent, greatly increases the susceptibility to these three emotions.

Axiom #5: Where unconscious envy is prominent in a patient, shame and humiliation are very likely to be more prominent in that individual. In effect the envious person lives in an inner world where baby states of

mind or qualities of behavior are hated, are projected when experienced in self, are viewed with scorn and contempt in others, and these maneuvers and attitudes become the "coin of the realm".

Definitions of These Three Emotions:
1 – Embarrassment: It involves self-consciousness because something has become visible or apparent to others that one would not ordinarily want to be seen or known, i.e. it is private. This exposure may be abrupt and one is often caught off guard. The resultant emotional state may be distressing, confusing, and put one ill at ease, commonly leading to a loss of composure.
– e.g. walking in public , stubbing one's toe on the sidewalk, and falling down

– e.g. having one's fly unzipped; having the top or bottom of a swimsuit slip down or come off; passing gas

2 – Shame: Originally, a painful feeling in early childhood that one has acted less than one's age and therefore has lost the respect of others and/or oneself. Later it can extend to a feeling of having lost the respect of others because of improper behavior, incompetence, etc. It can have a moral undertone.
– e.g. pooping or peeing in one's pants, (e.g. diarrhea, laughing, a "wet" fart w/ a bad odor, etc.)

– e.g. getting drunk and throwing up on someone's carpet, in their car, etc.

– e.g. making a politically incorrect comment that is overheard because one's microphone is on

– e.g. being caught taking drugs or having an affair when in the public eye

3 – Humiliation: Essentially an extension of shame, but with an emphasis on an individual, external to the self, viewing the loss of stature with triumphant hostility. This pleasure in the pain of the other adds an air of cruelty to humiliation on the part of the viewer toward the fallen individual.
– e.g. having your spouse yell at you and say derogatory things at a dinner party

– e.g. having your mother tell your teenage friends to go home when you are having a slumber party

– e.g. losing a football game by 63 to zero, getting knocked out in the first minute of the first round, etc.

– e.g. being accused of an act that knocks that person off an idealized pedestal, exposes hypocrisy, etc.

[Note: Any omnipotent, grandiose element in the personality that elevates one relative to others increases the risk of falling off that elevated pedestal. In other words, omnipotence and grandiosity as character features in a given person increase their susceptibility to humiliation. In turn, this demonstrates the degree to which humiliation has a link to unconscious envy via the arrogance and grandiosity that envious competitiveness often generates. Previous sanctimony and sitting in judgment of others adds to the severity of the humiliation because there is farther to fall and a greater paranoid expectation of hostile retaliation for the hypocrisy.]

Qualitative Differences Between Embarrassment, Shame, and Humiliation:
1 – Embarrassment emphasizes having something seen that would ordinarily be kept private. It is often generated by accident and does not necessarily imply that anything has been done "wrong" by the person feeling embarrassed.

2 – Shame has a greater emphasis on not living up to one's age or expectations. The result is a recreation of the painful baby feeling of being small, incompetent, helpless, dependent, etc. It may appear to be generated by the outside world seeing this state but it actually implies that the person themselves harbors a disapproval as well.

– As Eleanor Roosevelt said: "No one can make you feel inferior without your consent."

3 – Humiliation emphasizes that someone else is watching and is wishing to inflict pain by causing the victim to feel small, defeated, at fault, exposed, etc. It suggests cruelty, i.e. taking pleasure in the wish to inflict pain, as a motive in the other.

The Spectrum of Severity of the Reaction with Each Emotion:
1 – Since these spectrums are dependent on the definition given to each word, and many of the differences are subtle and variable, these spectrums are very arbitrary. They are meant to aid exploration, not to be taken concretely as fact.

2 – Embarrassment spectrum: self-conscious < indecent < blushing < disconcerted < mortified

3 – Shame spectrum: awkward < ignominious < improper < unchaste < ashamed < disgraced < dishonored < scorned < worthless < contemptible

4 – Humiliation spectrum: sensitive < vulnerable < thin-skinned < demeaned < belittled < slandered < debased < defiled < disfigured < demoted < degraded < humiliated

Why Isn't Shame in the Kleinian Literature?
1 – If one sees ES&H as emotional components of the second year of life, then the early super-ego, unconscious envy, projective process, the defensive elements that will underlay psychic retreats, etc. all have an origin in the first year of life and will therefore precede ES&H in the vast majority of situations.

2 – Interestingly, in early life, perhaps most of the first year, the child seems to be insensitive to embarrassment and shame, as commonly seen regarding nudity and toilet functions.

– This changes in the beginning of the second year as embarrassment begins to emerge like a movement out of paradise. This is perhaps linked to a developmental increase in awareness of separateness as motor activities and frontal lobe development lead to fewer and shorter episodes of feeling fused and/or inside one's objects

3 – The Kleinian dictum of looking for the maximal anxiety or emotional pain would take one to unconscious phantasies that underlay the hatred of baby states.

– In the case of shame, the feeling of shame would tend to be seen as a signal or manifestation that there is an underlying emotional state or phantasy that is seen as more primary than the shame.

– In the case of humiliation, there would be an implied hatred of baby states of mind in someone in the outside world who then cruelly projects those unwanted states of mind into the baby or child. The focus would then be on the projector's cruelty and the resultant impact on the recipient of the projections.

Expressions in Myth and Fairy Tales:
1 – Small children's nursery rhymes:

– "Humpty Dumpty sat on a wall, Humpty Dumpty had a great fall, all the King's horses and all the King's men, couldn't put Humpty Dumpty back together again."

– "The Incy Winsy spider went up the water spout, down came the rain and washed the spider out, out came the sun and dried up all the rain, and the incy winsy spider went up the spout again."

– I have never felt that I exactly understood why these are told to small children. I have a very strong suspicion that they are both describing birth, the first with a resultant feeling of catastrophic hopelessness, and the second offering a chance to be "unborn", as needed.

2 – Icarus of Greek Mythology: The son of master a craftsman named Daedalus, Icarus is described as wishing to escape from Crete with his father on wings crafted by his father out of feathers and wax. He and his father took off together after his father admonished him to follow him and not to fly too close to the sun. Icarus, however, giddy with being able to fly, becomes too adventurous, gets too near the sun, the wax melts, the feathers fall off, and although he keeps flapping his arms, he falls to the sea and drowns.

– This myth is commonly taken as an example of hubris or failed ambition.

– From a more psychoanalytic frame of reference, there is an oedipal quality of omnipotently taking possession of daddy's penis, and then arrogantly asserting that one has become the same as dad and can approach mother's body to possess it. From this point of view, it is analogous to Sophocles Oedipus story.

3 – The Emperor's New Clothes: An Emperor is only interested in showing off his new clothes which he is constantly acquiring. Two imposters arrive claiming to be weavers capable of making the most beautiful cloth imaginable. The cloth has this magical property of being invisible to anyone "not fit for his office" or "unpardonably stupid". While pocketing money and fine silk, the imposters have nothing on their two weaving-looms. The Emperor sends wise ministers and statesmen who, not wanting to appear unfit or stupid, repeated what the imposters tell them about the cloth they could not in fact see. When the Emperor finally has a procession in front of the town's people, an innocent boy says "But he has nothing on!"

– This story by Hans Christian Anderson seems to emphasize the impact of narcissism and environmental/cultural influence on the emotions of ES&H.

– Note that if one identifies with the nakedness of the Emperor, one might feel embarrassed for him. If on the other hand one projects one's own unwanted arrogance while simultaneously feeling envious of his status, then one may feel contempt for him and believe he has been humiliated, i.e. brought back to his original undesirable "baby status" that he tried to cover up with his preoccupation with fine clothing.

4 – The Garden of Eden Biblical Story: In Eden (Aramaic for "fruitful, well-watered") God places a man to tend the garden but forbids him to eat from the "tree of knowledge of good and evil" and then forms a woman from his rib to keep him company. The first man and woman break God's command, eat the fruit from the forbidden tree, and God expels them from the garden to keep them from eating from the second tree, the "tree of life" and then living forever.

– This myth can be taken in many ways. For this course it is useful to consider the infantile fantasy that the parents have magic and other possessions which the infant would like to possess himself/herself. The parent/God, fearing this envious intrusion and theft, expels the naked baby, leaving it in a diminished state.

5 – Snow White and the Seven Dwarfs: A very envious Queen wants to be the "fairest of them all" so she has her stepdaughter taken to be killed by her huntsman when the girl grows up to be more beautiful. The huntsman takes pity on her, leaves her in the woods, where she is discovered and taken in by seven dwarves, Bashful, Doc, Dopey, Grumpy, Happy, Sleepy, and Sneezy. When the Queen discovers SW is still alive, she makes a poisoned apple which she gives to SW claiming it is a "magic apple" that will help her find true love. SW falls into a death-like sleep, but is not buried because the Dwarves cannot bear to lose her. A Prince comes along, and saves SW because the evil spell could only be reversed by "loves first kiss".

– While this is a fairy tale that can be given many different meanings depending on which aspect is highlighted, extreme idealization of early infancy, as a result of splitting off destructive urges (born out of envious hatred) and projecting them, is one useful component interpretation. In the story, the Queen is ultimately chased to a mountain precipice from which she falls to her death, certainly an extreme depiction of the problems of envious narcissism and the grandiose positions it can lead one to take.

Prototypic Situations of Embarrassment, Shame, and Humiliation in Early Childhood:
1 – The "expressive" use of language tends to be adequate for to and fro communication around the middle of the second year of life. The infant has more capacity for the understanding language prior to that but not an equivalent capacity to elaborate on its states of mind. It still tends to rely on "song and dance" and the word "no" prior to the middle of the second year. As a result of this discrepancy, the states of mind attendant to ES&H are more inferred in the toddler than clearly elaborated through words.

– e.g. a child insists on feeding itself: e.g. insisting food be put on the highchair tray; insisting on holding the bottle or "sippy" cup or spoon, no matter how inadequately performed; etc.

– e.g. a baby hates having its diaper changed

– e.g. a toddler refuses to crawl, insisting on being picked up

– e.g. a toddler refuses to try to walk or gets furious when it falls despite the parents' encouragement

2 – There are situations where the small child apprehends that the parent's response to the child is negative in some way. That has the potential to intensify that child's unique reaction to the situation, for example feeling responsible for something bad, feeling blamed, bad, unlovable, unwanted, etc.
– e.g. the mother is ill or depressed

– e.g. the parents are ambivalent about the child's existence in their lives

– e.g. the parent, often psychotic, who tries to initiate "toilet training" in the first year of life

– e.g. the child is put up for adoption, born prematurely, mother goes back to work, etc.

3 – Family situations in which parents or siblings are overtly hostile or cruel to the infant or toddler greatly increase the likelihood of the child having a negative reaction to elements of its own status in the family.

4 – Unconscious envy can compound all of the above.

<u>Case Example</u>: [See last section of this course.]

The Problem of Distinguishing the Origin of Attitudes About Oneself:
1 – A toddler or child may have attitudes about its status as a child or baby that is a product of (1) its own attitude about being a baby, (2) its parents attitudes about being a baby, (3) its attitudes toward the parents (which alters the child's view of how the parents feel back toward the child), or any combination of the three.

2 – Attitudes about being an infant (i.e. attitudes as children toward themselves originally, and later as adults):
– some people embrace dependency and some abhor it

– some people compete with ferocity and some completely eshew competition

– some people are tremendously self-aggrandizing and some are modest to a fault (this includes those who are delusional in overestimating their abilities and those in denial of their true capacity)

In summary, some people feel that being a baby is a state of horrible inferiority and view it with contempt. Others feel it is simply a necessary phase of moving on to becoming bigger and more capable, i.e. a perfectly acceptable period of growth and development with lots of interesting adventures along the way.

3 – Attitudes and treatment by parents of their children:
– loving, nurturing, accepting versus neglectful, impatient, resentful of the child's existence and needs

– separate, encouraging, patiently educational versus projecting unwanted infantile parts of self into the child leading to fusion, or its opposite, rejection (often determined by whether the "center of gravity" of the sense of identity goes with the projected "baby part" or stays within the projector)

– lovingly setting boundaries and appropriately modulating youthful exuberance or grandiosity versus angrily, cruelly, or gratuitously being demeaning, rejecting, or punitive including emotional and physical violence

In summary, some parents find parenthood a hideous burden that reminds them of their own hated past and smallness, while interfering with having a life, in contrast to others who feel the sacrifices are worth it to bring a happy new life into being, and perhaps making up for some of what they did not get in their own childhood.

4 – Attitudes of children toward their parents:
– confident expectation of love, encouragement, and safety versus anxiety, doubt, and fear

– idealization of parents versus disapproval, disappointment, and/or contempt

– love and gratitude versus manic denial of goodness received, envious resentment, hatred, and rage
In summary, where the relationship between child and parent is satisfactory, and the child is not excessively enviously resentful of the parents capacities, etc., the parents will usually be idealized to some variable degree and be seen as positive figures overall who are loved. On the other hand, if the child has an excessively intense envious reaction to the parents, then it is more likely to focus on the parents' inevitable failings, handicaps, etc. with an uncharitable "eye" toward criticism and even contempt. This will greatly increase the expectation of being "eyed" in the same hostile manner back for anything done wrong by the child.

5 – Conclusion: When looking at a human's original attitude toward its status in the world as an infant, toddler, or child, it is typically very difficult to sort out the relative contribution of parental attitudes and behavior versus the child's very own attitudes about its position in the family and life. It can be said that where there is a congruence involving the child's attitude about smallness, being helpless, inadequate, needy, dependent, etc. and the parent's attitudes about those issues, the child's attitudes will be strongly reinforced.

Unconscious envy in the child toward the parent is perhaps the one crucial variable that can alter the situation and lead to a seemingly paradoxical attitude toward ES&H. In effect, the child's attitude may not follow the seemingly expectable, logical outcome that would have been predicted using the parent's attitudes and behavior as the primary determining variable.

Put in other words, it is possible for unconscious envy, when intense, to override the impact of what might otherwise appear to be very desirable attitudes and behavior from the parents that should not have generated in the child such intense feelings of ES&H.

Another way of saying all of this is that the "internal versions of the parents" (i.e. the "super-ego") may be fairly different from the actual external parents. As a result, all therapists must take with a grain of salt what the patient says the parent, spouse, boss at work, etc. was like in the past. The therapist must "take in" the patient's view of the figure but keep in mind the potential for distortion based on projections into the object.

The Formation of the Super-Ego and Its Relationship to ES&H:

1 – If one makes the assumption, as I do, that humans are phylogenetically predisposed to expect there to be a mother figure and a father figure in the world into which they are born (i.e. "preconceptions" of each), then it easier to see that internal versions of them will be created based on the combination of experience with them, and one's unique perception of those experiences with each parent. Envy, jealously, unexpected events before and after birth, sibling number and spacing, etc. can have profound and potentially distorting influences on what sorts of versions of mom and dad are created internally. These influences can be so powerful that the internal version may only minimally correspond to the actual parents, a truly daunting reality for parents with best intentions at heart.

– Profound emotional experiences in infancy (e.g. prematurity, a traumatic birth, being given up for adoption, sibling's spaced less than two years apart, colic, illness, parental separation or loss, etc.) will have a great determinative impact on the creation of internal versions of mom or dad. In such situations, these "internalized" versions of the caregivers may even be quite a bit more "fantastic" than the actual parents. This is particularly true of prematurity and adoption which are so profound and occur so early in infancy and are stored at a midbrain level and reworked for years thereafter. Intense colic in the first three months of life may also have such an impact. In all three situations the internalized versions of the parents are often quite different from the actual external ones.

On the other hand, highly repetitive experiences of parental behavior that is either positive or negative can have the same formative impact, more based on repetition than based on emotional profundity. These can also lead to rather fantastic versions of mom or dad but it is common for these internal versions to have more apparent correspondence to the real external figures.

2 – Children can be seen to have various consistent patterns of feeling and behaving that come to represent distinct aspects of themselves, experienced as distinct "parts of self", often held very separately in the child's personality and mind. Some may be "split off" most of the time, only to come home to roost when the child is tired or provoked in some specific way. An especially jealous, envious, mean, sad, or even crazy aspect/part of self may only be seen sporadically in fairly specific situations for seemingly no obvious or predictable reason.

3 – The result of the child's experiences of parental figures leads to a theoretical bare minimum set of possible versions of mom and dad in the unconscious inner world. These would include a good mom or dad and a bad mom or dad, resulting in a total of four versions of mom and dad. In a manner analogous to parts of self, some of these versions of mom or dad may be "split-off" and held very separately in the child's unconscious inner world.

4 – The various consistently seen aspects/parts of self are inherently and inevitable found to be paired with very specific versions of mom or dad. These pairings are typically the result of the child's consistent reaction to specific childhood situations that were either profoundly impactful on one occasion, or were repeated many times in the child's experience.

Put in slightly different words, the unconscious inner world seems to become populated by emotionally significant experiences during which a part of self and version of mom or dad were felt to be doing something to or with each other for some specific reason. It is the emotional context/situation that "pairs" the self and object together and generates neuronal patterns that are stored in the brain at various levels. The "meaning" given to these pairings can be elaborated and reworked during later infancy and childhood, sometimes making it more realistic, but often just cementing a distorted version of "who is doing what, to whom, and why".

5 – The primary reason for emphasizing the internal versions of mom and dad is to create an awareness that ES&H can arise almost entirely from internal sources, in some situations, and therefore have far less correspondence to the outside world than common sense would suggest.

– For example, a child could have parents that would never tease or shame the child and yet the child can feel that it is being viewed and treated with an eye toward embarrassing, shaming or humiliating it. This is, for example, an almost a universal attitude in adolescents toward their parent's behavior.

Omnipotence and Unconscious Envy in Relation to ES&H:
1 – If one has relied on omnipotent grandiosity to cope with painful feelings of being small or inferior, then giving it up will be greatly feared as exposing one to a great fall. Just ask "Humpty Dumpty".

2 – It is important to remember that envy is a universal, intensely painful emotion that is inherently embedded in earliest infancy as a result of the enormous discrepancy between the capacities of the mother and the infant. It seems to vary in intensity as a result of biological predisposition and is definitely exacerbated by environmental inadequacy or hostility.

– When envious hostility is directed at one's objects on a consistent basis in infancy and early childhood, the expectation of retaliation and hostility back greatly intensifies the predisposition to shame and the expectation of humiliation piled on top of the shame. Projection of this hated baby state of being adds to the paranoid expectation of retaliation.

Projective Processes and These Three Emotions:
1 – It is important to note that all three of these emotions suggest the presence of a second person who is viewing/seeing something. The person being "viewed" is having an emotional reaction to "being seen". The meaning of the fact of being seen is then a product of the emotional reactions of both individuals who are involved.

Either of the individuals involved may react emotionally in a manner that that can exist on several continuums.

– The reactions may be realistic and adult, or unrealistic and infantile.

– The reactions may be loving and supportive or hostile and cruel.

– The individual having the reactions may stay psychologically separate or either/both may immediately project into one another and distort their boundaries in relation to each other.

2 – Embarrassment is the emotion that is the least necessarily linked to projective processes. In other words, the embarrassed individual need not attribute anything to a viewer.

3 – Shame is most open to confusion about who is doing what to whom and why. It often requires some detailed exploration to sort out whether the person experiencing the shame is recreating their own internal situation, the viewers reaction, or whether the situation would have shame as a reasonably expectable response.

4 – Situations involving the experience of humiliation are the most likely to involve relatively clear cut projections from the viewer into the person viewed and feeling humiliated.

Embarrassment, Shame and Humiliation in the Therapeutic Relationship, General Issues:
1 – It is quite common for a patient to come into treatment with deep, pervasive confusions as to what represents "adult" attitudes and behavior versus "infantile" ones. In the Kleinian literature, this confusion was originally commonly referred to as "faulty horizontal splitting", implying that the individual had confusion about adult versus infantile elements in life.

A common example would be the mistaken equation of physical size with emotional maturity, as if to imply that a person who is physically "grown-up" has therefore also achieved a level of maturity at an emotional level that experience tells us is often not the case, as is so in evident in mid or late adolescence.

2 – One of the tasks, often quite prominent in the early years of analytic treatment, is the gradual recognition of and working through these sorts of confusions.

– e.g. confusion of size, material possessions, wealth, power, etc. with maturity

– e.g. confusion of independence, self-reliance, invulnerability to emotional pain, etc. with desirable achievements linked to mature emotional capacities and mental health

– e.g. confusing "addictive dependence" (which is "anti" growth) with healthy reliance on and need of the analyst/therapist (which is necessary to promote growth)

– e.g. confusion of a capacity to dominate, control, intimidate, etc. with earning or deserving respect (parents cannot demand the respect of their children, they have to earn it)

ES&H in the Therapeutic Relationship as a Result of "Psychic Retreats" [John Steiner]:
1 – A "psychic retreat", as developed by the English Kleinian psychoanalyst John Steiner, refers to a defensive organization that is used by a person to avoid anxiety and emotional suffering. It represents that person's set of consistently used unconscious defensive maneuvers and attitudes. Any disruption of those maneuvers leaves the patient feeling "naked and exposed".
– e.g. feeling expelled from the Garden of Eden and feeling shame
– e.g. having a large falling back to earth and reality when grandiosely overreaching to the Sun
– e.g. being exposed as "stupid" and "unfit" when one's cloak of fancy clothes is removed (protective clothing of the retreat)

2 – A "narcissistic type of object relationship" is the most common form of psychic retreat and has powerful unconscious envy at its root. In this type of relationship the good qualities of the object are appropriated while the hated and unwanted "bad" aspects of self are projected into the object (i.e. creating a role reversal).

– Because this reversal makes one "bigger" than one actually is, having this self-idealization and aggrandizement be seen can be intensely humiliating.

– ES&H are all so painful that, in a manner analogous to the defenses against awareness of envy, they to seem to demand immediate relief from the feelings of inferiority and feeling viewed with contempt, being looked down on, and feeling ridiculed.

3 – The psychic retreat requires that some aspects of the reality of self or object be "split off" and/or denied, because if these elements were seen and acknowledged, they would lead to mental pain. This in turn distorts the perception of self and object meaning that neither is seen in a clear, realistic manner. Projections into the object further distort these perceptions. The distortions often involve self-idealization and aggrandizement.

4 – Therefore, coming out of the retreat as a result of analytic work on it exposes the patient to the painful feelings of envy, jealousy, frustration, rage, guilt, remorse, etc. that had been previously hidden from sight.

5 – Periods of constructive growth and movement in therapy into the depressive position by definition require that the patient be more psychologically "separate" and face their treatment of their objects. This can expose the patient to very painful states of shame, etc. because of the resultant recognition that they have behaved badly, cruelly, crazily, etc.

– The patient must face the collapse of "self-admiration and narcissistic pride". With the resultant exposure to ES&H, the patient may become highly persecuted and paranoid or alternately retreat back to the previous defensive enclave.

– If the person stays in contact with their treatment of their objects, then they have the problem of facing intense guilt as well.

6 – There is the potential, as the patient is more separate and sees how they have behaved, that "being observed" accrues a particular quality of cruelty and pain where the observer is felt to be hostile, attacking with a goal of removing the patient's narcissistic state and make them feel especially inferior and humiliated.

– Therapy can stall at this point or even reach an impasse [See Herbert Rosenfeld's book "Impasse and Interpretation"]

Implications for the Therapist:
1 – It is necessary for the therapist to be aware of and sensitive to the pain the patient feels as they face their omnipotent, defensive maneuvers and their past treatment of their "good objects".

– Because narcissistic patients are particularly sensitive to "status" and unconsciously fear having their superiority challenged and fear finding themselves being "looked down on", some patients will treat all interpretations of their infantile states of mind as a purposeful "put down".

2 – It is useful to make clear the historical string of emotional reactions, showing the logical link between the earlier feelings and defensive maneuvers, and their later emotional consequences and evolutions. In other words, the patient is then able to see that maneuvers once needed for survival are no longer needed, but their original use was the best one could do and is human, not morally reprehensible.

– This carries an implication that the patient who is particularly shame based in their view of life need not feel such intense shame and humiliation now as an "adult" reaction to their current life. In effect, the ES&H that they continue to expect to feel are now anachronistically out of date.

Countertransference Difficulties in the Therapist:
1 – Attitudes of "sitting in judgment", as a tendency in the therapist, will greatly intensify the patient's realistic feeling of being viewed with contempt or cruelty with a motive of inflicting shame and/or humiliation.

– IT IS NEVER THE THERAPIST'S JOB TO BE MORALISTIC!

2 – Some patient's provoke contempt through their behavior or projections. The therapist must distinguish his or her personal reaction to the patient from the patient projecting a "shaming" reaction into the therapist as part of the repetition compulsion. In the latter, the patient could be projecting either a baby part of self that feels ashamed, or an internal version of mom or dad that is felt to be shaming.

3 – It is important for therapists to help patients see their distortions of their parents based on the infant's or child's projections into the parent.

– Remember that one of the greatest problems that results from having disturbed, abusive, or crazy parents is that it is more difficult to see and take back one's projections into them of unwanted parts of self. This is true not only for patient's, but also for the therapist of those same patients. In effect, therapist and patient can enter into a "folie au deux" in which they both project into the patient's parents.

– One of the most obvious ways to see these distortions of the parents, based on projection, is that those same projections will occur in the transference and distort the patient's perception and experience of the therapist.

4 – The therapist can benefit from an awareness that the models they use for understanding the patient may feel inherently aimed at shaming the patient, feeling superior, etc. This may require the therapist to go much more slowly with interpretations than they are used to, modifying the words they use, etc.

– Some patients are so concrete, project baby states of mind immediately when experienced, and feel so expecting of criticism, that anything the analyst describes that seems undesirable or childish will be experienced as a hostile attack on them.

5 – The take home lesson is that our work as "headshrinkers" is hard to do, and is hard to receive. It naturally has an undertone of shaming and humiliating the recipient. Therefore, the more models the therapist has for understanding these possibilities, the more likely he/she will deal with them empathically, effectively and constructively.

Case Example
Background:
A male in his mid-forties, with a high achieving professional career, came to treatment because of a lifelong paralyzing inability to be in public situations in which he feared he might have to abruptly go to the bathroom (i.e. possibly have diarrhea) or become nauseated (i.e. throw up). This limited his ability to be in a car with someone else driving, sit in a movie where he was not on the isle seat, go on any type of boating situation, go out to do anything with anyone if he had a mildly upset stomach that day, etc.
He had been briefly married in his twenties to a woman who was intelligent, very attractive, but very "private", completely career oriented, and abruptly told him about a year into their marriage that she no longer wanted to be married. They divorced without much fanfare and he never understood what happened.

Early History:
The patient was the second born of three children, all born roughly two years apart, to parents who were both "academics", the father in applied sciences and the mother in liberal arts. The patient felt consciously that he was close to his mother but distant from his rather perfectionistic and judgmental father.

Upon deeper inspection I felt that he was not in fact close to either parent. I thought he confused praise from his mother for his high achievement in school with actual emotional involvement, a capacity for which I felt his mother was lacking. His father was remote, narcissistic, critical, held grudges for perceived injuries from relatives and colleagues, and was generally feared by the patient as I experienced it.

The patient's infancy turned out to have gotten off to a poor start. Early in treatment I asked him to inquire how his infancy had gone as he could remember almost nothing before first grade. His mother then told him that he was a "difficult" baby, that she had tried to breast feed him for two weeks but had to stop and switch to the bottle (for some vague reason that she never explained in a fashion that I could make sense of based on what she told him).

[My reconstruction during the treatment was that she wanted a "perfect baby" that made no demands of her that were not in complete synchrony with whatever her desires were at that moment. I felt he had recreated that situation in his "ideal", but brief marriage that ended abruptly, with no apparent explanation.]

His only actual recollection of a formative experience was his first day of first grade when a girl sat two rows over from him and shortly after class started "threw up on the desk". She was taken out of the class and he did not recall if he ever saw her again. My take was that she was terrible anxious. Interestingly, his ultimate take home lesson, probably reworked over the years, was that she had done something terribly unacceptable and had been "removed" from the class for it.

Transference Behavior:
As he had been in childhood, the patient was clearly keen on being a very "good" patient, not in the sense of cooperation and developing insight, but in a more shallow concrete sense of being proper, likeable, and not being a problem for me. He was hypersensitive to any hint that I might be critical or disapproving.

Section 8 - The Fundamentals of Dream Interpretation: A Kleinian Approach

Goals of This Course:
1 – To expand the clinician's models of dream origin, structure, and function.
2 – To create a working logic for how to think about dream meaning and therefore dream interpretation.
3 – To expand the clinician's thinking about the manner in which the patient uses dreams in the therapy process.
4 – The concepts of this course are exemplified by an extensive "Case Book of Dreams" that follows this theoretical lecture. It is hoped that this overview of the theory behind the interpretative process will add to the understanding of the explanations in the case book.
Note: This course is meant to be a pragmatic introduction to a Kleinian approach to dream interpretation. For an overview of the theory of dreams and symbol formation, I would recommend two excellent books: Donald Meltzer's "Dream Life" (1983) and Hanna Segal's "Dream, Phantasy, and Art" (1991).

Introduction:
I personally think that dream interpretation is the most difficult area to learn in all of psychoanalytic technique. What makes it so difficult is that it requires a unique mix of having extensive models of emotional development and mental function, combined with as much clinical experience as is possible, and all mixed together in an environment of imaginative speculation by the therapist. I think imagination may be the most difficult to teach but I do think it can be learned to a considerable extent.

The therapist's own characterological issues add to the complexity. Doubt that one will ever learn to do it adequately will drive one away from it or move one toward formulaic approaches of the "this always means that" sort. Alternately, doubt and anxiety may propel one to omnipotent maneuvers and omniscience.

In the early years of my private practice, I liked the challenge of dream interpretation but found that I often started daydreaming during a dream presentation by a patient. I would have to politely ask them to repeat the dream, as if one aspect had not been clear to me the first time around. I think my distractibility represented my turning away from the process as a result of my own anxiety and distress about not having much of an understanding of the dreams being shared with me.

Personal supervision is probably the key antidote to this struggle. Finding a supervisor who seems able to make sense of dreams in a manner that feels useful is probably the best way to gain some facility with dream interpretation.

It is my hope that the "Case Book of Dreams" that follows this presentation will augment the task of seeing models for understanding dreams put to use. I do not propose that any two therapists would ever come to the exact same dream interpretation of a given piece of material. However, I do think that hearing how someone thought about a particular piece of material adds to one's own repertoire for coming up with imaginative potential formulations about a particular dream image. I hope to succeed in expanding yours.

Direct Quotes from Children that Are Expressions of Phantasies also Seen in Dreams:
1 – A boy of four put his hand on his dad's appendectomy scar and said: "I'm going to fix this dad – I'm just full of good penises"

Comment: It is difficult for adults to remember and imagine what the thinking of very small children is like. Adults have unconsciously devoted considerable energy to get away from that level of thinking that is inherently concrete, part-object, and preoccupied with the parents' bodies. If one looks at the phantasy life of adult males, of whatever orientation, one still sees enormous preoccupation with breasts, penises, vaginas, buttocks and the anus, etc. Size tends to dominate, rather than substance and maturity, which suggests baby level thinking is in operation.

This type of thinking represents evidence that the thinking of the "baby core" of the personality dominates in most people throughout their lifespan in their daydreams, and it completely controls their night time dreams.

2 – A girl of six asked of her mother: "Mom – am I yours or am I mine?"

Comment: Originally the baby lived for nine months inside mom's body and felt "joined" to mom. That fusion was destroyed in one massive event, never to be forgotten! From that point onward, that individual will forever wonder and question why that happened, what is now going on inside the place they once lived, and will phantasize about getting back inside.

The phantasies about mom's "insides" will include such issues as are there other babies still there ("unborn, inside babies"), does daddy's penis get to go inside and stay there, how and when do babies get selected for birth, can one return to live inside mom, can babies be born out of the rectum, how do they get food, etc.

One element held as a common underpinning of all of these questions is the idea of being in "possession and control of mom", and by extension it's reverse, mom possessing and controlling the baby. The concept of being in possession and control of another has, as its primary aim, coping with or evading mental pain, and usually most particularly separation.

With all of that in mind, I experience this little girl as asking a very sophisticated question that evidences her growing "separateness" from her mom, and wondering if it is okay for her to now have her own sense of "agency". In other words, will the concrete "possessiveness" that underlays living inside mom, and is followed by being utterly dependent on mom after birth, be relinquished by both of them (mom and daughter) so that they can be fully "separate". One gets the feeling that this little girl senses that being her own agent is coming, and that it is a desirable state of affairs.

[Dream Example #1: "There is a hospital room with a woman who has had the front of her chest torn off on one side. In another room is a baby with one side of its face missing. It was really upsetting to look at. That seems like a really weird dream."

Comment: This adult woman had been breast fed for two months when her well-meaning mother abruptly stopped the feeding and switched to a bottle because her pediatrician had said the baby was not gaining enough weight. We came to recognize that as a baby she must have felt very attached to her mother's breasts, that the breast feeding was going satisfactorily, and that the weaning was a catastrophic "tearing apart" of that union. The patient, who was morbidly shy, had no conscious knowledge of this weaning until it came up in the transference and in her dreams, and she then asked her mother about her early history which confirmed our impressions.]

3 – A girl of three stood up in the middle of her bath and shrieked: "Daddy – my penis is missing!"

Comment: No doubt she has always seen that she did not have a penis. Yet somewhere in her mind she has held on to the idea that she could also have a penis. After all, why wouldn't any child want all of the desirable body parts that are extant in the world. It seems possible that she is finally relinquishing that wishful phantasy.
On a different note, this example brings up a question with which many people struggle, how can a child

know of the existence of a body part that it has possibly never seen? For a discussion of this point I would refer the reader to the section in Module One of Minnick's Klein Academy on "Preconceptions".

4 – A girl of three (who had been breast fed successfully for a year) pointed to her mother's breast, as the mother was putting on her bra, and exclaimed: "That's the thing you bit me with!"
Comment: Clearly no nipple has ever bitten a child. In contrast, probably every breast fed baby has experimented at some point with biting the nipple and has been upset by mom pulling away and saying "Ouch", or its equivalent. Since the infant may immediately feel some primitive guilt, fear of abandonment, or anxiety about further aggressive urges toward mom, it is very likely to disown any or all of these into the outside world in the form of a projection into mom. Mom would then be imagined to be harboring both the infant's urges and her own urge to retaliate in kind by biting the infant back. [I have known mothers, rather concrete in their own thinking, who have bitten the infant back, just to show how it feels, and to warn the infant not to do it again.]

5 – A small boy asked in early childhood, after his brother was born and came home from the hospital: "Dad can we tie Billy to the back of the car and drag him on the freeway?"

Comment: At some level, conscious or unconscious, this type of "sibling rivalry" seems a universal reaction in one part of every child. Envy and jealousy, the two primary components of sibling rivalry, along with a feeling of losing one's possession and control of mom, are particularly evoked by the birth of a sibling. The antagonism that is generated toward the new baby is often breathtakingly cruel and not infrequently in evidence throughout the lifespan. While such aggression and destructiveness often becomes very unconscious after childhood, it is almost never gone from dreaming. Look at any holiday family gathering, observe the interactions, and then witness the dreams that night. Sibling rivalry will invariably be in the mix of dream thoughts.

[Dream Example #2: "…there was a family party with my parents and siblings and their friends…suddenly terrorists came over the back wall and started shooting and killing everybody…"

Comment: This depicts the natural tendency of most people to disown the destructive side of their personality and to feel it as foreign to their sense of identity. The woman who had this dream was about to go back East for a family, holiday visit and was frightened of her own envious and jealous feelings that were inevitably going to resurface.]

<u>Underlying Assumptions About the Origin and Significance of Dreams</u>:
1 – A Useful Definition: Dreaming is a phylogenetically inherited capacity for the human brain to be able to "think" using pictorial imagery. It is initially used by the infant to think about and bring order to the earliest experiences of life that are felt to be significant. These experiences are stored as something like "memories in feeling" at a midbrain level and are reworked initially, at a cortical level, before language has developed.

Dreaming remains the primary tool, throughout the lifespan, for the alive, active, "baby core" of the personality to think about (1) the "meaning" of its emotional states and experiences and (2) decide how it is going to "cope" with those issues.

[Note: I cannot decide if daydreaming, when we are awake, is its counterpart. I suspect that daydreaming is mostly a wishful, omnipotent activity that is largely in the realm of manic defenses.]

2 – Everyone dreams every night, about every ninety minutes, even if they never remember them. The REM sleep that occurs when dreaming comprises something like 20% of the total time asleep in the adult.

3 – Because dreams are written by the "baby core" of the personality, we can expect them, for the most part, to be "pre-verbal", "concrete", and "pictorial".

4 – By contrast, the "adult" part of the personality can, in theory, process experience with conscious thought, while awake, applying logic, reasoning, and abstract/symbolic thinking. Interestingly, it is common for someone struggling with an emotionally intense issue to need to "sleep on it" in order to finish off the processing, perhaps adding a layer of "baby feelings" to the process of digestion of the issue.

5 – Dreams often make it possible to discern the origin of a significant emotional state of unhappiness or distress when the individual cannot recognize that origin by conscious introspection. That is because such distress is invariably a product of feelings emanating from the "baby core" of the personality regarding deeply unconscious phantasies or emotional states that are "split off", being evaded, and/or projected.

[Note: "Self-analysis" after a successful psychoanalytic treatment, should leave an individual able to figure out what they are feeling most of the time, and why. However, I have not seen people be able to interpret their own dreams very well other than to get a general overview of what type of thing is going on in them.]

6 – The "manifest content" (the dream as written) is taken more literally by the Kleinian analyst than other analysts. This is implicitly linked to the idea of the "baby core" of the personality writing the dream in its own concrete language. The "latent content" (i.e. the dream's unconscious meaning) is therefore often seen as more directly linked to the manifest content. This contrasts with Freud's view that the manifest content is linked to guarding sleep, and that the real meaning is hidden from direct view.

The models of being an unborn inside baby, mother's body as the geography of phantasy for the baby, projective processes and paranoid anxieties, the vicissitudes of unconscious envy, and manic defenses against depressive anxieties and guilt, etc. are all examples of Kleinian issues that are displayed directly in the manifest content on a regular basis.

[Dream Example #3: "…I went to the back of my mom's station wagon to get the grocery bags, there were bowling pin type things in the bags and I started pulling them out and tearing them apart with my teeth and there was blood and guts everywhere…"

Comment: This adult male had been admitted to a psychiatric hospital for a psychotic depression and had this dream on the first night of his admission. It represented the degree of murderous violence he had felt toward his mother and her inside babies. The dream was not "psychotic" is the sense of its structure but it depicted a degree of primitive violence that might be typical of someone who was psychotic.]

7 – Kleinians assume that there is an "alive, active, unconscious inner world" that is operative 24 hours a day. Thus dreams, like transference reactions during a therapy session, are seen as an expression of the immediate, present internal state of psychic reality operative at that moment, not an archaic desiccated relic or recollection of an ancient past.

Put slightly differently, Kleinians see dreaming as "thinking", capable of elaborating new meanings. Freud, in contrast, saw dreaming as doing nothing original, essentially just guarding sleep while depicting reactions to the day's events.

<u>Useful Basic Assumptions When Trying to Interpret dreams</u>:
1 – The "geography of phantasy" for the "baby core" of the personality is the inside and outside of "mother's body". [Donald Meltzer]

This has huge ramifications. The first is the need to ask the question about any dream: Is the dream taking place "inside" or "outside" a person's body? Where separation is a key emotional element in a person's psychic functioning, and they spend a great deal of time, unconsciously, joined up to and inside their objects, then that fact will be evident in dreams in a manner that will aid the therapist in working with separation and defenses against it that involve "fusion" with the object.

The second key implication is that all children imagine that mother's body contains all of the desirable things in the baby's world. These possessions include fairly obvious things like food and "unborn, inside" babies. Less obvious, but necessary for understanding some dream elements, is the idea that "daddy's penis" is also one of mom's most prized possessions. [Meltzer suggests that a penis like structure is imagined to be "policing" every one of mother's bodily orifices to protect her from unwanted intrusions. He calls these "inside penises".]

A third key point about mother's body as the geography of unconscious phantasy is the idea that her body can be divided into natural zones, or as Meltzer refers to these as "natural lines of cleavage", based on the functions of the various zones of the human body as experienced and imagined by the infant. These zones would include: (1) an upper region linked to the "head"; (2) a "chest/breast" region linked to feeding; (3) a lower front, "genital" region linked to reproduction and sexuality; and (4) a lower back, "anal" region. All of the parts of mother's body that contain orifices, including the eyes and ears that "take in" sights and sounds, can be seen as potential "portals" into mother's body and will therefore often be treated as such in dreams.

[Dream Example #4: "…I was living in some room off the stairwell of your office, I would come and go as I pleased and you didn't realize I was living there…"

Comment: This patient had slept in the parent's bedroom for her first two years of life. She was only moved out, under great protest, when a sibling was born. She was a very cooperative patient, let me do all of the thinking for her, paid early and was always grateful for my help, but never grew an inch in the first two years of treatment. It was only after I learned in supervision about "unborn inside babies" that we made progress and she began to have many dreams like the one above.]

2 – The unconscious inner world of all babies probably stores all emotionally important experience as a "semi-permanent relationship" between a "part of self" and a "version of mom or dad" (at a part or whole object level), with some form of explanation of what each is doing to the other and why (= Klein's "unconscious phantasy").

These "parts of self" can usefully be divided arbitrarily into (1) an "adult part" (i.e. the most mature part of self at any age, and the part that wants to model itself after the "good parents"), (2) "good baby parts" (that by definition "turn toward" the good parents when they are available), and (3) the "bad" part of self (that by definition "turns away" from the "good family" both internally and externally).

The age of the characters in a dream, in relation to the dreamer's actual age, usually aids in distinguishing parts of self from various versions of mom or dad; and the activities or associations to the figures of similar age to the dreamer aids in differentiating the "good" parts of self from the "bad" self.

3 – The "bad" self (i.e. the "envious, omnipotent, know-it-all, destructive, self-sufficient part of self", to list its key characteristics) is commonly evident in dreams as an alien, a monster, dangerous animal, killer or criminal, foreigner, bum, black person, etc. [Note: With successful analytic work over a period of time, this "bad" part of self commonly becomes progressively more recognizably human, and ultimately nearer in age to the dreamer.]

The relationship between the "good" baby parts, the "adult" part of self, and the "bad" self are very regularly on display in dreams. The relationship is often a good indicator of whether the patient is "turning away" from caring and sanity and therefore has a prognosticating value in therapy.

4 – Roger Money-Kyrle is purported to have said: "Children put their parents together in every possible way except the right one."

This is important for dream interpretation in that one often sees elements that are improperly assembled or placed and it can represent an unconscious denial of reality or even an attack on it, particularly an alteration

of a proper loving relationship between the parents (that would leave the child in a state of emotional pain if properly acknowledged). These "attacks" on the parents' proper, loving relationship are useful to recognize as they give clues as to why the dreamer is then also incapable of or having difficulty establishing a proper, loving relationship.

[Dream Example #5: "I looked into a building window – I was outside. I saw a long metal table – I decided to go in. There was a table almost like a gurney or autopsy table. On it is a body that is twice as long as a normal body – I suddenly had this very depressing realization that I was not going to be able to leave the building until I had eaten the entire body."

Comment: This patient's view of her parents was right out of Money-Kyrle's idea. She had so ruined her parent's relationship, in her own mind, that it was a monstrous perversion of a loving relationship. The patient had become painfully aware of these attacks on the parents as a good couple and then had this dream.

She felt relief at the interpretation that she was going to have to face, accept responsibility for, and digest what she had done to them –which was essentially to smash them together in a distorted, dead cadaverous relationship – before she could finish her analysis.]

5 – It is useful to note the distance in the dream between the dreamer and the action of the dream. Putting it slightly differently, did the patient experience his or herself "living" the dream, or were they only witnessing the dream from some detached position. Do they experience themselves as responsible for and connected to figures in the dream, since they are the playwright, or is their sense of identity divorced from the events of the dream? This has significant implications for how the patient will react to interpretations of the dream. It may suggest a need to acknowledge the "distance" first to help the patient see the difficulty they may have in accepting certain implications of having dreamt that specific dream image.

<u>Key Models Needed for Understanding Human Development and Psychological Functioning</u>:
1 – As mentioned above, it is useful to think of the unconscious inner world as composed of rather permanently "fixed relationships" between parts of self and various versions of mom and dad. "Unconscious phantasies" represent what is imagined to be going on in these relationships, why it is happening, and these meanings will be represented in all of that patient's dreams.

[Dream Example #6: "I'm in the mountains in France – like WWII. My patrol goes into this mountain house – it reminds me of a ski chalet in Mammoth with stairs going up the front – I find those houses particularly appealing. We moved in and were living inside, had the lights on, etc. I go outside and see the village which is half empty because many have evacuated. I walk around and suddenly realize the large house next door has been taken over by a bunch of Nazi soldiers. I run back into our house and tell the guys that the Germans have taken over the house next door and we've got to grab our stuff and leave or we will all be killed. But they've turned into a bunch of babies – they've taken off their uniforms, etc. and are eating cheese whiz. I decide I have to leave them because I have to defend myself. As I am going into the woods I hear the Germans shooting and killing the guys. I kill a deer as I'm escaping and I'm collecting green wood and putting it into a backpack that I will need. I'm pulling the deer over the snow and making little fires to smoke bits of it to eat as I go. I finally get to the top of the hill and can see the bad guys off to one side and the good guys off to the other and I feel safe."

Comment: This dream is simultaneously well organized but highly persecutory and omnipotent. It has an extreme degree of violence that is kept in control by a highly separated and split distinction between the good guys and the bad guys. But there are no good parents around, only "babies", bad guys, and his highly omnipotent, self-sufficient part of self. Mother, in the form of the deer that he drags around, was in reality extremely passive but nurturing in a very rudimentary manner. He can only achieve peace by extremely obsessional splitting maneuvers, keeping dad and mom widely apart, but at a price of great persecution. His understanding of proper adultness is missing, and his own violent urges have been split off and projected

violently into the outside world, perhaps at the most primitive level into daddy's penis as personified by German soldiers occupying the big house next door.]

2 – It is helpful to have the concepts of the mental functions of (1) "splitting-and-idealization"; (2) "splitting-and-projective identification"; and (3) mother's role in building up a mental apparatus that can "think" about experience.

– Projective processes are of major importance in understanding what is going on in many, if not most, dreams.

3 – The "first task" of infancy: The infant must order its world into good and bad = "splitting-and-idealization", = Klein's "paranoid-schizoid position". When this is inadequately achieved, the result will be varying degrees and types of confusion, esp. about what constitutes proper food, etc. Inadequate and faulty splitting-and- idealization can also lead to primitive and excessive persecutory anxiety. [See Paranoid Schizoid Pos.: Module Two, Part Two of MKA]

A common byproduct faulty splitting processes early in life is that there remains a confusion of what constitutes proper "adultness". One regularly sees this confusion in dreams, often where size or power is confused with emotional maturity. In contrast, excessively rigid splitting-and-idealization hampers further emotional growth and development.

4 – The "second task" of infancy: To develop further, the infant has to undo the extremity of this splitting-and-idealization to bring the "ideal" and "bad" halves of the object together to create a whole, integrated view of mom, etc. This results in having mixed (i.e. ambivalent) feelings toward the same person (a developmental capability that commences in the middle of the first year of life). The infant can then develop the capacity to see how it treats it's loved figures, and then take responsibility for any mistreatment of them. This leads to the development of a capacity to tolerate the guilt of injuring the loved object in phantasy or reality, and develop the capacity to make repair of the damage out of concern for their welfare (= Klein's "depressive position"). [See Depressive Position: Module Two, Part Two of MKA]

5 – A model of "manic defenses" is needed to depict the defenses that develop in relation to Klein's depressive position. These are designed to avoid taking responsibility for damage done (usually done in UCS phantasy) to one's "good" objects both internally and externally, especially where early feelings of guilt were excessive, or because envy made repair difficult (i.e. too much hostile resentment toward a "good" object).

They historically have included a triad of attitudes. The object of the potential guilt is devalued and held in "contempt", simultaneously it is "controlled" so that it is not capable of being seen as separate, and then where unconscious envy is a part of the package, it is "triumphed" over, usually by unconsciously projecting hated baby parts of self into the object so that it is seen as inferior, etc while taking the desirable, grown-up qualities for oneself. [See Manic Defense: Module Two, Part Two of MKA]

[Dream #7: "The dream starts with me at my old job … there is something about me coming to see you – but you are my optometrist or ophthalmologist – my eye doctor. I am coming to get new glasses or contacts. I walk in – it's set up like an optometrist's office and the first thing I notice is a pint of vodka or gin. I thought gee – Chris must be having a drink or taking a nip during the day. There was no label on the bottle. I'm on friendlier terms than in reality – I say I need new contacts – so you take my glasses and do something on a machine and give them back to me and say this should be better. I thought wow – he can do this and I was flirting with you. I rubbed my leg against yours – as if this was perfectly normal."

Comment: This dream has two key elements, a denigration of the analysis and analyst, and a manic denial of an unequal, therapist/patient relationship where the patient is dependent on the analyst for needs she cannot meet on her own. The analyst is now degraded to an alcoholic, maybe not even a medical doctor, who uses a machine instead of his mind to do his work, and who is on an equal, erotized footing in an

erotic transference that denigrates the proper psychoanalytic feeding relationship of the baby part of the patient to the analyst/mother.

This dream occurred in the latter part of the analysis as the patient was becoming more clearly aware of envious competitiveness that had been split off and denied for years while being the good, dutiful daughter.]

6 – A model of the emotions of "separation, jealousy, and envy", and their relationship to any person (but originally with mom), both at a very early "part object" level, and at a later whole object level (i.e. the Oedipus complex).

Separation = This is ushered in as a lifelong major issue starting with the hugely impactful experience of birth. It will remain a key issue with which the "baby core" of the personality struggles. The biggest trump card in dealing with this emotion is to entirely reverse the process of birth by becoming an "unborn inside baby", an issue that is often most clearly depicted and exposed in dreams.

Jealousy = A three party triangular relationship, at a whole object level, based on love, in which one person wants the love of a second person for himself and does not want the second to give it to a third.

Envy = A two party relationship, at part object level, more closely linked to hatred, in which one compares oneself to another in terms of a quality, capacity, or possession, and finds the comparison very painful.

[Note: It is not the "envy" itself that is so destructive. The destructiveness is a result of the defenses against it because envy is so painful. Although the infant can defend against it by denying it, projecting it, etc., the quickest and easiest thing to do is "spoil" the envied object so that it is no longer enviable. This does so much damage because the spoiling must by necessity alter and harm the object's desirable, good characteristics and thus deprives the envious individual of having anything properly "good" to value, look up to, and receive goodness from that person.]

8 – It is crucial, for dream interpretation of destructive elements in a personality, to have a model of a "narcissistic personality organization". In such states of mind, the "bad" part of self gets the "good baby parts" of self to join up with it, and they all "turn away" from the "good parents and good family", both internally and externally. This is also something that is commonly depicted in dreams in a manner unavailable to conscious awareness, often giving credence to the existence of this organization in dramatic ways in dream life.

[Dream #8: "I'm on an island – people live nice comfortable lives on one side – but the other side over the mountains is forbidden, off-limits, dangerous. A pirate ship is marooned there and the water is shark infested or for some reason they can't leave the ship. I'm curious to see what is on the other side of the mountain and a young woman agrees to take me to see what they are doing on the forbidden side. I see the ship in the water and row a boat out in the water which I can see is rat infested. As I get close to the boat I see that these are mean, violent guys who will kill me and so I turn the boat around and wake up."

Comment: This dream vividly depicts a narcissistic personality organization. The patient had been making progress in his treatment for a year, had this dream, and then quit treatment a week later despite his therapist's attempts to interpret a return to an old, destructive personality approach to life. What is interesting is the confusion of good and bad with a "young woman" essentially luring him to the dark side of life. The threat of brute force by the bad guys, if he betrays their influence in his personality, has him consciously turning around in the dream but in external reality he is knuckling under to the destructive bad part of self. His quitting treatment represents a return to the narcissistic personality organization that got him through his disturbed childhood. That organization is now threatened with extinction by the treatment and is therefore fighting for its life.]

9 – A model of "anal omnipotence" is an absolute must to really understand certain aspects of dream interpretation. The model I use is that the infant, when in distress that is not being relieved by a good parent who is available, turns to its own body and bodily products to comfort and sooth itself until the good parent returns to relieve the distress. Where good objects are felt regularly to be unavailable, or where unconscious envy of them is too intense, then there is a hypertrophy of this "turning to one's own body and bodily products".

The anus, buttocks, and poop have dramatic appeal. They have abundant sensation, an orifice leading to the interior of the body, a round shape like breasts, and deliciously smelly products that are moldable into anything you wish them to be. But most importantly, the baby who has so little, never runs out of poop, and the whole region is never more than an arm's length away.

It is very common in treatment for such states of mind, and their attendant behaviors, to be reflected in dreams before the patient will admit to them, often because of shame and persecutory anxiety. Anything dark, dirty, smelly, emanating from below or behind, "things" idealized in place of people, riches taken from the ground, etc. are all likely to have a link to anal omnipotence.

[Dream #9: "…I was walking along a ditch bank, not much water in the ditch, when I saw a coin in the mud. I bent over and reached down in the mud and pulled it out. I wondered if there were more and reached around in the mud and found a whole bunch of coins. I was really pleased and looked around to make sure no one else saw me and might try to take them if there were more there. I woke up in a really good mood."

Comment: This is anal omnipotence personified, early in an analysis. The patient can make anything he wants or needs, with his own bottom, which is never more than an arm's length away. What could be more joyous!]

Tips for Thinking About the Manifest Content of a Dream:
1 – Examine its "overall structure" in a concrete, literal sense:

– First note the "location" in which the dream takes place: Is it on the inside or outside of a building or structure, in front or behind, upper or lower, north or south, etc.

– Note the "number" of elements or figures: The infant is involved with pairs of mom's body parts and in triangular relationships to people. The number of anything often aids in distinguishing part versus whole object levels of phantasy.

– It is always useful to note the "function" for which something is being used including whether or not it is a "proper" function, or a "perversely" distorted or misused function.

2 – The "cast of characters" in the dream:

– First note the "age" or "size" of characters in the dream, whether human or animal. If they are similar to the dreamer, then they should be considered to represent parts of self or siblings. If the characters are older individuals or dramatically larger, they are likely to represent versions of the parents. If they are much younger or smaller, they should be considered to possibly represent mother's other babies (both unborn and/or born).

– One should next note the "qualities" of these dream figures, i.e. the key qualities they have at their essence. Is the dream portraying such emotional elements as destructiveness, envy, confusion, paranoid anxiety, turning toward or away from "goodness" and constructive development, etc. It is often useful to try to distill a figure down to his or her "essence" in order recognize what they are representing or symbolizing in the dream.

Note: All of the characters in a dream will be linked to the "internal family" in some manner. The parts of self, versions of mom or dad, or representations of siblings are usually represented by other figures. The elements or qualities found in these figure may have been projected into the figure, or alternately the figure has been selected because it symbolizes something needing representation. The greater the difficulty the dreamer has in accepting or acknowledging his or her feelings about these internal family figures, the more likely these figures will be represented by less obviously recognizable characters in terms of "relatedness" to the dreamer.

– In patients who are turning toward a "narcissistic personality organization", it is common for all of the characters to represent parts of self, "good" parts versus "bad" parts, and "adult" versus "infantile".

[Dream Example "#10: "There were two penises together touching each other". Analyst asks for more details. "My penis was next to another penis – they were side by side – the other one looked the same as mine."

Associations: – "It seemed like one penis was going to feed the other – like ejaculate into it, it doesn't make sense there would be two penises side by side."

Comment: This rather perplexing image is a type of dream that is greatly aided by "speaking baby". This man had a very narcissistic mother and felt very abandoned by her as an infant. His image of his mother at a very primitive level was apparently that the two breasts went off together to feed each other instead of feeding him. His solution was to equate his penis with her breasts and have his penis become a feeding organ.

As a teenager he had masturbated very compulsively and had this dream while I was on vacation. The dream seemed to represent how his masturbatory activities achieved a sense of self-sufficiency by being equated with his mother's breasts. Whether the other penis was mine was something that was difficult for him to think about (although I suspected that might be the case) as he was heterosexual in orientation and a homosexual phantasy was too disturbing to contemplate. In any case, it seemed to represent "self-sufficiency" and denial of baby neediness.]

3 – Relationship to "reality":

– Is the dream depicting the choice of a magical, omnipotent, or evasive solution or approach to a problem/issue at hand?

[Note: Since "masturbation" is the most common potentiator of an omnipotent state of mind, look for repetitive movements, anything going in and out, up and down, etc. that may indicate masturbatory activity performed consciously or unconsciously.]

– Does the dream evidence "grandiosity" for curing smallness, insignificance, dependence, envy, etc?
[Note: Flying is almost NEVER a good sign in a dream. It commonly depicts a massive denial of being restricted by reality, i.e. having your feet on the ground. It is often meant to cure dependence and/or denying the limitations of being human, and particularly being a baby.

– Denial of "caring or guilt", i.e. "manic denial" of the psychic reality of damage done is very commonly depicted in dreams to cope with the pains attendant to caring about another human and admitting it to oneself.

– "Unconscious envy" often leads to an alteration or misrepresentation of a person or thing so as to spoil its enviable qualities. This is often done to a figure standing for parents and/or the therapist.

– A more “healthy, realistic” depiction, by contrast, of concern for someone or something, etc., often after insight and growth accomplished by the work of therapy, is most commonly seen later in analysis.

4 – The “emotional tone or mood” of the dream:

This is often a key element in a dream. It may be subtle, it may be denied, it may be in contrast to or even contradict the manifest content, but it is always arguably the most important aspect to consider when looking at any dream.

– The emotional tone may be linked predominantly to a recognizable “feeling state” like anger, sadness, guilt, confusion, etc. Sometimes the absence of an emotional reaction to something that should be evocative is the issue.

– The emotional tone may be one of grandiosity or omnipotent wish fulfillment or denial of reality.

– The tone may be a function of damage repair, guilt, or “manic” denial of such feelings.

– It is often useful to distinguish in dreams with extensive persecutory anxiety: does the persecutory anxiety result from (1) an attempt to evade a piece of reality through denial, procrastination, etc.; or is the persecutory anxiety more linked to (2) destructive phantasies or urges (and/or the projection of those urges into external reality).

[Dream #11: “…I showed up for my final exam in a math class and I couldn’t find the class and I felt horrible because I realized I hadn’t studied, I hadn’t gone to any of the classes all semester, and I knew I would fail…”

Comment: This is the quintessential type of dream about the persecutory anxieties and depression that are generated when one is manically running away from psychic reality and refusing to “add it all up” and face what is going on inside one’s unconscious inner world and then dealing constructively with external reality.

In this case, I asked the patient what he felt he might be avoiding and without hesitation he said “visiting my parents”. We explored why that mattered so much and it led to a fairly guilty discussion of a feeling that he wants to be a good son but they always ending up “bugging me about when are we going to have a baby?. That, in turn, led to a deeper exploration of his ambivalence about giving up his current lifestyle to make the sacrifices necessary to become a parent. An exploration of that brought out a deeper feeling that he had never really wanted to grow up and take on life’s responsibilities.]

5 – “Turning toward or turning away” from mental health, goodness, and developmental growth:
This is a major element in dream interpretation. It is often a function of mental pains linked to separation, jealousy, envy, guilt, fear of loving dependence, etc. that are evoking a magical, omnipotent reaction at a deeply unconscious level. It is common for “negative transference reactions” and “therapeutic impasses” to be foreshadowed in dreams long before the proverbial crap hits the fan.

By contrast, growth and development, when sincere and structural, will also be depicted in dreams, often lending reassurance that the growth is taking hold in the individual’s psychic structure.

– “Narcissistic personality organization” [a la Herbert Rosenfeld and Donald Meltzer] is probably the most important model needed for understanding the negative trends developing in an individual and manifested in that person’s dreams.

– “Anal omnipotence”, which regularly goes hand in hand with the omnipotent “self-sufficiency” of a “narcissistic personality organization” is usually depicted in dream life when the patient is too ashamed to consciously acknowledge it in their waking life. It invariably involves something dirty, dark, smelly,

"behind or rear", clearly not nutritious or growth promoting, secret or very private, backward, improperly configured, perverse, etc. toward which the patient is turning.

6 – Always look for evidence of the "therapist/therapy" being represented in the dream (i.e. "transference"):

– For example, when a patient is in analysis on the couch, anything taking place behind the patient in a dream or on the patient's head or shoulders, etc. needs to be considered in relation to the seating relationship of the therapy.

– Whenever someone is "sitting in judgment" of the patient, or being critical, or being helpful, etc. it should be considered for linkage to the treatment.

– When a patient has multiple sessions per week, consider those as represented in the dream by a similar number of figures or elements.

Psychotic Dreams:
1 – There is a distinctive quality to dreams that have a psychotic underpinning. The dream usually has an element of distortion of reality that is palpable and occasionally may be disturbing in its crazy or bizarre quality. Sometimes it is more subtle and embedded in a matrix of "pseudo-reasonable" stuff, often reflecting the patient's denial of their underlying disturbance.

When thinking about the psychotic aspects of a dream, it is important to remember that a human can have a walled off area of "craziness" in the baby core of their personality that does not show up in their ordinary daily functioning. It may only be activated when having extreme emotional pain or stress. In other words, a person does not have to be overtly psychotic for there to be a psychotic element in their dreams.

[Note: When a patient is actually acutely psychotic, they are commonly by definition unable to distinguish a dream from a delusion from external reality so that it is questionable as to whether they are having a dream or a hallucination (i.e. internal reality projected into the outside world.]

[Dream #12: "Weird, terrifying dream – in elevator – doors open – grandpa said You are special in other ways that people can't see in you – whether you think it or not. The doors open and I'm in a really weird mental institution – like art gallery – guided in pairs – I'm screaming or weeping or laughing. One painting was this eye – the part around the iris is blood red and I got sucked into the painting. Then I was in my room and like a series of days it was done. I'd come in and not remember it. Every day it was more finished. I got scared – what now? Then someone came through the painting – a big black man, arms out vertical – like floating – standing much taller than me – like up to the ceiling. Then I get pushed out of the painting and warped somewhere. Then I was back in front of the painting – like the Cheshire Cat. I was screaming – then I see another patient who was screaming. I say this is enough for today and a woman asks me if I can go further…it was sort of like rehabilitation, like to hell and back – makes you more of a person."

Comment: This is a psychotic dream in a person who was not actually psychotic at the time of the dream but had had a very disturbed infancy and childhood. It has very omnipotent, magical elements in it; extremely intense, terrifying feelings and images; and extreme time, space, boundary confusions. Interestingly, he seems to have a capacity to limit how much he stays in contact with this side of his personality as depicted by saying "..this is enough for today.." even though the analyst mother asks if he can "..go further..".]

2 – Extreme denial or alteration of reality is perhaps the most elemental component of a psychotic aspect to a dream. This is usually a result of "massive" projective processes.

– Turning time backwards or forwards just because you wish to evade something painful.

– Altering the passage of time, gravity, and any other limitation of reality often emanates from the most disturbed elements in the personality.

[Dream Example #13: "…I looked at the clock, which said ten, and I thought that can't be because I'll miss my 9:30 appointment and then I looked back again and it was only 9:00 and I was relieved…"

Comment: This dream represented the psychotic aspect of a neurotic patient who, when reality became too painful, simply went temporarily insane and altered reality.]

3 – Severe boundary confusions:

– Massively altering or confusing identities by getting inside or taking possession of someone's identity.

4 – Fantastical omnipotence of any sort should be contemplated as being more disturbed in its nature.

5 – Extreme violence fragmenting things:

This may show up as Bion's "bizarre objects" that have been fragmented and then projected so that they are nearly unrecognizable in relation to their origin, but they are nearly always very persecuting. They might show up as a mass of dangerous insects, animals, aliens, etc. or a cloud of poisonous, minute particles. The fears and anxieties that these fragments generate are helpful to understand the motivation embedded in what was projected, e.g. are they devouring, poisonous, biting or stinging, invasive, etc.

[Dream Example #14: "…I noticed a bump in the back of my hand and I squeezed it and all of a sudden bees started coming out of it and I was terrified they would start stinging me…"

Comment: When baby elements from one's internal world are violently expelled, projected, split off, fragmented, etc. they often return as minute little persecutors, threatening to do back to oneself what the projector had as urges or motives before that aspect of self was disowned and violently projected.

In this patient's case, the patient was very distressed to see a nasty, envious side of his personality that was always making "biting" remarks and "stinging" criticisms about others. He had always seen himself as the good guy while despising his father's "mean" streak and feeling triumphantly superior to him.]

6 – Extreme concreteness in the use of the dream in the therapy sessions, or reaction to the dream upon awakening, may reflect its relationship to a psychotic aspect of the personality. This may be reflected quite concretely or alternately more subtly by a patient who feels a dream is telling him or her "what to do" in the world.

<u>Tips for Thinking About How the Patient Presents or Uses the Dream in the Session</u>:

1 – Does the patient have any "hunger" for understanding the dream?

– It has been my observation that therapists often overlook this issue. They may have a patient that brings in dreams regularly, even every session, but is clearly making no use of them, just dutifully depositing them in the therapist's lap. In contrast, the most "talented" patients learn a great deal from their dreams and develop an increasing capacity to interpret their own dreams over time, using them to prepare for their own eventual "self-analysis" in anticipation of no longer being in therapy.

2 – How is the patient "using the dream" in the session (i.e. process vs content)?

– Is the patient only bringing dreams to “please” the therapist/parent. This may recreate childhood rivalry with siblings, etc. but is shallow, often a product of patients who do not really “believe” in the idea of an unconscious inner world.

– Is the patient “flooding” the session with dreams, often not waiting for or seeming to want insights about them. This may be a product of pure “evacuation or dumping” of the unconscious contents “into” the therapist who is then left with complete “responsibility” for doing something with them. This can be the result to an acute situation of overwhelming emotion, but is more often a characterological pattern of “evacuation” as a preferred method of coping with unwanted emotional states. The therapist is a “toilet breast”, but never a “feeding breast”.

These patients often take years to convince that they need to acknowledge and take responsibility for their own unconscious inner world. They not infrequently feel that mom or dad should do all of that work for them, as if they can wear diapers forever and poop whenever they feel like it.

– Is the patient “deadening” the process of dream interpretation by offering no associations or thoughts that would be an aid in the dream’s interpretation. If this type of process is chronic, it is likely to reflect an ongoing attack, often out of envy, on the analyst’s creativity in sessions and originally the parent’s creative intercourse that could produce a new baby.

[Dream # 15: “My husband and I were in bed and about to be intimate. Somebody was outside the bedroom door and was feeling mean and envious. The person could see through the door. Then the scene shifted and I was out on a the field of an Ivy League school where the teams were playing and a man, maybe the coach, was in a bad mood and arguing with another man.”

Comment: She felt significant relief when I said that a part of her is upset when anyone is lovingly enjoying being together with anyone else (the couple, the teams playing) because there is always someone who is feeling left out, angry, and destructive.

Earlier in her treatment, her anger at me for having everything she needed had led her to often come into sessions with five or six dreams, try to present them all, and then feel unsatisfied when whatever I said did not leave her feeling “fixed” or “completely relieved”. It was only when we repeatedly addressed the process of how she brought in dreams and “dumped” them, with little being constructively done with them, that she slowly began to allow a more proper intercourse about her dreams.]

– Does the patient associate “mechanically” or make “guesses” about the dream’s meaning, while having and using precious little contact with their own emotional states that would greatly aid in seeing the dream’s meaning. This is likely to reflect a rather “schizoid” relationship, internally, to emotional states. It may be a product of growing up in an emotionally impoverished infancy and childhood, or a massive retreat from overwhelming emotional pain in childhood. However, it also important to distinguish those situations from one in which an ongoing unconscious attack on the parental relationship is taking place, out of envy and/or jealousy, in which all emotional life is being stripped from the parents’ relationship to each other, so that nothing creative is produced as a new “baby” idea.

3 – What does the patient do with your interpretations?

Does the patient gain insights that are used for future thinking about themselves, as evidenced outside therapy and in therapy, for example in their increasing ability to understand and interpret aspects of their own dreams?
In contrast, does the patient continue to dream the same issues and show little evidence of an ability to recognize the same issue appearing again, maybe for the “nth” time?

It is often useful to ask in the following session, if an appropriate opportunity arises, what the patient took away from a dream interpretation in a previous session. Not so much as a test, but more as an indication of

how much the interpretation "made sense" to them in a way that they could hold on to it. They need not remember the dream or its interpretation to have gained some "unconscious" insight, but it is still interesting and at times revealing to see what they found of value or held onto consciously.

Transference Interpretations versus Reconstruction of Childhood:
1 – As a general rule, interpretations about the transference relationship with the therapist will have the greatest likelihood to lead to "emotional growth" and structural change in the personality. Virtually all dreams can be taken up in relation to the transference if the therapist works at thinking about how the dream could relate to the therapy and the relationship with the therapist. This may be in the dream content or more in the process of presenting the dream.

[Dream Example #16: A patient who had been in therapy for a couple of weeks had the following dream: "I had a weird dream last night. I was holding a gun in my hand and noticed there was writing on the side of it. I looked very closely at it and saw that it said 'SHOOT YOURSELF'. The patient had no particular reaction or feelings about the dream other than to say it was strange.

Comment: In contrast, I had a very strong reaction. I thought it represented a strong suicidal element in the patient's personality. The patient was actually quite depressed. I felt that she was projecting into me a part of herself that she could not bear to experience. Coming to therapy provided the possibility that I would be a mother that could deal with the powerful "death instinct" elements in her personality that she had always kept at arm's length.

I insisted that we meet daily, adjusted my fee to fit what the patient could afford, and saw the patient five days a week from then on. I had to put her sessions at the end of each day, as an add-on, as I had only two open times we could use during my regular schedule. The patient was cooperative, relieved, and ended up in a successful long term analysis.]

2 – Most dreams have elements that can be related to the patient's external life, the patient's childhood, and the therapy relationship. Because of this, it is usually helpful to start with whatever element the patient seems to have the most immediate "emotional" connection or reaction. This commonly takes one into the area of the patient's current external life, less often back to childhood or the relationship to the therapist.

I find that a dream that is evocative can ultimately be taken up from all three angles, often clarifying for the patient the totality of how their childhood, current life, and relationship with therapist all fit together in a logical fashion because their "unconscious inner world" is the common denominator to all three.

The reconstruction of how the patient viewed his or her infancy and childhood gives an "anchoring" quality to the therapy and their understanding of themselves. But it is desirable, to the degree possible, to always include an understanding of how the patient is reacting to the therapy and therapist because that is virtually always the most emotionally "immediate and alive" element, even if obscure to the patient's conscious awareness.

Technical Issues in Dream Interpretation:
1 – "Introducing" new patients to the dreaming process:

I find it helpful to tell new patients that dreams are actually a representation of how their unconscious inner world is "thinking" about and trying to "cope" with issues of emotional importance at the moment. I will usually follow this up in the very first session by asking if they have had any repetitive dreams or if they had one they remember from recent times.

This gives me an opportunity to demonstrate the significance of dreams right off the bat. Some patients like the idea of looking at their dreams, some say they "never dream", and very occasionally I get a patient who thinks the whole idea is preposterous. In the latter case, I am at least forewarned about a side of the patient that is likely to be against the idea of an "unconscious inner world", the primary arena in which I work.

2 – Deciding to interpret "content" versus interpreting "process" (i.e. the use to which the content is put in the session by the patient):

Occasionally a patient is acutely or chronically using the presentation of a dream for some unconscious purpose other than to gain insight. When this is the case, the use to which they are putting their dreams becomes more important to address than the content of the dream, no matter how evocative the content may be. We can always go back to the content at a later date.

3 – Clarification of "content" – versus – asking questions about "meaning":
The Kleinian analyst Albert Mason is well known for suggesting that asking the patient questions about the possible meaning of a dream is often an evasion of the therapist's inability to understand the dream and/or the process taking place. It is difficult for most patients to ever "plum" the depths of their own dreams and interpret them, even after years of treatment.

Thus, asking a patient "What do you think the dream means?" is different from asking for clarification of an aspect of the actual content that was not clear to you in the presentation or that you can't remember because the patient is presenting a long dream. Rather than ask the meaning, which the patient will often volunteer if they have an idea in mind, let the dream be presented, take it in the context of the entire session, let the session unfold, and await inspiration as to what to do with the dream and its presentation.

4 – Asking for associations is usually not a good idea for two reasons:
– First, all that has gone on in the session prior to the patient mentioning that they have a dream to share, and then reporting it, should be taken as one big association to the dream.

– Secondly, if you have to ask for associations, the more important question is why do you have to ask? Why isn't the patient offering associations, context, etc. to aid in the process of understanding the dream? The therapist has to explore these "process" issues now before going back to the "content" of the dream.

5 – Selecting key elements, issues, or images on which to focus:
– Dreams are a reflection of "character patterns" for coping, as well as "acute emotional issues" at hand requiring attention. Some patients regularly bring in long, convoluted dreams. At other times, the therapist might feel that one area of the dream is of particular importance in the current context of the treatment. In either case, it is often helpful to narrow one's focus and do a more detailed exploration of a specific issue or area.

– The choice of specific area to focus one's interpretive efforts is typically "context" driven i.e. mood, external circumstance, etc. in patient's life at that moment. Sometimes the dream represents a particularly "ripe" opportunity to highlight an issue the therapist wishes to reinforce.

– As a general rule, it is better to digest one idea or element than to overwhelm the patient with so many ideas that they lose all of them. It is often useful to hold on to particularly "evocative" or "instructive" dream and come back to it in future sessions.

[Dream Example #17: Four variations of a dream of "riding in a car":
– Variation A: "I was in a car with my parents but nobody was driving the car. I was in the back seat but somehow I took over driving it."

Comment: This dream led to a discussion of his essential view that his parents were irresponsible, self-centered and had left him, an only child, to fend for himself from early in life. The image of being in the back seat seemed less to represent anal omnipotence, although there was some of that, but more to be a pun on how his existence took a "back seat" to his parents' focus on themselves. What was particularly prominent in his associations to the dream was how incompetent and inadequate he felt in life and how he felt like he was put in an impossible position in life, "You can't drive from the back seat!"

– Variation B: “My dad and I were driving somewhere in a car. He was in the passenger seat and I was in the driver’s seat. I realized that my feet wouldn’t reach the pedals and I woke up.”

Comment: I had been commenting to this woman for some months that she didn’t seem to want to allow any dependence on me or the therapy, often cancelling sessions at the last minute, asking for changes in time for some important reason, all while consciously thinking that she valued the once per week relationship with me. This dream was our first breakthrough and allowed me to demonstrate to her that she feared giving up control even though she was too young, according to the dream (feet would not reach the pedals), to be running things on her own. Multiple associations of needing to feel self-sufficient, with problematic consequences, aided me in convincing her to increase to twice a week. The therapy finally settled in to doing real work.

– Variation C: “I had a funny dream last night. I’m hitch hiking and I get in a car with a guy who sort of looks like Dennis Hopper from “Easy Rider”. He asks if I want a ‘hit’ from his cigarette and I say no I don’t smoke. We end up in some part of Mexico and I am thinking I will have to call in sick to work tomorrow. There was more to it but I can’t remember it.”

Association: “I wonder if this has anything to do with Jill (a younger employee at work) sending an email invitation that Meredith (his boss) told me about. The invitation was her to Jill’s baby shower (Jill is pregnant and due in a few months).”

Comment: Patient is the second of five in his family of origin, in his fifties, and never married. He goes on in this session to talk about work and does not go back to the dream. After about ten minutes I start to feel irritated that he has just dumped the dream in my lap, giving me no help or showing any interest in it when it is actually a rich sounding dream.

I mention to him that he seems to have lost interest in the dream and is leaving it up to me to think about it. Since I had a summer vacation looming, I wondered if he felt abandoned by me, as if my vacation was me going off to have a baby.

Later in the session we had a profitable discussion about how alone he often felt in life, and how when in that state of mind, he would go out on his back porch and have a cigarette even though he “didn’t smoke”. This would usually happen on weekends.

We came back to this “Easy Rider” dream a number of times as it compactly conveyed his rage at his mother making so many babies, leaving him abandoned, forcing him to turn to his own bottom (Mexico) and feed himself shit (cigarettes), and let the “death instinct” – who care about life or anything – part of himself take over and run his life, with his murderous urges split off (the guys who kill the Jack Nicholson character in the movie).

On a more subtle level I think this dream depicts a “narcissistic personality organization” component to his inner world that has undermined his growth over the years. It is as if he is chronically playing “hooky” from life by taking the “easy rider” way out, leaving all responsibility for caring about growth up to analyst/bosses while he “calls in sick”.]
– Variation D: “I was parked outside school waiting to pick up my daughters. I was driving a really fancy convertible, like maybe an old Cadillac convertible, really big, and I had the top down. This next part is kind of weird. I was having a martini, sort of celebrating the new car. The girls came and got in and we drove home. My wife came out of the house onto the driveway and saw the martini glass I had left on the front seat. She went all crazy and I said
chill out, I was just celebrating the new car, I am not drunk. I thought to myself, she is such a bitch, she spoils everything.”

Comment: This essentially “manic” dream, denies all sorts of destructive urges and irresponsibility (driving his children while drinking) and projects all responsibility and blame into his wife/mother who he provokes

with the martini glass. He is completely out of touch with this while focused on the excitement of the Cadillac convertible.

We spent some time in the session focused on his denial of responsibility which seemed to put me increasingly into the position of "lecturing him" on his irresponsibility and provocativeness. I began to feel fairly irritated with him and realized I needed to take up the process between us in terms of his view of me as the container of a bad version of a parent who only criticized him and never saw life from his point of view.]

6 – Always start with the most "straight forward" and obvious implication or issue in the dream:
I have been impressed over years of doing supervision at how often a therapist assumes their patient sees an obvious "interpretation" and so the therapist looks for something more obscure or hidden. I have learned after decades with my own patients, never assume the "obvious" is in fact obvious to the patient, or that they can't benefit from one more review of it. After all, they unconsciously chose to put it in a dream again for some reason. It almost always indicates there is still more to understand regarding whatever the issue is.

7 – Break interpretations into digestible, logical components:
I have often been amazed at a therapist making a five minute interpretation of a long dream, and I can't follow it or hold on to it, so what must have happened to the poor patient? I am guilty of making overly wordy and detailed an interpretation, and find myself retracing the entire process as a "do-over" to help the patient.

As Bion said about the interpretative process in general, I find it useful to make preliminary "sighting shots" regarding the dreams possible meaning. I may highlight a particularly evocative element, the dreams tone, or even offer a couple of simple, possible "meanings" to aid in the patient's "reverie" about the dream.

8 – Most dreams can be interpreted in "layers":
This can mean a number of things. Most obvious or accessible to consciousness is one layer. Things about which you feel more speculative, or may distract a bit from the main theme but seem important, might represent a second layer. Things that may be more difficult for the patient to accept, or require some digestion and acceptance of the initial themes of the dream, may represent a third layer.

A slightly different meaning to the word "layers" can be related to the "developmental level" to which one chooses to focus. For example, it is not uncommon for a dream to be depicting and working on a current life issue that has an infantile prototype. After the current level has been discussed it is often helpful to go to the deeper, earlier, more primitive layer of meaning to add to the understanding of the current, external life one.

It is possible to do this layering of interpretations and discussions in the same session or in successive sessions.
[Dream Example #18: "I was saying to my daughter that these schools are too dark for a proper learning environment."
Context of dream: Dreamer had been upset and depressed about a project going poorly at work. She had been lying down at home on the living room couch that evening and her daughter said "Mom – you look dead."
Comment: This dream can be interpreted at multiple levels and/or areas:

– At an external reality level she is concerned about her mothering of her children (she is too "dark", i.e. depressed and pessimistic) interfering with her children's capacities to see life in a "good light".

– At an internal, psychic reality level she is being like (i.e. identified with) her damaged internal mother which is interfering with her ability to move ahead in life.

– At an infantile, genetic history level, her mother was very disturbed and was unable to provide a proper learning environment for the patient to grow in a healthy manner. The patient was afraid she herself would never escape the orbit of her infantile darkness as evidenced by her struggle at work that day.

– An even more primitive offshoot of that was a baby phantasy that she was bad and her mother was unable to love her and "see her in a good light".

– In relation to therapy and the transference, the dream could be taken as a complaint that I am not fixing her so that she has not been brought to life on my couch. It might even depict an envious attack on the "light" of the analysis, preventing a proper learning environment from being created by me.
We actually took up the dream as relating to recent discussions regarding the inability of her "adult" self to look after pained, "good" baby parts of herself that wanted to grow, but were being consistently undermined by a highly competitive, enviously greedy "bad" part of herself that was particularly operative because a rival at work won an award.]

9 – The patient is almost always the "ultimate arbiter" of whether or not a particular interpretation of a dream "feels" correct and helpful.

Most patients will display a physical or emotional reaction to a correct interpretation of an aspect of a dream. Even when they say the interpretation doesn't feel right, or they have no reaction even though the therapist suspects the interpretation is in the correct ballpark, patients will often acknowledge the interpretation's correctness in a future session.

[Dream Example #19: "I was parked on a street in front of a flower store to buy a dozen roses for my wife. I decided to make sure the trunk was not messed up so I could possibly put them there. As I was getting rid of the junk – I found an old [marijuana cigarette] wrapped in aluminum foil. I said to myself "I don't need this anymore, I'll throw it away with the trash". I walked over to the trash can to throw it away and I put it in. Just at that moment a black man appeared and began shooting at me trying to kill me. I started running for my life, I woke up in a panic."

Comment: This dream occurred at the tail end of a long analysis in which great effort had gone into dismantling a "narcissistic personality organization" linked to "anal omnipotence" as manifested by, among other things, chronic marijuana smoking which had been given up some years earlier. The patient was trying to preserve a loving relationship to the good family internally, and give up all destructive omnipotent maneuvers.

The dream graphically depicts the idea that the "bad" part of self feels it is being "murdered off" when the "good baby parts of self" turn toward goodness, the "adult" part self, and "good" parents internally and externally. The "bad part of self" starts shooting immediately, as the marijuana joint is discarded in the trash. That act, by the adult self, is seen by the "bad part of self" as tantamount to killing off its sphere of influence and the narcissistic personality organization. Thus it is fighting for its life.]

<u>Counter-transference Issues in Dream Interpretation</u>:
1 – Donald Meltzer highlights three CT issues:
– Fear of Invasion: He highlights how intimate an experience it is to share the details of a dream with someone, and how the dream may have little "fish hooks" of emotional reactions that stay in the mind of the therapist. This is particularly true where the recounting of the dream projects a very disturbed part of the patient into the therapist's mind.

– Dread of confusion: This does not refer to a "confusing presentation" of a dream but rather where the dream contains evidence of deep confusions in the patient. These might be regarding what is or is not proper food (usually linked to confusions about bodily zones and their products), boundaries between individual's obscured by projective processes, envious reversals and perverse twisting of the proper order of things, confusions about ethics and morality, etc.

Where any of these is relatively subtle in a dream or pervasive as a confusion in a patient, the therapist may find themselves opting for some arbitrary, rational method of dealing with the dream, in effect prematurely, rather than awaiting an emotional understanding that gives a more firm triangulation of all of the elements involved.

– Intolerance of impotence: I would have thought that Meltzer was referring to the feeling of not understanding what the dream is conveying and therefore feeling small and inadequate. But what he is empathizing is the experience one has with a patient who does not really believe in an unconscious inner world and therefore doesn't see dream analysis as more than some "silly game" that the therapist likes, so the patient is indulging the therapist's folly, but with no real involvement in the process.

2 – I think it is important to "remove the pressure" on yourself to make a "complete" interpretation of the entire dream, or for that matter, to understand a specific dream at all. I enjoy dream interpretation and am usually fairly successful at getting some purchase on a dream's possible meaning. Yet I still occasionally have dreams presented where the only reaction I have, usually not shared with the patient, is that "I have no frigging idea what this dream is about!"

Remember that any dream can be interpreted on multiple levels, from multiple frames of reference, any and all of which may have some growth value. Don't expect to make a "complete" and "correct" interpretation of a whole dream very often, if ever.

3 – Often, just trying to say something useful, if not very profound, is the best one can do, so the patient knows we are listening. This is mostly what I did in my first years of private practice where I had many dreams presented to me about which I had very little understanding.

e.g. "The dream seems to show that you are really struggling with your violent phantasies."

e.g. "We need to keep a lookout for more dreams in this area to see if we can get a better handle on what is going on."

e.g. "This dream is helpful because it gives us a sense of what you are trying to deal with in the back of your mind."

4 – Don't be afraid to use Bion's "sighting shots" where you might say things like "I'm not sure if this is correct but this reminds me of …" or "I wonder if this could be about …" and then see what the patient has as a reaction. I find it a common experience to have an association of my own that I don't know if it is only mine, or if the patient will find it parallels their own association, and will find it helpful.

With some patients, dream interpretation is a very collaborative process. However, there are patients who for whatever reason seem to lack much natural capacity to think imaginatively and need constant associative assistance that does not seem to reflect resistance. I think this is more common with patients who tend naturally to be somewhat concrete in their thinking.

5 – In summary, make dream interpretation a fun adventure. Be curious, imaginative, creative. There will always be more opportunities to cover whatever was missed the previous time around!

Section 9 - Dream Case Book

Table of Contents:

Introduction:
There are several points that I would wish to have the reader keep in mind while going through these dream examples:

First, these dream categories are very arbitrary. All of the dreams in each category could fit in other categories to varying degrees. I have put them in specific categories with the hope that they give a flavor of certain types of dreams, how one might think about them, and the concepts they might exemplify.

Secondly, confidentiality and space limitations make it difficult with some dreams to give sufficient information to make the dream's understanding more detailed and thoroughly explained. I am not trying to give a "convincing" explanation to the reader. Dream interpretation is too much a product of the unique, intimate relationship between therapist and patient to lend itself to that sort of conviction. What I do hope for is that the reader will take the time to "bathe" himself or herself with a number of dreams to gradually have a broader feel for this type of thinking about dreams.

My final point is probably the most important one. Dream interpretation is arguably the most difficult thing an analyst/therapist can try to do. It takes years of clinical experience, a broad familiarity with a wide range of models for understanding the primitive workings of the mind and its emotionality, and a lot of imagination. No two experienced and competent therapists would ever come up with exactly the same interpretation of a dream. However, each interpretation would have the potential to grow the patient.

You may or may not agree with my specific approach to a given dream, but I hope the discussions expand your own way of thinking about dreams.

[Please note that I have numbered all of the dreams in this case book in continuous fashion so that they can be referred back to in other parts of MKA as Dream Case Book #…]

Section 1: Primitive, Paranoid – Schizoid Dreams:

Dream #1: "I'm in the mountains in France – like WWII. My patrol goes into this mountain house – it reminds me of a ski chalet in Mammoth with stairs going up the front – I find those houses particularly appealing. We moved in and were living inside, had the lights on, etc. I go outside and see the village which is half empty because many have evacuated. I walking around and suddenly realize the large house next door has been taken over by a bunch of Nazi soldiers. I run back into our house and tell the guys that

the Germans have taken over the house next door and we've got to grab our stuff and leave or we will all be killed. But they've turned into a bunch of babies – they have taken off their uniforms, etc. and are eating cheese whiz. I decide I have to leave them because I have to defend myself. As I am going into the woods I hear the Germans shooting and killing the guys. I kill a deer as I'm escaping and I'm collecting green wood and putting it into a backpack that I will need. I'm pulling the deer over the snow and making little fires to smoke bits of it to eat as I go. I finally get to the top of the hill and can see the bad guys off to one side and the good guys off to the other and I feel safe."

Comment: This dream is simultaneously well organized but highly persecutory and omnipotent. It has an extreme degree of violence that is kept in control by a highly separated and split distinction between the good guys and the bad guys. But there are no good parents around, only "babies", bad guys, and his highly omnipotent, self-sufficient part of self. Mother, in the form of the deer that he drags around, was in reality extremely passive but nurturing in a very rudimentary manner. He can only achieve peace by extremely obsessional splitting maneuvers, keeping dad and mom widely apart, but a price of great persecution. His understanding of proper adultness is missing, and his own violent urges have been split off and projected violently into the outside world, perhaps at the most primitive level into daddy's penis as personified by German soldiers.

Dream #2: "I was a five year old girl, Tim is going to molest me in Mary's room. Mary comes in with her Boa constrictor that has a huge mouth (holds up arms to make two foot diameter circle) and it will swallow up and kill Tim."

Comment: The thirty something woman, who had been in therapy for less than one year when she had this dream, was very concrete, limited in life experience, and awkward in relationships. She tended to project any uncomfortable states of mind, most commonly distributing them into family and girlfriends, occasionally co-workers. Mary is the patient's older sister and Tim is her boss at work who she consciously envies and toward whom she is privately denigrating.

The dream has a rather blunt, unsophisticated quality of "If you do this to me, I'll do that to you". Even though the word "molest" is in the dream, the dream has more of an "infantile" quality than a sexual one, with "big mouths" that "swallow up" to engulf and kill someone if they become a threat. One gets a vague feeling that this was the patient's view of sexuality, and her parent's relationship in particular, when she was five years old, and it has probably changed very little since.

I took the dream up at the level of relationships between men and women, saying that I thought she tended to see those relationships as competitive and adversarial rather than loving and supportive. I added that she had recreated that adversarial quality of relationship at work with her boss, in her own private phantasies. We got into a discussion later in the session about her family of origin and her competitiveness with her dad for her mom's attention, as well as her viewing her parents as having no love between them, when in reality, as far as I could tell, they clearly loved each other even though they argued a fair amount.

I did not have time it that session to take up the dream at the level of the transference relationship with me. The emotional intensity seemed focused on understanding the idea that she tends to see and expect all relationships to be dominated by negative feelings rather than positive ones. However, I felt that all of that would have to be revisited with respect to our relationship, which she clearly kept idealized.

I felt that idealization was partly motivated to keep us from molesting or swallowing up each other, or deteriorating into a competitive, denigrating bad couple (as I suspected was her deeply unconscious internal view of her parents). I also felt the idealization was a way of holding onto something "good" in the face of her doubt that anything good would ever come her way (as her relationship to her mom had been inadequately loving on a consistent basis).

Dream #3: "It was my teeth and they were all jagged with pieces missing."

Comment: This is a very common type of dream that usually leaves the dreamer awakening in a state of dread, as if everything in life has disintegrated and is ruined. The emphasis in this horrible state of mind may be one of feeling hopelessly damaged and wondering if this can ever be fixed. Alternately, the bad mood may emphasize how it will look to others with intense embarrassment and shame.

In either case, teeth are one of the baby's first developments that have the potential for being used constructively (i.e. for chewing) or destructively (for biting). They are scary when they first arrive because they hurt, but they also become a source of pride because one is getting what the "grown-ups" have. Thus they have the capacity to represent growth and development, narcissistic pride, and/or aggression, all in one compact bit of symbolic imagery.

In the case of this patient, who tended to be frightened of his aggression and envious competitiveness, I took up the dream as him struggling with an urge to attack everyone. That mood had arisen as a product of not getting the raise at work that he had anticipated. I said that at a baby level he felt like "biting everyone's head off", including me for not suffering with him (I had given him his monthly bill the day before so in effect I was getting his "raise"). He was now being attacked back by his "teeth falling out", turning him back into an ugly baby (he hated feeling like a disgusting, "shitted up" baby).

I took these points up in our relationship (transference) by asking if he was aware of feeling at times that "I bit off his head" or if he ever felt like "biting off" mine. We ended up in a discussion in which it became clear that he felt that either he or I was feeling critical of the other more often than I would have imagined.

He ultimately felt some relief when the discussion lead to the idea that he was afraid to be a fully potent man, lest it provoke one or the other of us to "tear up" the other, as if there were concretely room for only one person to possess a potent penis. His relief seemed to be a product of the hope that it would be okay for him to grow up to be a man also, emotionally speaking.

Dream #4: "I was being chased by the Predator and I see a girl on the rocks below and then I see a man under the water – just there for a really long time, staying stationary. I jump off – shoot down into the water, then go further than the guy was. I see rocks below me, the floor of the ocean – I could touch it – around one foot away. I see the guy starting up. I follow him. I start spinning in the water – feel I'm not going to make it. I keep swimming up- and the next thing, I do make it. I take a deep breath and then get onto the rocks. And then the guy who was under water says something like, "You did a pretty good job – you go further than I ever did." I say there's this thing that is chasing me and he says "ya I know – he's chasing everybody". And then – I forget what else happens, but then something else happens and we have to run away and a whole bunch of people are trying to escape this – the monster, the Predator. Then that's pretty much it."

Comment: This dream feels very primitive, concrete, omnipotent, life reduced to "scary monster versus good guy". But the dream also has a sweet side to it, boy saves girl, man works with man and they even give each other compliments and reassurance.

I chose to emphasize the transference relationship to me, saying that we seemed to be working well together, going under the surface of his unconscious inner world, and surviving, even feeling good about it. But we still had work to do on a very scary side to his feelings, embodied in the Predator image. I said that it linked to his most violent baby feelings, which we knew he had historically projected into his rather explosive (but not actually mean) father, which he was going to have to face and own, but which still seemed too dangerous to fully embrace. I said that we could expect them to be recreated between us in our relationship, and we could keep an eye out for any times when one of us was feeling mean toward the other.

Section 2: Mom's Body Dreams

Dream #5: “I had a crazy dream last night – It was Dorothy and Todo. I came out of a door at some place. There were two doors, one was Verona and one had Babbs (her mother’s nickname) on it. A teenage girl with short reddish hair takes me out on some sort of guided tour – like on a trip. We go into a place (outside a large auditorium like building) which fills up with people who poke and prod and harass me. I try to drive away but then an auditorium empties out (she associates it to Radio City Music Hall in New York) and a crowd of people block my driving and harass me further. I end up back at the two doors and as I try to decide which door to go through – I remember that I came through the Verona door. But just as I start to go toward it a young woman comes out of it and vomits violently. A liquid spews out across the room so I immediately go through the Babbs door and – you’ll like this – I’m in a tube like a water slide – going in a somewhat thick fluid and I’m pleased to see I can breath and I say to myself ‘I never got to do this before’ [she was a C-section] so I’ll enjoy it and I’ll get to see what it is like. Then I end up in a larger pool of warm water and I enjoy it but I stay in the water breathing under the surface.”

Comment: This patient was an emergency C-section because her mother had toxemia and the infant began to show signs of fetal distress. She and her mother had difficulty bonding in the first few days but ultimately it all was worked out. The patient tended to be shy, and quite attached to her mother growing up.

This dream, early in her treatment, seemed to suggest that life had two choices, be “star crossed lovers” like Romeo and Juliet (the Verona door), where the world is against you and you must ultimately die, or stay fused together and allow nothing to ever change. One can see how her experience of birth, which apparently felt like an overload of stimuli attacking her from all sides (a crowd in frenetic New York City), contributed to her shyness and preference for staying close to mom. When her mom was preoccupied or upset, perhaps depicted by the girl who vomits and cannot be a good “container” (probably her baby “self” projected into and then confused with mom), then the patient apparently felt growing up that she had no choice but to take matters into her own hands and get “unborn” back inside mom.
There is a distinct transference element in this dream, bringing a dream that is very “Kleinian”, that would please me (“you’ll like this..”), with my good little girl’s creation. This dream remained, as one might imagine, a pivotal dream which we revisited many times over the course of her treatment.

Dream #6: “I drive by a building – it is beautiful, it has exquisite apartments with an arch with the name ‘Heavenly Vision’ and I go into an underground parking and see a girlfriend and her boyfriend. Then a man is chasing people and I run. Next door is a men’s prison.”

Comment: This is an interesting dream illustrating a number of elements. It starts with an enviable, idealized vision of mom’s body, a wonderful place to be if you can get back in. This male patient had a very unsatisfactory relationship with his narcissistic mom and aloof dad. He had kept his parents widely split apart in his inner world view of them. This was recreated in a marriage where he was secretly quite denigrating of his wife, who was very attractive, but had turned out to also be aloof. He was chronically feeling angry and deprived, and he masturbated with very hostile phantasies toward women.

This dream laid out the anatomy of his masturbatory activities. He sees the desirable mom/wife (the “beautiful” building with “exquisite” apartments) as something he simultaneously idealizes and holds in envious contempt. “Heavenly Vision” is an expression of this mocking of the positive aspects of this mom/wife representation, as the concept of heaven is something which he does not believe exists and he holds religious people in contempt.

Notice he enters the building through an underground parking structure. This could represent entering mom’s body from the front side (i.e. genital) or the back side (i.e. anus). When I asked, the patient had no idea if it was the front or the back of the building as he “didn’t notice” which, but he did think the boyfriend and girlfriend were probably teenagers in high school.

My interpretation to him was that when he felt especially left out of all of the “heavenly” good stuff that anyone had, a part of him felt that he could make it for himself by masturbating. Then he could become a completely self-sufficient little couple (the boyfriend and girlfriend probably “making out”, which was his

association) and not need anyone else. He was already familiar with the idea of masturbation and self-sufficiency, so in a sense this was old news.

What was not yet understood by him was that when he masturbated, he was also invading mom's body out of frustration and envy. This resulted in a feeling of "stealing" the mom and dad's sexual relationship, and displacing dad, who then became a hostile, retaliatory figure, the "man chasing people".

As the paranoid anxieties become nightmarish at this point, one can see the deterioration of his inner world from life in a world of "Heavenly Vision" apartments, to a "men's prison". While I would suspect that the men's prison represents his hostile exile of dad away from mom, perhaps to his own anus, all I said to the patient was that there was a lot more hostile, cruelty in his masturbatory activities than he realized, and it risked turning all relationships into mean, controlling prisons rather than constructive places for growth. I added that we would probably at times see the same quality in our relationship, me being mean to him or vice versa.

Dream #7: "It felt like a birth dream – a magical quality. I was with several people, one was like a mom at my son's school – she is one the healthiest moms at the school but she looked kind of butch in the dream. We got small – we shrank – going into a tunnel going somewhere, secret and special, kind of elf like. A big man is trying to follow us. He is kind of wizardy – had a beard – was a cross between a street person and a wizard. He had robes on – was kind of magical. We heard him yelling and told him he couldn't come."

Association: "It really reminded me of going back to the womb. We didn't want the grown- up to come."

Comment: As one might imagine from the dream, this is a woman who is prone to consciously idealize relationships, and try to keep negative feelings at bay, usually split off entirely from conscious awareness. Her infancy had not gone well, but her rather shallow mother was decent after she got the hang of parenting, albeit a bit mechanical. The father was equally shallow and prone to professorial aloofness.

We can see her preference for an idealized version of life in the "magical quality", "..healthiest moms", being able to back inside a "secret and special" place, and a "wizardy" man who is "kind of magical". Her focus in thinking about the dream was on these pleasant elements, the essence of which could be thought of as the idealized phantasy of being able to become an "unborn inside baby".

But the dream also has elements which belie secret hostility and contempt which she keeps split off from conscious awareness. These went unacknowledged by the patient until I pointed out the enviably healthy mom is "kind of butch" and the enviable, wizard dad is also a "street person", i.e. pathetic and homeless.

I chose to take up this dream in the transference, as it occurred the week before my vacation. I said that I thought the dream was a way of avoiding any negative feelings about being left by me while I go on vacation. She could get rid of feeling "left out" by just getting "unborn back inside some magical place", reverse the situation, and then I could become a "left out, homeless, street person". She didn't much like this interpretation, although she did say that the mom at school looked like what she imagined my wife would look like. We left it at that for that session.

In the following session I had an opportunity to come back to the dream, as she was complaining about feeling distant from her husband. I said that it might link back to the dream in which the father figure is exiled into homelessness, not allowed to go along with her back inside mom, and that mom is thus made into a lesbian who doesn't like men, "kind of butch" in her dream. I said that if those images represented an attack on my relationship with my wife, splitting us apart, then "water can't rise above its source", so how could she be allowed to have a loving relationship with her husband.

I could not resist adding that if she did not let dad "come", she could not only keep mom and dad split apart, but she could also prevent any siblings from being born. She didn't like any of these ideas but she acknowledged that they seemed to fit the dream and how it felt.

Dream #8: "…I was living in some room off the stairwell of your office, I would come and go as I pleased and you didn't realize I was living there…"

Comment: This patient had slept in the parent's bedroom for her first two years of life. She was only moved out, under great protest, when a sibling was born. She was a very cooperative patient, let me do all of the thinking for her, paid early and was always grateful for my help, but never grew an inch in the first two years of treatment. It was only after I learned in supervision about "unborn inside babies" that we made progress and she began to have many dreams like the one above.

Dream #9: "There is a hospital room with a woman who has had the front of her chest torn off on one side. In another room is a baby with one side of its face missing. It was really upsetting to look at. That seems like a really weird dream."

Comment: This adult woman had been breast fed for two months when her well-meaning mother abruptly stopped the feeding and switched to a bottle because her pediatrician had said the baby was not gaining enough weight. We came to recognize that as a baby she must have felt very attached to her mother's breasts, that the breast feeding was going satisfactorily, and that the weaning was a catastrophic "tearing apart" of that union. The patient, who was morbidly shy, had no conscious knowledge of this weaning until it came up in the transference and in her dreams, and she then asked her mother about her early history which confirmed our impressions.

Section #3 – The Bad Self and the Death Instinct

Dream #10: A patient who had been in therapy for a couple of weeks had the following dream: "I had a weird dream last night. I was holding a gun in my hand and noticed there was writing on the side of it. I looked very closely at it and noticed it said 'Shoot yourself'." The patient had no particular reaction or feelings about the dream other than to say it was strange.

Comment: In contrast, I had a very strong reaction. I thought it represented a strong suicidal element in the patient's personality. The patient was actually quite depressed. I insisted that we meet daily, adjusted my fee to fit what the patient could afford, and saw the patient at the end of each day as an add on as I had only two open times we could use during my regular schedule. The patient was cooperative, relieved, and ended up in a successful long term analysis.

Dream #11: "I see a fairly large, black bug flying in the house and realize it is a termite (patient had seen termites swarming that week after a rain) and looking for a place to crawl into some wood and I want to kill it before it can get into some inaccessible space and do damage. I grab it in a paper towel and try to smash it with my fingers and I realize it is full of termite babies that are crawling out and seem too hard to crush to kill with my fingers. I'm afraid they will escape and I wonder if I can put the piece of towel in the garbage disposal and grind them up before they escape."

Comment: To me this is a really interesting and very rich dream that could be taken in a number of different directions. At one level it is about babies, on the inside or outside of mother's body. At another level it could be taken up regarding thoughts, both good and bad, where they end up within one's mind or personality, and what the result is for personality stability and growth. On that level it could also include a transference component as regards the therapist's and patient's impact on each other and how they are going about doing it (i.e. invading or destroying each other's thoughts or possessions).

What I wish to take up, because it was more to the point of my discussion with this patient, was the problem of having "split off" his destructive urges to such a degree that he was really quite out of touch with them and thus his own behavior which was quite problematic at times, mostly in a self-destructive manner.

He came from a large family and harbored very ambivalent feelings toward his mother who was a decent person but, as the patient said, "…spread way too thin by the time I came around". To me the dream conveys the dilemma for a baby as to where it places the "bad" part of itself and all of its attendant murderous feelings (i.e. toward a mom and all her babies who interfere with the patient/baby getting its fair share).

In this case it seems that his bad self, and the bad version of mom that would be the object of so much resentment, are "split-off" simultaneously, as a paired relationship (the mother termite with his "destructive self" equated with babies inside her that will eat up his home). One can readily see the confusion that ensues. Is mom good or bad, are his siblings for him or against him, is he bad for resenting mom and his siblings, etc.

As a general rule, Kleinian therapy aims to reduce the width of splits between good and bad elements in the personality, with an eye toward a more stable, integrated character structure. With that in mind, I took up with him an interesting dilemma. Termites, like so many creatures in nature, are just trying to do what they are instinctively programmed to do to survive. They don't have harm to others as their motivation, even though they can do great damage.

By extension, the patient and his many siblings were once babies who didn't ask to be made, but ended up having a greater totality of needs than his two parents could meet without resulting in some deprivation. I said that he had understandable frustration, resentment, even envious hatred toward mom and his siblings, but that those feelings were felt to be a threat to his loving relationships, and so he had to get rid of them. The problem was that he couldn't really get rid of those feelings. It was wishful to imagine having gotten rid of that part of himself with its angry, hurt, destructive urges. They had come "swarming" back at family events, or is this case, the week of his birthday, and the attempts to deny them had contributed to his life-long predisposition to depression

Furthermore, I added that the dream suggested that in order to kill off a bad part of himself, or the bad versions of mom and siblings, he was actually then also taking with them good versions of himself, mom, and siblings (because no such real division could be made between bad and good parts since they were, in reality, aspects of one and the same person, whether it be self, mom, or sibling).

This patient's situation, as depicted in this dream, demonstrates the problem of too wide a split in the task of bringing order to its world via "splitting-and-idealization" in early infancy (i.e. Klein's "paranoid-schizoid position"). It may be necessary to keep good and bad very far apart (i.e. good and bad aspects or parts of self and object) to survive infancy, but it makes the task of bring those splits back together in the middle of the first year of life, so that one can have a more accurate, integrated view of reality (i.e. Klein's "depressive position"), a great deal more difficult.

His predisposition to depression could be thought of as largely related to his hurt, angry, envious, jealous feelings being disowned at too great a distance for him to do the work of bringing them back so that they could be modified by insight, and his capacity for "love" could be more firmly established as the core of his personality, counterbalancing his human, inevitable, negative feelings.

Dream #12: "I had a funny dream last night. I'm hitch hiking and I get in a car with a guy who sort of looks like Dennis Hopper from "Easy Rider". He asks if I want a 'hit' from his cigarette and I say no I don't smoke. We end up in some part of Mexico and I am thinking I will have to call in sick to work tomorrow. There was more to it but I can't remember it."

Association: "I wonder if this has anything to do with Jill (a younger employee at work) sending an email invitation that Meredith (his boss) told me about inviting her to Jill's baby shower (Jill is pregnant and due in a few months)."

Comment: Patient is the second of five in his family of origin, in his fifties, and never married. He goes on to talk about work and does not go back to the dream. After about ten minutes I start to feel irritated that he has just dumped the dream in my lap and giving me no help or showing any interest in it when it is actually a rich sounding dream.

I mention to him that he seems to have lost interest in the dream and is leaving it up to me to think about it. Since I had a summer vacation looming, I wondered if he felt abandoned by me, as if my vacation was me going off to have a baby.

Later in the session we had a profitable discussion about how alone he often felt in life, and how when in that state of mind, he would go out on his back porch and have a cigarette even though he "didn't smoke". This would usually happen on weekends.

We came back to this "Easy Rider" dream a number of times as it compactly conveyed his rage at his mother making so many babies, leaving him abandoned, forcing him to turn to his own bottom (Mexico) and feed himself shit (cigarettes), and let the death instinct – who care about life or anything – part of himself take over and run his life, with his murderous urges split off (the guys who kill the Jack Nicholson character in the movie).

On a more subtle level I think this dream depicts a "narcissistic personality organization" component to his inner world that has undermined his growth over the years. It is as if he is chronically playing "hooky" from life by taking the "easy rider" way out, leaving all responsibility for caring about growth up to analyst/bosses while he calls in sick.

Section 4 – Narcissistic Personality Organization / Self Sufficiency Dreams

Dream #13: "I saw a woman who looked like a working class woman, perhaps a maid. She might have been foreign. She had very thick cake make-up, large breasts, and I decided to flirt with her. After a while she seemed more interested and turned into a tall, slim, beautiful woman. We went around a corner and were going to have sex and I woke up."

Comment: The essence of a "narcissistic personality organization" is the idea of avoiding being vulnerable to any painful baby states of mind. This means avoiding feeling small, helpless, needy, dependent, etc. The "envious, omnipotent, know-it-all, destructive, self-sufficient, bad part of self" promises to the "good baby parts of self" that it will keep them invulnerable to these baby pains. To achieve this, no one in the outside world is ever to be truly loved and needed, because this would then subject one to potential loss, etc. If one allows love for a living human, it is "precariously uncertain that they will go on living", even if they promise to always love you and never leave you, so love must be squelched.

The resultant solution is that to remain invulnerable to mental pain, one must create a world that prevents one from ever entering into the sphere of loving relationships. The "hallmark" of a "narcissistic personality organization" is therefore that all people are treated as "things", merely extensions of oneself, to be used as long as they are useful, and discarded when they are no longer useful, or become a source of pain.

This dream perfectly depicts a narcissistic type of relationship. The person is devalued from the beginning, inferior to the patient ("working class", "maid", "thick cake make-up"), only valued as a part object (i.e. "large breasts" and a vagina to be used as a seminal repository). Once safely controlled by the devaluation, the patient can allow a desire for a "tall, slim, beautiful woman" to be acknowledged.

While consciously a pleasant dream to the patient, it is actually quite a bit more disturbed and ominous than one might think at first blush, if one just takes it as a "wishful phantasy". The ominous elements, as I see them, are a rather vicious devaluation of women and a delusional idealization of his own anus and its contents.

I took the dream to be about anal masturbation in which he can turn an ugly, "cake make-up" stool, and his smooth round buttocks (i.e. "large breasts"), into a beautiful slim woman with whom to have sex (going "around the corner" to bimanual masturbation). This idea may seem harsh to some but this man was actually constantly remarking about how his anus itched and he had to scratch it, and then felt compelled to smell his fingers.

Although in his forties, he had never married and was actually rather frightened of women, worried about premature ejaculation, and occasionally was unable to achieve an erection. It was not surprising to me that if he was unconsciously very envious of women, secretly hostile and spoiling of them, he would be unable to imagine safely having a loving relationship with them.

My interpretation to him in that session was that I thought a relationship with anyone that was proper and equal was too scary to allow himself to be that vulnerable, there was too much risk of being hurt. Therefore, he felt that it is was safer to have total control over someone inferior to himself, but that it left him unsatisfied and alone.

I imagined that the same problem would occur with me, i.e. that it would be hard to allow me to become important to him. It would be better to turn to his own body and its products, which were always available, and never more than "an arms-length away".

We spent years trying to dissect apart his masturbatory attachment to his own anus which was slow arduous work, as he had so little connection to his mom originally, so little belief in any goodness in relationships, and our work was consistently undermined by any separation disrupting his treatment relationship to me which was just about all he had in life, aside from his anus.

Dream #14: "The mafia or someone was after me and I went to a restaurant with two women and Harvey Keitel. He said that I was sitting in a vulnerable position or place. I felt protected and taken care of by him. And there was this sexual attraction between us that I felt."

Comment: This patient associated to HK, the actor, as a man who plays very strong figures who can do anything and can protect you, but can be a "little scary". At the most straightforward level, this dream suggests that life out in the world is a dangerous place with lots of anxiety about being safe. That would be a simple beginning comment to make about the dream. HK fits in to that world. He could easily represent a good guy or a bad guy.

If we go deeper into the dream, we might ask ourselves several questions. Why is it taking place in a restaurant, why are two non-descript women there, and why is a sexual attraction to HK mentioned?

This is where dream interpretation gets into the idea that dreams are written by the baby core of the personality, which often sees things at a very primitive, "part object" level. If one were to make an interpretation of the manifest content, one might say that when this patient feels persecutory anxiety (e.g. "someone wants to hurt me"), her reaction is to get inside mom's restaurant body, with the two breasts (the two women) and daddy's penis (HK) there, and imagine she is being taken care of by the daddy/penis.

Let us add a comment by her that she had too much to drink the night before she had the dream, and had been offered cocaine by a girlfriend. She had declined the cocaine but had previously used it to a dangerous degree of becoming dependent on it. She had also recently broken up with a boyfriend. With all of that in mind, I felt that the dream was describing an urge to turn to an omnipotent, masturbatory, self-sufficient state of mind (i.e. getting inside, HK as her protector, and the air of sexual excitement) in the face of her current distressing life situation. But I also felt that she sensed at some level that this is precariously close to the mafia's "underworld", and there is precious little difference between HK as a protector and HK as a bad guy and potential persecutor.

I said to her that the dream suggested that she was feeling very alone and in need of protection, but rather confused about how to achieve safety. I added that she was aware at some level that her past approaches were too dangerously close to being very destructive to her mental health, and physical safety (i.e. drug use), and that the dream suggested that she was afraid she might go back to them (i.e. drugs, manically compulsive sexuality, etc.).

She responded that when she got home and went to bed the night of the dream, she was starting to feel "depressed". I commented that at some level she realized she was in danger of giving into confusion about what is good and what is bad, and then going back to allowing a destructive, bad part of herself take back control of her life.

Dream #15: "I was at my place, in the bedroom with Will Smith who was quite taken with me, I was naked, we were embracing on the bed, about to have sex, my roommate opened the door and looked surprised but I didn't stop."

Comment: This is a very context driven dream. At a surface level, who wouldn't want to be with a handsome, charming movie star, and feel quite flattered if he was attracted to you. The fact that this is a very light complected black man, and the patient is caucasion, seems inconsequential if one is being politically correct.

But let's go deeper after putting the dream in context. It occurred after she had a huge fight with your husband and it was the week before her analyst was going on vacation. Taken in that light, I interpreted that she was feeling abandoned by me, and furious with me, and to retaliate she was going to "turn away" from me to her own body and bodily products, to be self-sufficient, and not need me at all.

I said that she was going to hide the fact that she was turning to her own bottom and its products, to achieve this state, by representing it as a handsome, light skin colored black man so the "anal eating poop" quality could be easily rationalized. I said the roommate represented a sane part of her that was surprised that she was going back to this destructive state of mind, and approach, to her current situation.

Dream #16: "I'm having sex with a black woman who has a penis and I'm thinking the only place left for my husband is my anus, and that doesn't sound pleasant, and I wonder how is he going to feel?"

Comment: This is the very same dream as the one above. It depicts being a self-sufficient couple (i.e. being both a woman and a man so that you can have sex with yourself). It also emphasizes a hostile state of mind toward her husband who is left out and probably is containing the "left out" baby part of self, that has been projected into him. The woman being "black" again suggests anal omnipotence as a means of having a "stool/penis" and not needing anyone else.

What is more emphasized in this dream, compared with the one above (where there is only a vague reference to a roommate looking "surprised"), is a feeling of concern for her husband and his feelings. One could imagine that this is a dream of a patient who is less narcissistic and has a greater capacity for empathy for another person. Alternately, it might suggest that this patient is further along in treatment, which was actually the case.

[It is worth noting that in this kind of "narcissistic, self-sufficiency dream", instead of becoming a couple with oneself (i.e. vagina or mouth and penis at a "part object" level, or man and woman at a whole object level as in this dream), it is very common for the dream to depict "twins", in the sense of two emotionally equivalent parts of self, at the same age, "joining or twinning up" together so as to not need anyone else. See the next dream below.]

Dream #17: "I was parked on a street in front of a flower store to buy a dozen roses for my wife. I decided to make sure the trunk was not messed up so I could possibly put them there. As I was getting rid of the junk in the trunk – I found an old [marijuana cigarette] wrapped in aluminum foil. I said to myself "I don't

need this anymore, I'll throw it away with the trash". I walked over to the trash can to throw it away and I put it in. Just at that moment a black man appeared and began shooting at me, trying to kill me. I started running for my life. I woke up in a panic."

Comment: This dream occurred at the tail end of a long analysis in which great effort had gone into dismantling a "narcissistic personality organization" linked to "anal omnipotence" as manifested by, among other things, chronic marijuana smoking which had been given up some years earlier. The patient was trying to preserve a loving relationship to the good family internally, and give up all destructive omnipotent maneuvers.

The dream graphically depicts the idea that the "bad" part of self feels it is being "murdered off" when the "good baby parts of self" turn toward goodness, the "adult" part self, and "good" parents internally and externally. The "bad part of self" starts shooting immediately as the marijuana joint is discarded in the trash, an act by the "adult self" that is tantamount to "killing off" the sphere of influence of the bad self, and the narcissistic personality organization.

Dream #18: "I can't remember much of the dream except that I was being chased by a person who intended to kill me and I was trying to escape, running all over the place, in and out of buildings and stuff, but he kept finding me and chasing me. I woke up feeling depressed and wondering why I would have a dream like this when life is going so well. I haven't done anything that I would feel bad about or paranoid or anything."

Comment: The "bad self" is always threatened with a loss of its hegemony over the good baby parts of self when progress is being made in the therapy. Earlier in treatment, this dream would have the patient chased by a wild animal, a monster, an alien from outer space, etc.

Dream #19: "I'm on an island – people live nice comfortable lives on one side – but the other side over the mountains is forbidden, off-limits, dangerous. A pirate ship is marooned there and the water is shark infested or for some reason they can't leave the ship. I'm curious to see what is on the other side of the mountain and a young woman agrees to take me to see what they are doing on the forbidden side. I see the ship in the water and row a boat out in the water which I can see is rat infested. As I get close to the boat I see that these are mean, violent guys who will kill me and so I turn the boat around and wake up."

Comment: This dream vividly depicts a narcissistic personality organization. The patient had been making progress in his treatment for a year, had this dream, and then quit treatment a week later despite his therapist's attempts to interpret a return to an old, destructive personality approach to life. What is interesting is the confusion of good and bad with a "young woman" essentially luring him to the dark side of life. The threat of brute force by the bad guys, if he betrays their influence in his personality, has him consciously turning around in the dream but in external reality he is knuckling under to the destructive bad part of self. His quitting treatment represents a return to the narcissistic personality organization that got him through his disturbed childhood. That organization is now threatened with extinction by the treatment and is therefore fighting for its life.

Section 5: Omnipotence, Denial of Reality, and Projection of Responsibility Dreams

Dream #20: "I had this really neat dream last night but it had an upsetting ending. I was flying in the air in this round sort of donut or inner tube type thing. I was really enjoying being able to see everything and go anywhere I wanted. But then I realized I had no way to get down, back to earth. I would have to turn the donut upside down in order to go down but I realized I would fall out then. I got really upset."

Comment: I said in the dream course that "flying is never good"! It is conceivable that a patient could have a unique circumstance where the meaning of someone being able to fly on their own was not problematic. This dream, for this patient, is not one of them.

Flying almost always represents an "omnipotent" point-of-view, commonly linked to the wish not to be constrained by reality and gravity, as was the case in this dream. A not uncommon variation is that it represents seeing the world from the parent's lofty point of view, sometimes even out of mother's eyes, usually achieved by intrusion into her body in phantasy. Occasionally it has a link to death, expressing a phantasy of the soul (or its equivalent) leaving the body and the constraints of mortality.

In the case of this patient, the round donut stood for "anal omnipotence", which was in abundant evidence everywhere in her life, in a fairly problematic manner. The dream was actually a product of the developing awareness of the difficulty she was going to have in giving up her omnipotent, grandiose approach to her life.

The phantasy that she could fly was a product of the "insane" aspect of her personality, and the realization that it put her in an untenable position, was a product of the "sane" part of her personality. What that realization was foreshadowing was a nascent recognition of how much her omnipotence pervaded her whole approach to life and how problematic that approach was to her well-being. We both felt that this dream was a positive sign, even though it was almost a nightmare.

Dream #21: "I was parked outside school, waiting to pick up my daughters. I was driving a really fancy convertible, like maybe an old Cadillac convertible, really big, and I had the top down. This next part is kind of weird. I was having a martini, sort of celebrating the new car. The girls came and got in and we drove home. My wife came out of the house onto the driveway and saw the martini glass I had left on the front seat. She went all crazy and I said chill out, I was just celebrating the new car, I am not drunk. I thought to myself, she is such a bitch, she spoils everything."

Comment: This essentially manic dream denies all sorts of destructive urges and irresponsibility (driving his children while drinking) and projects all responsibility and blame into his "wife/mother" whom he provokes with the martini glass. He is completely out of touch with this while feeling the "excitement" of the Cadillac convertible.

We spent some time in the session focused on his denial of responsibility which seemed to put me increasingly into the position of "lecturing him" on his irresponsibility and provocativeness. I began to feel fairly irritated with him and realized I needed to take up this "process" between us in terms of his view of me as the container of a bad version of a parent who only criticized him and never saw life from his point of view.

As one might imagine, given the content of this dream, this man was capable of denying almost anything that he didn't wish to face, and was in fact very good at provoking others into feeling states of mind that should have been his. Simultaneously, the dream hints at masturbatory activity that generates a mood of "excitement" while allowing him in unconscious phantasy to get inside a parental figure (.."really big",.. "really fancy", .."old Cadillac") and take over their identity. This dream hints at the possibility that it is "daddy's penis" he is taking possession of, in order to then be able to get inside and possess the desirable mother "Cadillac".

Dream #22: "I was at a farm-like place – small I think – I had just bought the place – I was with somebody else. There was a large dirt area the size of a pool – I needed to shovel the dirt out. I was surveying the thing and this other guy came over looking at the middle of the pool type thing and called my attention to a huge boulder I was going to have to get rid of – it weighed a couple of tons. The guy had a combination of grass clipper and electric razor – he said he could use the side extension blade for the rough stuff and I thought – ya ya – I've used it before. I thought there was shrubbery around the boulder to use it on – some was in front. The front of the boulder was a projection lamp or screen and I thought maybe I can cut the stuff in front."

Comment: This is a difficult dream to think about without the use of the Kleinian models of projective processes, anal omnipotence, omnipotence as a potentiator of an "I can do it" state of mind, and an "analytic" model of the transference.

The arc of this dream's emotional states seems to start with hopeful desire (i.e. for a farm/home/pool), followed by someone pointing out the obstacles to achieving those desires (i.e. dirt needing to be shoveled, the boulder needing to be moved, and shrubbery needing trimming), and ending with what I would describe as an "arrogant" state of mind ("ya ya – I've used it before, I can cut the stuff in front").

Now this is where it all gets trickier. The person pointing out the main obstacle (i.e. the boulder) has a "combination grass clipper and electric razor", clearly not suited for moving a boulder. The patient seems confident that he can do all that is needed himself, i.e. trim the shrubbery blocking the "projection lamp or screen". One can surmise that the man in the dream is thinking the boulder needs removal but the patient is thinking at some level that all that is needed is to make the projector work.

So my interpretation to the patient was that the dream was about our relationship and his increasing recognition of our different approaches. I was felt to be making a big deal of his turning to his own bottom, imagining that he could make everything he needed including food and pleasurable sensations, and then feeling that he did not need me. I was felt to be saying that his turning to his own bottom was actually a huge obstacle to his growth (the boulder) and we were going to have to eliminate it.

But what he was really beginning to recognize as the biggest obstacle was the "projective processes" (i.e. the boulder is actually one giant projector) that he relied on so heavily. That he could project any unwanted state of mind out of himself, or he could "get inside" anyone and take possession of their desirable qualities whenever needed.

I said that it was wishful thinking that to do an analysis, all one had to do was alter (trim) how one's hair looked, as if hair was the equivalent of states of mind. I added that I was felt to be taking away his "magical maneuvers", which he had used all of his life, and a part of him didn't like that at all.

What I felt was tricky was his concreteness which allowed a misuse of logic. It is not valid to say that states onf mind are in your head and hair comes out of your head so they must be the same. That bit of concrete confusion allowed him to say that states of mind can be modified by hair trimmers, which in turn resemble hedge/shrubbery trimmers, which he can use to then do his own analysis by going back to projecting anything he needs to get rid of. At some level he was beginning to recognize that this logic is "baby level" and irrational, but he also saw that it would be hard to give up.

Dream #23: "…I was walking along a ditch bank, not much water in the ditch, when I saw a coin in the mud. I bent over and reached down in the mud and pulled it out. I wondered if there were more and reached around in the mud and found a whole bunch of coins. I was really pleased and looked around to make sure no one else saw me and might try to take them if there were more there. I woke up in a really good mood."

Comment: This is anal omnipotence personified, early in an analysis. The patient can make anything they want or need, with their own bottom, which is never more than an arm's length away. What could be more joyous!

Section 6 – Schizoid Withdrawal Dreams

Dream #24: "I was high on a hill looking way below out to a body of water that goes off to the horizon as far as the eye can see. I notice a boat near shore – there is nothing on the deck – it's just flat – the front and back look the same. Then I begin to realize there is a small child on it – I say to my wife – I wonder if that's X [their child]. Then a huge wave washes over the boat and she is washed off the deck – I run down and dive into the water and get her and pull her to shore…"

Comment: This is the sort of dream that can be taken in many directions, all of which might have value, but it is difficult to know which to pursue without a context or association or emotion.

At face value, the dreamer is at some distance from the action ("high on a hill") but with a panoramic view with often has a hint of seeing the world from a grown-ups point of view when compared to a baby's short stature and limited perspective physically and emotionally. The scope of the view is vast and with a gigantic expanse of water that not infrequently seems to represent the unconscious inner world with its wide array of underwater, unconscious components including people and emotions of all shades.

When the dreamer brings his gaze closer to home he sees something very disturbing and immediately turns to his wife to ask if it is their child. That is followed by a giant wave and his heroics to save the child.

The context for this dream was that this was a rather emotionally aloof man who was married with a child who had a brief affair with a co-worker during his wife's pregnancy, something about which his wife was unaware. He had become depressed and his wife had insisted that he go to therapy because his depression was not improving, and she assumed that he was ambivalent about being a father and staying married, both of which were true. He had this dream after his wife insisted on his seeking help and before our first session and reported it on the first session when I asked if he ever remembered dreams.

Our understanding of the dream had multiple levels that were explored many times over two years of treatment. The most straightforward one was that the wave represented his guilt over his destructive act (the affair) that threatened to harm his infant daughter.

At a characterological level it depicted his tendency to look off into the distance and remove himself from his own immediate internal situation. He had left it up to his wife their decade of marriage to "contain" the emotions for both of them hinted at by his asking in the dream if that was their child. I got the feeling that his "splitting off" his feelings made it difficult to know if he should "care" about a drowning child if it wasn't their child.

At a genetic level the dream seemed to depict his ambivalence toward his younger sister who was only 14 months apart from him in age. I suspected that he must have had murderous ambivalence about her existence, represented by his willingness to wash her out of this life with a massive wave.

The most curious element in the dream is the boat that is "…just flat…", and "…the front and back look the same". This depiction is significant because this man had been an avid sailor and knows a lot about boats. We came to feel that the flat deck represented his feeling that his mother was emotionally "flat" and that the front and back of her were treated as if they were the same in his mind. In parallel, he treated the front and back of his own body as if there was no difference, meaning that his poop and buttocks were no different than mother's breasts and milk.

This latter idea seemed linked to his turning away from his mother, and his own emotions, leaving him fundamentally confused about which direction to go in life (the boat could go in either direction since front and back were the same).

The element in the dream germane to the transference relationship to me was that the turning to his wife to ask if it was their child suggested tome that he might tend to allow me to be responsible for all emotions and expect me to also contain the caring baby parts of himself, seeing the world through my eyes and not experiencing it through his own. This did not turn out not to be a particular problem as he seemed to have an honest aspect of himself that would accept the truth when it seemed to make sense.

<u>Section #7: Dreams Prominently Featuring Unconscious Envy</u>

Dream #25: "…I noticed a bump in the back of my hand and sqeezed it and all of a sudden bees started coming out of it and I was terrified they would start stinging me…"

Comment: When baby elements from one's internal world are violently expelled, projected, split off, fragmented, etc. they often return as minute little persecutors, threatening to do to oneself what they had as urges or motives inside the self before being disowned and projected.

In this patient's case, the patient was very distressed to see a nasty, envious side of his personality that was always making "biting" remarks about others. He had always seen himself as the good guy while despising his father's "mean" streak and feeling triumphantly superior to him.

Dream #26: "My husband and I were meeting our friends Bill and Mary to go to a Disney Hall performance. Mary – who is very chatty – was talking with people and hanging around too long. I suddenly realized I had lost my wallet or purse. I was concerned about my driver's license and credit cards. Mary kept talking. At one point my husband said to me "you are always losing your wallet". Then this is where it gets confusing – there was a woman who was responsible for my wallet missing. This crowd of people had found her and they were abusive – spitting and shouting, etc. Somehow my wallet was found but I thought I should cancel my credit cards because these people had had it."

Association: Bill and Mary are really nice, they are about 10 years older, and have been married for a long time, have three kids, and seem really happy.

Comment: This is an interesting dream to me because it is a variation of a common thread in dreams, losing one's wallet, purse, driver's license, etc. I often get the feeling that these "lost" elements have something to do with an attack on the dreamer's sense of identity or feeling of safety, essentially a loss of "this is who I am" sense of security. It commonly evokes in me the question, as I listen to the dream, why would your secure "sense of identity" be lost or undermined at this moment, as depicted in this dream.

As I listened to this dream, I could not help feeling that the couple, Bill and Mary, were "fancy" people, i.e. socially connected people of importance going to a socially important and fancy place, "Disney Hall", to listen to "fancy, grown-up" music. Simultaneously, I also felt that Mary was being subtly denigrated as too "chatty", "wouldn't stop talking", sort of suggesting that she was a shallow, social gadfly. It is at this point in the dream, i.e. of becoming maximally irritated with Mary, that the patient loses her purse or wallet.

A bit of background will add to our understanding of this dream. The patient was the fourth of five children, had an enviably competent mother who was socially very popular and happily married, a sort of life of the party type, and the patient's siblings were all fairly successful in childhood and life. One of the patient's primary motives for therapy was not being happy with her life, uncertain about career, marriage, or if she wanted to have children (she was at an age where it would be common to start a family). She had been in treatment for about a year when she had this dream.

I experienced the dream as having two phases, the viewing and reacting to others phase, and the "confusing" phase of a woman taking her wallet. Most commonly, when someone loses their wallet in a dream, they don't catch and then "verbally abuse and spit on" the culprit. I thought that the husband saying "you always lose your wallet", suggested that the patient had a growing sense that she did all of this to herself and that the thief was a part of herself.

So that was what I took up. I said that I thought she was having a very rough time as she increasingly recognized how hard it could be for her to be around anyone who had all of the things she wanted in life, a successful career, happy marriage, children, being popular, etc. She was beginning to see that her inability to stand being around that kind of enviable success was robbing her of an ability to be a success, as she was afraid everyone would be as mean to her as she felt toward them when they were enviable.

This was not a new idea to us, but her dream seemed to lay out the anatomy of that dynamic in a potentially useful way, i.e. connecting envy, subtle denigration of others, and a fear of being envied if one's envious wish to rob other's is seen. It creates a vicious cycle that undermines growth in life.

In my experience, it takes a very long time for a patient to fully digest a dream like this that lays out the anatomy of a fairly large dynamic in their character structure. It is the sort of dream that one comes back to multiple times over an extended period, sometimes years. We were able to use it to understand elements from her childhood, her current life, and relationship with me.

I would summarize the dynamic in the following way. The patient felt very envious (and jealous) of her mother, and some of her older siblings, growing up in her family. She had a powerful urge to rob mother and siblings of anything they were felt to have that she particularly desired but lacked. The urge to rob them was such an odious thought that she unconsciously settled for subtly denigrated those enviable qualities. That thread private denigration could be detected in her recounting of her childhood, and at times in her misinterpretation of my motives in the therapy.

Because she also loved her mother and siblings, her envious hatred was sufficiently frightening to her that she had to "split it off and disown it". That process diminished her capacity to "be all that she could be", essentially robbing her of her of part of her identity.

In the dream that envious, spoiling, thieving part of her is depicted as the woman who had taken her wallet or purse, and was now being treated back in the same way as the patient privately reacted to people who she envied and robbed of their good qualities by spoiling them. One can see how she feels she can't trust herself to not do this destructive stuff, so she has to "cancel" the credit cards because they had been in the possession temporarily by this bad part of herself.

It is interesting, but not surprising, that even if the dynamics of the envious part of self are recognized fairly early in therapy, they seem always to be the last thing left standing that still needs analysis. In fact, in less prominently envious individuals, it is the last area to come up in the analysis before the analysis can be said to have produced a fairly thorough exploration of all of the important areas of mental function needing modification.

Section 8: Manic Defense Dreams Against Depressive Anxiety and Guilt

Dream #27: "…I showed up for my final exam in a math class and I couldn't find the class and I felt horrible because I realized I hadn't studied, I hadn't gone to any of the classes all semester, and I knew I would fail…"

Comment: This is the quintessential type of dream about the persecutory anxieties and depression that are generated when one is manically running away from psychic reality and refusing to "add it all up" and face what is going on inside one's unconscious inner world and then dealing constructively with external reality.

Dream #28: "My dad and I were driving somewhere in a car. He was in the passenger seat and I was in the driver's seat. I realized that my feet wouldn't reach the pedals and I woke up."

Comment: I had been commenting to this woman for some months that she didn't seem to want to allow any dependence on me or the therapy, often cancelling sessions at the last minute, asking for changes in time for some important reason, all while consciously thinking that she valued the once per week relationship with me. This dream was our first breakthrough and allowed me to demonstrate to her that she feared giving up control even though she was too young, according to the dream (feet would not reach the pedals), to be running things on the own. Multiple associations of needing to feel self-sufficient with problematic consequences aided me in convincing her to increase to twice a week. The therapy finally settled in to doing real work.

Dream #29: “There were two penises together touching each other”. Analyst asks for more details. “My penis was next to another penis – they were side by side – the other one looked the same as mine.”

Associations: “It seemed like one penis was going to feed the other – like ejaculate into it. It doesn’t make sense there would be two penises side by side.”

Comment: This dream was from a heterosexual man who was somewhat embarrassed and confused by this dream. The context of this dream was that he had gotten a poor review at work and was feeling depressed, deflated, and inadequate.

I said to him that the dream probably represented how he had imagined coping when he was a baby. If he could just have possession of both of mommy’s breasts he wouldn’t need anyone else. By the time he became an adolescent, and discovered that his penis could generate not only wonderful sensations but was also sort of a “milk secreting organ”, he could turn to it to not need mom or anyone else. He could feed himself wonderful sensations and simultaneously empty out any unwanted feelings or states of mind.

He was reminded of a period in early adolescence when he and his older brother would “jack off and see who could come first”. I responded that he felt he needed some reassurance that he could survive what felt like a setback at work, and that perhaps I stood for his older brother in this situation. That would imply that he needed to feel he could literally take in my potency in life (i.e. putting our penises side by side and equating them), to augment his feeling of lacking potency at the moment.

He seemed visible relieved by my comments and confessed that upon awaking he had wondered if the dream meant that he was “gay”. I understood him to be implying that my ideas, which explained his very primitive, part object level dream in a manner that made some sense to him, as a relief compared to his simplistic, concrete assumption that it meant he was a “latent homosexual”.

It is worth noting that although this dream is essentially a “manic dream” in the sense that it tries to deny his feelings of smallness and inadequacy, it does not have a quality of a hostile “turning away” to self-sufficiency that was present earlier in his analysis. Instead, it has more of a quality of needing reassurance of being able to survive the painful feelings of infancy and “this is all I know how to do to cope”.

From the discussion and emotional tone of the session, I sensed that he was in fact more unconsciously concerned about ever being an effective adult male. What might have once led to vicious attacks on the parents and their relationship, out of envious hatred or jealousy, was giving way to a concern about his proper growth and a relinquishment of manic denial need and dependence.

Dream #30: “I got a phone call from my old boss, Mary, to remind me that we had a 1:00 pm appointment where I was supposed to meet her new staff. I felt slightly proud underneath like I was wanted or needed. I said I would be there but as I started to think about it I recognized that even though it was fairly early in the morning, I wouldn’t be able to take care of all my obligations and still make it at 1:00 pm.”

Context: The patient had suffered a serious illness recently from which he was recovering. Prior to the illness, he had left a career in which he felt highly competent and successful (and Mary was the younger replacement for his position). The patient had this dream the night before the first session back after I had been on vacation.

Comment: This dream has multiple levels at which one could focus a discussion, and could be seen arguably as with a manic dream or a depressive position dream.

The first point to be made, based on this patient’s current life circumstances, is that it is hard to face the reality that you would like to be more things than reality is allowing. Obviously, anybody would rather be a

big, successful boss whose wisdom is valued. That is far preferable to feeling that you have been "put out to pasture" on your way to becoming a "helpless baby again" (i.e. his illness and slow recovery).

I made that comment to him that his career had been the antidote to his childhood feeling of being unloved or valued, and the dream seemed to take him back to his feeling of being valued. I added that it was also making him aware of a state of mind that took him away from his current life and family (i.e. the morning obligations he would not be able to perform if he went back to work?

His response was to say that "I also think the dream is somehow about coming here because I would have had to miss this session. I then remembered that he had called the day before and left a message saying that he was scheduled to see me the next day and asked if the appointment was still on? So I interpreted that the dream might also represent his hedging his bet, if I had forgotten about him and lost interest in being his therapist/parent during my vacation, at least someone wanted him in the dream. His response was to say that it had crossed is mind when he called me that I might have forgotten his appointment.

He then went on to say that his recovery from his illness was going much slower than he had expected. His small granddaughter had comment "… for a grandfather – you're not very strong". I responded that he was feeling like he was decaying, feeling unloved and unwanted, and that the dream was reminiscent of how he had dealt with such feelings in the past, but he was now sadder and wiser, trying valiantly to face a reality of aging that was very upsetting but had to be faced. His response was to say "Yes – it is really hard and I am aware of needing support".

Section 9: Oedipal Dreams

Dream #31: "There is some kind of celebration – I am with my childhood neighbor Leo [on whom the patient had a guilty crush during adolescence] and his younger sister Joan. Leo and Joan are in the water with sharks nipping at their feet. They decide to get out of the water into a boat – they seem to be held above the water by some kind of apparatus for a while. Then they are in the boat. There are two men – they seem to be scientists from Auschwitz using the sharks to just round up people from the water and get them in the boat to be used in experiments by the two men.

Then there is a shift in the dream to a scene where there is a man and a woman who have been experimented on – the man's penis has been cut off almost to the base and the woman's genital has been mutilated so that it was cavernous. The two people realize that the way to save themselves is to have a baby. The man tries to ejaculate from his stump and the woman starts having a liquid coming out of her vagina. I am thinking that this going to get worse as the two men continue the experiments – they will induce the man and woman to vomit and decide to use the vomit for another experiment."

Comment: This dream has all of the elements of a "B" grade horror movie. The young woman who had this dream had enough therapy to know that she had a significant amount of resentment toward her parents and her siblings. She was not overly bothered by the dream's violence but more focused on the peculiar images of mutilated genitals combined with "making a baby" and "vomiting", etc. She was still a virgin and had not dated much during her childhood as her fairly religious parents has discouraged it.

What I chose to take up in the dream was the transference implications of our work being some sort of sordid Nazi experiment in which our work together was in danger of being a cruel moralistic torture of each other rather than something that led to the birth of a "brain child". I said that there was a part of her that saw our relationship as one where we took turns "vomiting" our states of mind into each other but that we were not allowed to come together in a more constructive, loving "meeting of the minds".

Somewhat to my surprise, she then associated to the neighborhood friends Leo and Joan and said that they were both happily married and Joan had recently had a child. I took that association to suggest that she agreed with my interpretation at a deeper level and that she knew her view of parents was distorted and interfering with her own growth and development.

It is worth noting that one could go into detail regarding possible meanings of the mutilations in the dream, all of which are likely "early infantile, part object views" of mom and dad's bodies, but I felt with this patient, at that point in time, that would turn the session into a perverse horror flick and enact the phantasies rather than learn from the process of how two people interact properly.

Dream #32: "I looked into a building window – I was outside. I saw a long metal table – I decided to go in. There was a table almost like a gurney or autopsy table. On it is a body that is twice as long as a normal body – I suddenly had this very depressing realization that I was not going to be able to leave the building until I had eaten the entire body."

Comment: The English analyst Roger Money-Kyrle is quoted as saying that "Children put their parents together in every possible way except the right one." This was a patient who had so ruined her parent's relationship that it was a monstrous perversion of a loving relationship. The patient had become painfully aware of her attacks on the parents as a good couple and then had this dream. She felt relief at the interpretation that she was going to have to face, accept responsibility for, and digest what she had done to them – essentially smash them together in a distorted, dead cadaverous relationship – before she could finish her analysis.

Dream #33: "My husband and I were in bed and about to be intimate. Somebody was outside the bedroom door and was feeling mean and envious. The person could see through the door. Then the scene shifted and I was out on a the field of an Ivy League school where the teams were playing and a man, maybe the coach, was in a bad mood and arguing with another man."

Comment: She felt significant relief when I said that a part of her is upset when anyone is lovingly enjoying being together with anyone else (the couple, the teams playing) because there is always someone who is feeling left out, angry, and destructive. Were then explored in greater detail why she herself often felt so left out and angry, always imagining that everyone else was "coupling" up happily while she was left out and miserable.

Section 10: Sibling Rivalry Dreams

Dream #34: "I was in a house with my parents and sisters getting ready for a party. I had to move the bed in one of the bedrooms. There was a toilet in the room but the waste would not go down. It came out of the bottom of the toilet instead. Now there was waste on the bedroom floor! I was trying to make the bed with nice linens. My sister was there with her dog and I was worried that he would get sick from the waste. People were coming for the party. I used the toilet again… holy shit…I just made a mess! The toilet still wasn't working. I put a sign on the door letting people know it is out of order."

Comment: This unmarried woman was fairly out of touch with her resentment and anger toward her family members, but it was expressed regularly with an ongoing sarcasm of the "geez – I'm just kidding – don't take it so personally" sort. This dream was provoked by a wedding shower for the patient's younger sister that the patient was flying back home to attend. One can see that she has a powerful urge to spoil it, literally "shit" all over it, but in the dream sees herself as trying to be a loving, helpful sister, trying to keep from poisoning everyone.

I took the dream up in relation to the patient's sincere desire to be a loving sister that was undermined by a part of her that humiliated that her younger sister was getting married before the patient who should have been getting married first.

I did not bring it back to the transference at that point because she was so preoccupied with leaving town and tolerating her envy and jealousy that were being provoked by the immediacy of seeing them. I did feel that the same envy and jealousy would be provoked by anything that suggested that I had a life separate from her, in effect favoring my wife and/or children over her.

Dream #35: "I was at a party in a big house. Bill (her ex-husband) and I were arguing. He said something about an ultrasound … he and miss white trash (a woman Bill was dating) are having a baby! I was furious and wanted to break a glass dish. There were a lot of pregnant women in the living room, so I warned them that I am going to throw things and they had better leave so that they don't get hurt. Then I repeatedly threw the cordless phone into a pillow that was in Bill's favorite chair…I tried to get the antenna to hit the center of the pillow."

Comment: Clearly the idea of her ex-husband having a baby with someone other than her seems to provoke murderous emotion. The rage seems by equal measures to be directed at the male ("antenna" and "Bill's favorite chair"), the female ("miss white trash", "a lot of pregnant women", and the new baby ("ultrasound", "pregnant women", and "pillow").

One could take this as a dream about siblings and their births, or about the parents who make them. I felt that this dream emphasized the hatred of the baby that was inside the "center of the pillow" and her envy of anyone who got to be the "special, unborn, inside baby", something that she had idealized in her mind and longed for. It was interesting that the reason why she and her husband had divorced was that she saw him as "lazy", leaving her to do all the work and make the money, while he got to be the baby.

Much of her resentment in childhood, being the middle of three children, was that her dad did not rescue her and make her "his little wife", and that now I was also failing to take care of everything so that she could have relief from her envy and jealousy.

Dream #36: "…there was a family party with my parents and siblings and their friends…suddenly terrorists came over the back wall and started shooting and killing everybody…"

Comment: This depicts the natural tendency of most people to disown the destructive side of their personality and to feel it as foreign to their sense of identity. The woman who had this dream was about to go back East for a family, holiday visit and was frightened of her own envious and jealous feelings that were inevitably going to resurface.

Section 11: Dreams From the Psychotic Part of the Personality

Dream 37: "My shadow is chasing me all the time and I'm afraid of getting caught and there are people who can distort or change time and space and I'm running and can't get out of it."
Comment: I take this dream to be a depiction of the patient's feeling that he cannot escape the "crazy" part of himself, no more that one can outrun one's shadow. The ability to "distort or change time and space" was once seen by this patient as a desirable bit of omnipotence to cope with his disturbed childhood, but not was felt to menace his desire to grow-up in the world of reality.

Dream #38: "I'm looking in a lake and my shadow is looking at me." Associations: Sometimes in my dreams I get stabbed over and over. Sometimes my shadow tells me I shouldn't be here anymore and should kill myself – I know he's not real – if he was, then let him do it."

Comment: This dream is from the same patient as above, the night after the above session, seemingly elaborating on the struggle he is having with the crazy part of himself. Apparently, he feels pursued relentlessly by that part of himself that seems to be urging him to suicide. His response to this "death instinct" element from his unconscious inner world ("looking in a lake") is rather concrete, as if to say if it is really separate and can kill me, let me see him "do it".

From a theoretical level I took this more as the destructive side of his personality fearing that it would be put out of business permanently if the patient no longer saw it as powerful and in control. While there is always a suicidal risk with such patients, more likely by unconscious accidental behavior, I did not feel this patient was actively or acutely suicidal, but more exploring how his personality worked. This is in contrast

to Dream #10 that was mentioned previously where I thought the patient's dream did indicate and immediate, active, suicidal risk.

Dream #39: "Weird, terrifying dream – in elevator – doors open – grandpa said 'You're special in other ways that people can't see you – whether you think it or not'. The doors open and I'm in really weird mental institution – like art gallery – guided in pairs – I'm screaming or weeping or laughing. One one painting was this eye – the part around the iris is blood red and I got sucked into the painting. Then I was in my room and like a series of days it was done. I'd come in and not remember it. Every day it was more finished. I got scared – what now? Then someone came through the painting – a big black man, arms out vertical – like floating – standing much taller than me – like up to the ceiling. Then I get pushed out of the painting and warped somewhere. Then I was back in front of the painting – like the Cheshire Cat. I was screaming – then I see another patient who was screaming. I say this is enough for today and a woman asks me if I can go further…it was sort of like rehabilitation, like to hell and back – makes you more of a person."

Association: "It reminds me of a science fiction TV show I used to watch – where people are corrupted by power – automatically become bad – eyes turn red and could learn things instantly"

Comment: This is a psychotic dream in a person who was not actually psychotic at the time of the dream but had had a very disturbed infancy and childhood. It has very omnipotent, magical elements in it; extremely intense, terrifying feelings and images; and extreme time, space, boundary confusions. Interestingly, he seems to have a capacity to limit how much he stays in contact with this side of his personality as depicted by saying "..this is enough for today.." even though the analyst mother asks if he can "..go further..".

Dream #40: "…I went to the back of my mom's station wagon to get the grocery bags, there were bowling pin type things in the bags and I started pulling them out and tearing them apart with my teeth and there was blood and guts everywhere…"

Comment: This adult male had been admitted to a psychiatric hospital for a psychotic depression and had this dream on the first night of his admission. It represented the degree of murderous violence he had felt toward his mother and her inside babies. The dream was not "psychotic" is the sense of its structure but it depicted a degree of primitive violence that might be typical of someone who was psychotic.

Dream #41: "…I looked at the clock, which said ten, and I thought that can't be because I'll miss my 9:30 appointment and then I looked back again and it was only 9:00 and I was relieved…"
Comment: This dream represented the psychotic aspect of a neurotic patient who, when reality became too painful, simply went temporarily insane and altered reality.

Section 12: Dreams Struggling with the Depressive Position

Dream #42: "I was saying to my daughter that these schools are too dark for a proper learning environment."

Context of dream: Dreamer had been upset and depressed about a project going poorly at work. She had been lying down at home on the living room couch that evening and her daughter said "Mom – you look dead."

Comment: This dream can be interpreted at multiple levels and/or areas:
– At an external reality level she is concerned about her mothering of her children, she is too "dark", i.e. depressed and pessimistic, interfering with her children's capacities to see life in a "good light".

– At an internal, psychic reality level she is being like (i.e. identified with) her damaged internal mother which is interfering with her ability to move ahead in life.

– At an infantile, genetic history level, her mother was very disturbed and was unable to provide a proper learning environment for the patient to grow in a healthy manner. The patient was afraid she herself would never escape the orbit of her infantile darkness as evidenced by her struggle at work that day.

– An even more primitive offshoot of that was a baby phantasy that she was bad and her mother was unable to love her and "see her in a good light".

– In relation to therapy and the transference, the dream could be taken as a complaint that I am not fixing her so that she has not been brought to life on my couch. It might even depict an envious attack on the light of the analysis preventing a proper learning environment from being created by me.

We actually took up the dream as relating to recent discussions regarding the inability of her "adult" self to look after pained, "good" baby parts of herself that wanted to grow but were being consistently undermined by a highly competitive, enviously greedy "bad" part of herself that was particularly operative when a rival at work won an award.

Dream #43: "I was in a car with my parents but nobody was driving the car. I was in the back seat but somehow I took over driving it."

Comment: This dream led to a discussion of his essential view that his parents were irresponsible, self-centered and had left him, an only child, to fend for himself from early in life. The being in the back seat seemed less to represent anal omnipotence, although there was some of that, but more to be a pun on how his existence took a "back seat" to his parents' focus on themselves. What was particularly prominent in his associations to the dream was how incompetent and inadequate he felt in life and how he felt like he was put in an impossible position in life, "You can't drive from the back seat!"

What I felt was particularly significant, as he recounted this dream, was the mood in the session. It was one of sadness, not one of blame and therefore a justification for "turning away". The mood was almost the opposite, one of facing his childhood, his pain, and the consequences of how he felt in life. There seemed to be a recognition that it was now his "own responsibility" to drive his own car, as an adult , separate from his parents. The image of the parents in the car but not driving it reflected his need to accept the loss of childhood, his wish to be taken care of, and that time marched on and he had to move on with it.

Dream #44: "My left contact lens (which he later added was tinted and made his eyes look more attractively green than their natural hazel color) was really hurting my eye. I took it out and put it into my mouth to lubricate it and it broke into a bunch of pieces and I felt horrible".

Comment: This is a variation on the same type of persecutory dream, but with an emphasis on a loss of a good capacity, eyesight, as a result of a hostile misuse of it. The dream occurred as the patient was going on a trip with his father back to his childhood home which he had not seen for twenty years. He was feeling unconsciously depressed about being with his father (who tended to show off), reliving his unhappy childhood, leaving his wife for the weekend.

After some discussion of these issues and associations, I commented that the patient was feeling "down in the mouth" when comparing himself to his father, as his self-esteem and pride were disintegrating because he was feeling so painfully small and filled with frightening hatred toward his father. We were able to take this same dream up in the next session, in the transference, discussing his envious hatred of my "cleverly" interpreting with the phrase "down in the mouth". I cannot say whether I was projecting into him my "bigness", just as his father tended to do, by using that phrase at that moment, but it is a reasonable possibility.

Bion was known to say that someone was "depressed by persecution" and/or "persecuted by depression". Both of those ideas seemed to apply to this patient. He wanted to be a "loving" person but he was depressed by his instinctive tendency to "turn away" when his envy was aroused. The automatic nature of this "turning away" reaction, with its attendant phantasy of being manically self-sufficient by turning to his own bottom for food and comfort, was very "persecuting" to him in a manner similar to how a drug addict who wished to quit drugs would feel by the lure of heroin or cocaine when in emotional distress.

This patient still had considerable work ahead of him in analysis, but the dream seemed to convey the struggle that patients have as they work at what Donald Meltzer described as the "threshold of the depressive position".

Dream #45: "I was walking down a very narrow path and if I moved to either side I was immediately shocked on both sides."

Comment: This is a dream that is very difficult to interpret with a feeling of relative certainty about the correctness of the interpretation because it is too compact and lends itself to multiple ways of thinking about it. For example, the word shock could refer to being tortured or it could refer to being emotionally startled.

But if one looks for the dream's most emotionally prominent feature, it would seem to be that the patient feels that he is going through life at the moment of the dream where there was a very narrow range of emotional operation ("path") available to him. So the key issue is: What are the two "sides" of the "narrow path" representing?

I happened to know that this patient had worked hard at giving up omnipotent self-sufficiency but was still struggling with the anxieties that loving feelings would lead to great loss and emotional injury, recreating great losses from childhood.

With this in mind, I chose to interpret the dream as depicting the struggle the patient was having as a result of trying to allow loving feelings to predominate in his personality. On one hand it made him vulnerable to the "emotional shock" of potential loss, as a result of allowing his loving feelings to effectively "put all of his eggs in one basket". When he allowed his loving feelings to predominate, the destructive part of himself felt that it was threatened with being put out of business and murdered off so it threatened to torture him from the other side.
This dream can be taken to depict the essential conflict of the "threshold of the depressive position", turning toward "caring" and tolerating "ambivalence", or "turning away" to manic denial of caring.

Section 13: View of Therapy (Transference) Dreams

Dream #46: "I see a decapitated head and arm in some kind of series of rooms and there is an executioner with a hood over his head, no shirt on – he has been carrying out a series of beheadings and I'm apparently to be the next. I'm given a choice of axe or sword and I choose the sword (because it's faster, cleaner, one sweep) (I'm reminded of a tour of the Tower of London). There is no chopping block, I'm supposed to walk thru the doorway and he'll remove my head and I won't see it coming. So I walk toward the doorway – a little apprehensive but not terrified and decide to shut my eyes – so everything is black. Then I feel the Karate blow to the back of my neck – a blunt blow – then I feel like I'm falling forward and I realize that it is my head that is falling forward and I'll only be alive or thinking for another few seconds – then I start to feel this incredibly warm sensation from my abdomen going up to my shoulders – it rises to my shoulders and peaks and then there is nothing. I awake feeling very anxious."

Comment: This dream also made me anxious. I felt the reference to his therapy sessions with me was unmistakable. What puzzled me was why he would see therapy as so murderous a proposition and why he seemed so fatalistic about it, as if he had no choice but to die.

What I took up with him was that this was a dream, written by a baby part of him, that felt hopeless after birth, and did not see how life could be anything but one giant pain until one could stop being out in the world where the pain hopelessly outweighed the pleasure. I said that since he had never fully convinced himself that being born and out in the world was "worth it", he had to put that suicidal part of himself into me, to keep from giving up on life. I said I thought the dream poignantly conveyed what we were going to have to struggle together with if we were to be successful, namely that one or the other of us was going to have to tolerate feeling murderous.

Dream #47: "The dream starts with me at my old job … there is something about me coming to see you – but you are my optometrist or ophthalmologist – my eye doctor. I am coming to get new glasses or contacts. I walk in – it's set up like an optometrist's office and the first thing I notice is a pint of vodka or gin. I thought gee – Chris must be having a drink or taking a nip during the day. There was no label on the bottle. I'm on friendlier terms than in reality – I say I need new contacts – so you take my glasses and do something on a machine and give them back to me and say this should be better. I thought wow – he can do this and I was flirting with you. I rubbed my leg against yours – as if this was perfectly normal."

Comment: This dream has two key elements, a denigration of the analysis and analyst, and a manic denial of an unequal, therapist/patient relationship where the patient is dependent on the analyst for needs she cannot meet on her own. The analyst is now degraded to an alcoholic (the bottle with a clear liquid), maybe not even a medical doctor (optometrist instead of ophthalmologist), who uses a machine instead of his mind to do his work, and who is on an equal, erotized footing in an erotic transference that denigrates the proper psychoanalytic feeding relationship of the baby part of the patient to the analyst/mother.

This dream occurred in the latter part of the analysis as the patient was becoming more clearly aware of envious competitiveness that had been split off and denied for years while being the good, dutiful daughter.

Dream #48: "I have to teach a class on computers – it is supposed to start at 8 am – I don't know where it is, I don't know anything about computers, I feel horrible".

Comment: This patient had an 8:00 am therapy session. He was from an older generation that is often not so computer savvy, and he was no exception. I took the dream to imply that he was denying how difficult it actually is to do my work and takes years of experience and effort to become competent at it. If he equates it to working on a computer, then he can learn to do it himself and not need me.

My interpretation to him was that the therapy was making him aware if his tendency to feel small and inadequate if he couldn't do it all himself and would have to be dependent on me. I did not choose to bring up his envy of me expressed by the idea that he would "teach a class" instead of be the student.

Section 14: Dreams at the Threshold of Old Age

Dream #49: "I was someplace with people around. Johnny was there and it seemed like other people from that period of my life. He said he was going to kill me and he had a gun. I thought to myself that I don't have any way to escape and I don't have a gun or something to protect myself. I woke feeling a little panicked."

Association: Johnny and I were good friends through high school and into college. He committed suicide in college.

Context: The patient recently had a serious illness that was requiring extensive rehabilitation that was going more arduously that the patient had anticipated.

Comment: I asked the patient, for clarification, if Johnny had the gun in his hand or if the patient could see it in the dream? The patient said he didn't see it but Johnny said "I am going to kill you".

I said that Johnny in the dream clearly represented a part of himself (same age, close childhood friend, etc.) but the problem for us was to decide he stood for a destructive part threatening to encourage suicide or if he stood for "death" menacing him as a result of his illness and approaching old age.

Without hesitation he said "It is the second one". We went on to have a detailed discussion of his fear of death and realization that he may never be like he was before his illness. This in turn lead to his description of what he has to live for but also his awareness of the limits of the time remaining.

[Note: I think that the death instinct and bad part of self are always operative in the unconscious inner world throughout the lifespan. Ideally the adult self has a preeminent and predominating role in modulating the pain that the baby parts of self are capable of suffering.

As one approaches old age, with all of the losses, physical deterioration, and impending death with less time remaining each day, the bad part of self and the death instinct (i.e. urge to be unborn and immune to mental pain and anxiety that comes from caring about life) begin to reassert themselves. This resurgence is most visible in dream life. "Death" itself becomes personified and the hint that it is death is commonly reflected in the dream by a sense that it is unrelenting and/or inescapable.]

Section 10 - The Art of Engaging a Patient in Treatment and Its Natural Extension: The Conversion of Psychotherapy to Psychoanalysis

Abstract:
This paper outlines a method for conducting psychoanalytic psychotherapy in a manner that makes it natural to have the patient's progressive engagement in the treatment lead to psychoanalysis. The rationale underlying this method, based on decades of experience with few patients presenting as seeking psychoanalysis, has three main components. The first is the assumption that it is possible to conduct psychotherapy in a fashion that is fully compatible with psychoanalysis, but with the understanding that the unsophisticated patient requires some introduction very early in the work into what is going on and why. The second assumption is that the patient has to be introduced to and ultimately convinced of the scope and importance of their own unconscious inner world before they can truly understand the reason for and commit to an in depth treatment. And finally, the movement from once or twice a week psychoanalytic psychotherapy to the frequency and emotional intensity of psychoanalysis is achieved by a careful exploration of what the patient has done between sessions with the contact he or she has made with their unconscious inner world in the last session.

Introduction:
I was recently the discussant of a lovely paper given by English psychoanalyst Elizabeth Spillius on her experiences of supervising psychotherapy and psychoanalysis in London England. The experience led me to reflect on the details of how and why I do psychotherapy in essentially the same manner that I do psychoanalysis. I realized that this congruence is a consequence of pragmatic design, a result of thirty years of trial and error in a private practice where true analytic patients were rare. With as few as two or three referrals per year in my first five to eight years of practice, usually of patients with little or no money and serious characterological difficulties, I learned that psychoanalytic patients were made, not born. I also learned what it took to hold onto patients and did careful postmortems when they quit. This paper is an outline of my thoughts about that technique. It is essentially a "show and tell" of personal experience rather than an overview of a theory of technique.

Two Guiding Technical Principles:
I came to recognize two overarching principles as I explored which patients stayed in treatment and which felt they could justify quitting. The first was the realization that no patient felt a personal necessity to be in treatment until they came to fully recognize that they had an unconscious inner world that influenced in some fashion everything they thought, felt, and did. In effect, I did not have a "patient", or perhaps more accurately the individual did not accept being a patient, until I succeeded in convincing them that they had an inner world, and that to neglect their inner world was to risk peril to their lives and jeopardize their most precious commodity, internal harmony.

The second principle was that once they recognized that they had an unconscious inner world, typically a task of a few months to a year, then the frequency of sessions simply flowed as a natural offshoot of how well they could bear to stay in touch with that inner world between sessions. Where I could demonstrate that the pain of contact with themselves became more than they could stand before they got help with it in the next session, typically propelling them to some unconscious action to unburden themselves, I could then suggest that the obvious solution was do diminish the wait for the next session. Thus frequency became a matter of an inescapable logic, one that we were both able to see. It had added benefits in that it tended to diminish the paranoid fantasy that I wanted more sessions to satisfy my own needs and it undermined future moments of manic impulse to cut back on sessions.

Essentials of My Technique:
I would like to highlight some of the things I do in the earliest stages of treatment that lend themselves to the task of engaging the patient and simultaneously diminishing the need to "switch hats" technique wise as we gradually move to an analytic intensity of work. These elements fall readily into the following groupings:

1 – Introducing the patient to an analytic therapy setting, with analytic type boundaries.

2 – Gently introducing the patient to their unconscious inner world, often with some initial explanation that has a mildly educative quality, especially when the issue of the moment is beyond access using common sense. This introduction includes unconscious modes of functioning with an emphasis on projective processes, and emotional states of mind including the importance of envy, jealousy, and separations.

3 – Introducing the concept of levels of maturity in thinking, feeling, and functioning, with a particular eye toward learning to recognize infantile states of mind.

4 – A regular linkage of reactions to the outside world with the possibility of a similar reaction to me, long before the frequency of sessions is sufficient to make transference interpretations a staple of the work.

5 – A continual vigilance to anticipating and interpreting negative transference reactions before the patient is in the compelling grip of a negative juggernaut toward quitting therapy.

Analytic Boundaries and Setting:
I graduated from my psychiatric residency and within two months simultaneously began psychoanalytic training and opened my private practice. I very much wanted to do things as I imagined a proper analyst would, so I was running a fairly tight setting and attempting my version of analytic boundaries right from the beginning, awkwardly of course.

Perhaps most prominently, I never answered direct questions about myself and my private life. Over the years I came to realize that although this was originally omnipotent rigidity on my part as I "got inside" the identity of an analyst, it actually served the purpose of creating a serious work atmosphere that was reassuring to patients. It also avoided collusion with the patient's manic unconscious phantasy that therapist

and patient are on the same level of functioning and dependence on each other. I became very proficient at responding to the typical sorts of anxiety driven questions, when first meeting a patient, such as the nature of my training, was I married, did I have children, etc. I would point out that the questions were reasonable and fair, but if I could be allowed to do "my psychiatrist thing and not answer them directly", I thought that the questions were an expression of an understandable concern about my competence, but in reality would at best be only a wishful reassurance. The one question that might work, namely how long was my training analysis and with whom, was a question they wouldn't know to ask. Even if they did, it wouldn't guarantee that I had made good use of it, and ultimately we would have to get to know each other by a trial of working together as true trust is necessarily a function of experience over time.

This fairly strict approach to answering questions, as with all the things I say and do early on in establishing a serious working environment, is always buffered by an attempt on my part to explain the logic or rational determining my approach. I assume with all patients, because it is usually correct, that they don't really understand how or why talk therapy works, and it is unreasonable of me to expect cooperation from them when they don't really know what cooperation would look like. This assumption leads me to be mildly educational with patients in the early weeks as new issues come up.

Introduction to the Unconscious Inner World:
Perhaps the area in which I do the most explaining of what we are doing is in relation to introducing the patient to their unconscious inner world. During our first meeting I will often suggest that the things the patient is presenting have their roots in ways of thinking and feeling that were developed in much earlier life, even infancy, as hard to believe as that may seem. I say that I will go out to the frontiers of what we know about the patient, speculating about the possible origins or meanings of things, and will try to protect both of us from going in the wrong direction by not getting too attached to my own ideas. For example, a very mild mannered man was working on a Sunday in his office, feeling very sorry for himself, and went berserk, totally destroying everything in his office. He went home, his wife insisted he consult a psychiatrist, and a day later he was in my office. For reasons I cannot explain, his description of that Sunday led me to liken his feelings to what I could imagine might be experienced by a colicky baby. It was only six months later that he confided, as he was already well on his way to what became a five day per week analysis, that he would never have come back for a second session if I had not mentioned the colic. He had been told that he was severely colicky from three weeks through three months of age. As I had no way of knowing that, it impressed him that there might be something of value to what I was suggesting and his curiosity was piqued.

I view that type of experience as essential to aiding a patient in recognizing the possible links between their early experiences and their adult personality functioning. I am always on the lookout for historical data from adolescence or adult life that can be speculatively linked back to infancy. These links might include a history of being adopted, born prematurely, having peri-natal difficulties, being weaned from the breast too early or precipitously, having a sibling born while the patient was still a baby themselves [e.g. at 18 or 20 months or less], having serious early childhood illnesses or separations, etc. Whenever I have anticipated such a background, historical element, and asked a pointed question that gets a response of "how did you know to ask that?", I know I have a patient who is likely to be impressed by the linkage between their early experiences and their later functioning, i.e. they have an unconscious inner world.

In a similar fashion, I will suggest to patients that their dreams can be thought of as being written by the baby core of their personality. Because of this, dreams give us a window into what is of the most concern at that deepest unconscious level at that moment and what is being done to deal with those concerns. This approach of the early encouragement of bringing in dreams, which I was taught was undesirable as it is too directive, never the less, jumpstarts and augments the process of learning about the unconscious, especially in the patients who have a natural facility for remembering their dreams. I first learned to bring it up when many months into treatment I remarked to a man that he never brought in dreams and to my dismay he said he had them every night but he didn't know that they were of any significance! That taught me to change my beginning approach. I have never found this early encouragement regarding the value of dreams to be a problem as it is a fairly easy task to interpret their misuse, should that turnout to be an issue.

A typical example of the overarching value of dreams in recognizing the existence of the unconscious world and its myriad of links to early life occurred in the second session with a man who had committed an act that was very out of character. After I had suggested, in our first meeting, that making an effort to remember dreams might particularly aid us when so many of his thoughts and feelings seemed unavailable to his conscious awareness, he brought in two dreams. The first dream clearly expressed his anxiety that I might not take him into treatment, something that he was unable to see until I pointed it out but with which he then wholeheartedly agreed. The second had him trying to get his mother's attention, barely succeeding, and then:

"the scene shifts and my family and I are crammed into a very small car, like a Geo-Metro, and a man is driving it through an outdoor museum. The field is overgrown with grass around all these varied objects, in various states of neglect and disrepair, cars, airplanes, and lots of other stuff. People are walking around working on various things to restore them. At that point the car has to be driven across a ditch or canal and I'm afraid the water may be too deep to cross. The car manages to splash through it, it is not as deep as I thought, and the car then goes up the bank on the other side and crashes through a fence coming safely to rest".

I suggested to him that this dream seems also to be about our relationship and how it parallels his childhood and current life. In the dream he is waiting for his mom and has to go to some length to get her attention in the midst of a crowd of siblings. In parallel, he has to go to some considerable length to get my attention. I further suggested, and this idea really stuck with him after the session, that the outdoor museum represented his unconscious inner world which he had neglected his entire life and now required attention and restoration. He wasn't sure he could safely undertake that restoration, and maybe would even like to passively leave it up to others to do on his behalf. If the water and ditch stood somehow for the perils or obstacles of going into therapy, the dream seemed to end with some feeling of relief at having gotten through it and survived. He listened intently, and if his body language was any indication, it was having some impact on him. I then told him I was willing to take him on as a patient, but we would have to struggle for a bit to arrange a regular meeting time. As seems often true with patients, the fact that he authored a dream about which sense could be made, increased both his belief that a lot was going on in his unconscious and that he was even having fairly intense reactions to me, i.e. an early introduction into the idea of transference, and that those reactions had parallels to his childhood.

Because this patient was someone who had a sibling born when he was only 18 months of age, I was also able to suggest that the act he had committed was linked to his anger at his mother for making the sibling, the significance of the sibling and possibility of anger at his mother both being novel ideas to this man who was fairly naïve about psychological issues. I am again both speculating out to the frontiers of our knowledge and being mildly educational. But as I experience it, I am also laying the foundation for an ability to differentiate levels of maturity in what the patient thinks and feels, a crucial element in my arsenal for convincing patients that their unconscious contains really important things about which they know very little.

Infantile States of Mind:

I had a troubled infancy, I knew that fact long before I understood it, and it seems to have created an instinct for intuiting, as I tend to put it, "baby level difficulties" in patients. While it leaves me open to the criticism of being reductionistic or worse yet, projecting my baby stuff into my patients, I can only say again that I try not to get too attached to my own ideas and I always look for corroborating data from multiple vertices. But the key point is that the earlier back into childhood I can trace the origin of an attitude, defensive style, emotional tendency, etc. the broader its implications and explanatory value. Inextricably bound up with this recognition of what I usually refer to as "baby states of mind", is the clarification of what an "adult" attitude or level of functioning might look like in contrast. I suggest in the beginning that the distinction is often hinted at by the intensity of emotions evoked, baby ones often being excessively intense for the situation or issue at hand, adult ones often having a more balanced quality in terms of intensity, less impulse to action, and are more likely to have constructive coping ideas more easily accessible.

There are two key elements in this differentiation that are quite beyond the scope of this paper but are crucial to my work toward an educational introduction to the patient's unconscious. These are the vicissitudes of projective processes and unconscious envy. I view the operation of both to be among the most crucial to mental functioning at a baby level of the personality. I also view the two to be the farthest away from consciousness, and common sense access, of any important mental activities. However, once patients understand how projective processes and unconscious envy operate in daily life, they both tend to be readily embraced by most. This is especially true of envy. I cannot recall any patient who had a significant difficulty with unconscious envy ever bringing it up until I first broached the topic. But I can remember a number who made it a regular staple of their analytic diet once they truly grasped its significance in their daily reactions to people and events around them.

Projective processes are a more complicated and problematic issue for therapists, in no small part due to the confusion attendant to Melanie Klein's monumental discovery of the importance of projective processes in mental functioning at the core of the personality, but unfortunate use of the phrase projective identification. As a colleague once said to me, when he heard I was going to teach a course on the topic, "Okay, I get the projection part but where does the identification come in?" I have abandoned the phrase although I could not practice without the concepts. I explain to patients that it is useful to imagine that the baby part of the personality treats mental and physical states of experience as if they both can be dealt with in a similar concrete fashion, roughly approximating the functioning of the digestive tract. For example, babies will often cope with physical states, especially when uncomfortable, as if they can relieve themselves of the state by pooping, peeing, spitting up, coughing, sneezing, crying, etc. In a similar fashion, they can treat states of mind as if they could be concretely put outside themselves, evacuated into the outside world. I then suggest that this process continues, even in adult daily life, at a deeply unconscious level, completely outside of conscious awareness. That it is easy to recognize and follow its consequences once the existence of its concrete operation is accepted. All one then needs is to be on the lookout for the content of the projection, the motive for the projection, and/or the imagined consequence of the projection. In fact it can be treated like an algebraic equation in which one can figure out the third element if one knows the other two elements. Any state of mind, part of self, or internal version of mom or dad, etc. can be the content. The motives often range from:

1 – The evacuation of an unwanted or even hated internal element, felt to be uncontainable, but with no particular motive to do harm to the recipient.

2 – The getting rid of something felt to be bad or undesirable with a primary motive of doing harm to or diminishing the value of the recipient to the projector, as is so often seen both in projections that could be described as "envious reversals" and states of manic denial of the importance of the person to the projector.

3 – Depositing something in someone with the hope that the recipient will then better understand how the projector feels, i.e. for the purpose of communication.

4 – Depositing something felt to be good into someone as a gift or for safe keeping where the projector is unsure of their own goodness or ability to preserve it.

One can readily imagine how each of these motives, when combined with the content of the projection, leads to a relatively predictable consequence in the phantasies of the projector and the experience of the recipient. The patient who was mentioned earlier who brought two dreams to his second session, desperately wanted me to be a good parent that could help him, and I think projected that good analyst parent into me. I could palpably feel his assumption that I had the capacity to understand him, even though he had yet to have the requisite experience over time to trust that wish. Any negative projections into me, such as a bad mom who is unavailable to him, was not immediately central to the work at that moment but would probably be a staple of later work in the transference.

In the example I am about to give, the patient projects a traumatized baby part of herself into me, and I am temporarily traumatized as I receive it. But the patient was probably also strongly motivated unconsciously to communicate about this issue that so desperately needed to be born into the light of day, and the evacuation was easily converted into a very valuable communication. My final example, regarding negative transference, contains elements of several motives. This patient regularly projected very bad versions of internal parents into me, especially an alcoholic mother, and would temporarily view me as ruined and ruining her in retaliation. This was often an envious reversal, sometimes a more straight forward ridding herself of something felt to be uncontainable but no harm intended, and occasionally primarily a communication.

Of great importance to the therapist and patient is the realization that all projections, for any motive, are automatically converted into a communication if the therapist can understand them and convey that insight through an interpretation. Nowhere is this more important, as I see it, than in working with the negative transference. Because the patient's inner world is a product of how they viewed their infancy and childhood, and is now alive inside them directing their daily life, I am in a position to anticipate that everything that was negative in their view of their earlier life has a good chance of being repeated with me. My experience has taught me that I should comment in passing, as I take a history or intuit something negative about the patient's attitudes toward others, that that same attitude is quite likely to come out in our relationship. This seems consistently to make it easier for the adult part of the patient to recognize a projection into me from a baby part of the patient, and to more easily consider the distortions of me and our relationship attendant to those projections, when they inevitably come home to roost at some later date. I often then have a better chance to modify with interpretations, what will otherwise be an impulse in the patient to potentially problematic or destructive action based on the anxieties and distortions caused by the projection.

I would now like to go back to the issue of the importance of recognizing infantile experiences and very primitive states of mind, buttressed by the tools for understanding that a model of projective processes affords.

A very dramatic example of infantile aspects of the personality coming up in the transference occurred with a morbidly shy woman early in my career. She came in on a Monday and told me that she had decided over the weekend to quit her treatment. She had only been in therapy for three months but I had a strong sense that the work was very helpful to her. I had been looking forward to the session with positive anticipation, and was so devastated by her announcement that I was literally speechless for the rest of the session and couldn't wait to discuss it with my supervisor. In the supervision it was suggested to me that she was recreating something of powerful significance from her early childhood. In the patient's next session I broached this possibility and to my amazement she told me, for the first time, that her mother had breast fed her for three months and then abruptly stopped because a well meaning pediatrician had suggested that the baby was not gaining enough weight. The patient who did not quit after all, once she realized she had enacted something primitive with me as a communication about her own infancy. Over the next year she had dream after dream about mothers and babies who had gaping wounds on their chest or face and were in the hospital in various stages of illness and distress. We came to the powerful and inescapable conclusion that she had felt very comfortably joined up to her mother's breast and that the precipitous weaning had been a catastrophic disruption of that union. She went on to a very fruitful seven year psychoanalysis!

This is but one of innumerable experiences I have had over the years where an experience from very early life, particularly in the first days and weeks of infancy, and the patient's "baby" reaction to it, has been crucial in giving meaning, much like a Rosetta stone, to the reactions and interactions that dominate the patient's emotional climate on a daily basis.

Summary of the Early Phase of Treatment:

I would like to summarize, using slightly different words, what I have just highlighted about my approach to early phases of psychoanalytic psychotherapy.

1 – First, I am interested in helping the patient see that they have an unconscious inner world and that it is a product of their childhood, and in particular their infancy, and how they viewed and reacted to those experiences.

2 – That these experiences, especially going back to earliest infancy, typically have a far greater impact on how their mind works than common sense would allow them to recognize.

3 – That this unconscious inner world, being the only game in town, is all they know of how relationships work and will necessarily, therefore, be recreated in all intense relationships including the one with me.

4 – That this recreation with me affords us the valuable opportunity to put our heads together and compare our mutual experiences of what goes on between us.

5 – That this same baby core is the author of night time dreams, and these dreams are a valuable resource, in pure culture, of what is most important in the patient's unconscious inner world at that moment, and how at that deeply unconscious level they are choosing to deal with those emotionally significant issues.

Frequency of Sessions and Mental Pain:
During this time I am continually observing and commenting on the patient's ways of coping with the mental pains they experience as they conduct their daily lives. This includes explorations the origins of these pains and the origins of how they adopted the methods they use to cope with these pains. Of particular interest to me is the degree to which they find our discussions helpful to them in coping with these issues. In turn, how well does this feeling of being helped to cope hold up between sessions. Can they bear to stay in contact with what we have stirred up. When the patient has not been able to sustain contact with the issue between sessions, I can then explore why they couldn't and what maneuvers they then used, almost always unconsciously, to cope. Where these coping maneuvers involve problematic defensive actions, which at times with more seriously characterologically disturbed individuals may lead to serious acting out, I am then in a position to demonstrate specifically why this is a problem that can be linked to the frequency of sessions. That, in effect, we need a frequency that is adequate to hold the patient from the previous session until the next opportunity for us to work on understanding their unconscious pains. Our goal would be to achieve the necessary frequency needed to be able to tolerate these pains without being driven to unburden themselves through action during the gap between sessions.

This is all in the context of the external reality factors of time and money, but they are probably less critical than one might imagine. How this process develops probably correlates more with such variables as:

1 – How much pain the patient experiences and how problematic their outside life is.

2 – How intensely wedded they are to manic maneuvers and omnipotent acting out to cope with mental pain.

3 – How seriously they turned away from their primary objects in infancy to form a narcissistic personality organization.

4 – How much healthy encouragement versus destructive collusion they get from those around them.

A key point for me is that none of this is mysterious, privileged information that I have and visit from my sophisticated position down to the patient. The need to increase the frequency, for example, is invariably

obvious to both of us before either of us is sure how to achieve it. It becomes a shared mutual decision even though I am often the first to suggest an additional session.

Because this all tends to happen naturally over time, organically if you will, we rarely make a distinction about what to call what we are doing. Initially, the patient tends to recreate the relationships from their unconscious inner world by externalizing them with such significant figures as spouse and immediate family, relatives, people at their workplace, friends, etc. But over time, as frequency increases, I am able to demonstrate those same recreations occurring with me in the transference, and that slowly but inexorably eclipses the outside focus. A psychoanalysis is born, albeit with a long gestation and a not so dramatic delivery.

As an aside, regarding the use of the couch, I tend to bring it up whenever a patient seems to be distracted by our looking at each other. I simply point out that it is easier to focus on contacting their own thoughts and feelings if they don't have as many distractions. This might occur with a once a week patient, but is common place with three times per week.

Summary of Key Points:
So we now have an overview of the three main points of this paper. First that it is possible to do psychotherapy in a fashion that has as its natural extension, doing a psychoanalysis without significant modification of technique. The second point is that I don't really have a patient who believes they need treatment until they have a conviction that they have an unconscious inner world. Once they truly see that fact, and want to alter those elements that are problematic in their inner world, they will want to become intimately familiar with it.

In that process they will also become familiar with how they cope with contact with this inner world between sessions. The needed session frequency will then be a logical and obvious function of how well they can tolerate staying in touch with their inner world between sessions. This naturally leads quickly to twice a week which is always experienced as more than just a double of once a week, and fairly readily extrapolates out to three, four, and five times per week over a period typically of one to three years. I do not wish to sound like a Pollyanna who thinks this will all unfold smoothly. I have, with virtually all my patients that ended up in a four or five day per week analysis, gone through many trials and tribulations about which I would have gladly spared us both. But childhood necessarily develops unevenly, and so does the best of analytic relationships, as is self evident to anyone in this business. I do think that for patient and therapist alike, forewarned is forearmed. This I believe to be especially true of negative transference reactions.

Anticipating the Negative Transference:
I would now like to turn my attention away from therapy relationship enhancing issues to therapy destroying issues. When one gets only two referrals a year, it becomes necessary to anticipate every possible resistance that could torpedo the work. The most obvious are always money and time. With this is mind I learned never to set a fee without detailed exploration of both the external realities of the patient's finances, and a good overview of the emotional significance of the fee to the patient. I have always tried to get the patient to decide what he or she feels would be a fair fee for both of us. Not infrequently I go with a slightly lower fee in anticipation of a greater frequency sessions. I don't want to be a reasonable approximation, in the patient's unconscious phantasies, of a greedy part of the patient or a selfish internal parental figure because I appear more interested in the money than the patient.

In similar anticipation of negative transference possibilities, I have tended to analyze idealizations of me as they come up. I was taught to assume that when I'm being made "all good" that there is some scary bad stuff lurking around and I would rather get to it sooner rather than later. As I say to patients, I realize that "it is a quick, short drop from being idealized on top of the pedestal to being crushed underneath it"! So we might as well go looking for what is so bad or anxiety producing that it has to be kept out of our relationship.

Maybe even more directly to this point of negative elements that will come home to roost sooner or later, I try to actively anticipate all negative transferences long before they arrive in full bloom with their inevitable high potential for irreparable harm. Anticipating them doesn't seem to stop them, it just seems to aid in the patient's ability to more readily differentiate their bad internal version of me from the [usually less bad] real me. Nowhere is this more apparent to me than with patients who turned away from a flawed, but good enough parent, who is also the object of considerable envy for those good qualities that were not consistently available to the patient. This brings me to a graphic case example of negative transference impeding a needed frequency to adequately support the patient and diminish her regular desire to quit treatment.

A woman came to me for treatment because she was very chronically unhappy with her life despite a superficially successful marriage, two lovely teenage children, and a very successful career as an artist. She felt herself to be much too perfectionistic in her art work, unable to make use of praise, and she led me to believe for the first two or so years of treatment that this was all the fault of her out of control alcoholic mother who had ruined her childhood. This was all presented to me as historical fact and I had no reason to doubt it. In her second year of treatment, coming at a frequency of twice a week and with regular worries about the financial burdens, and what if this or that bad thing happened financially, a pattern began to develop. We would have what I often thought of as a good session, and she would come to the next session with every intention of quitting because I had been so insensitive and cruel in whatever I pointed out to her in the previous session. I would try not to be overly defensive, try to see her point of view, but would always question why she didn't confront me at the time if what I had done was so cruel or insensitive. I would also remark how everything that had ever been good in our work seemed so completely lost for her at those moments. My above mentioned bit of defensiveness was usually in the form, at least to the extent that I'm consciously aware, of reminding her that I had become all bad just like her mother was for her internally.

Our breakthrough came in that second year when she had a dream in which "a beautiful woman was giving a party and everyone in the neighborhood of her childhood was there, singing the praises of this woman, how beautiful and fun she was, etc." This watershed dream led to several sessions in which a number of facts emerged about her mother that were revelations to me. First, and most importantly, her mother had not become an alcoholic until the patient was pubertal although had always been a relatively heavy social drinker along with the patient's father. Secondly, her mother was quite beautiful when the patient was young, even though later she looked like a fairly dissipated alcoholic. Finally, her mother was by all accounts a very colorful woman in every possible way. She dressed with a flair, was the life of the party, and to add insult to injury, the patient's friends would come over to hang out with the patient's mother instead of the patient. This led to an instant association on my part as to where the patient got her artistic talent for color but could not enjoy, or at root, take any credit for it. She denied her mother any credit for teaching the patient how to put color together, and now her own work was nothing but un-attributed plagiarism. Virtually all of these attacks on her mother had gone on unconsciously, and it was a disturbing revelation for her to see how she had ruined her mother inside herself.

It also became a template for deciphering what was going wrong between us. When she would leave a session, she would find herself focused on some small slight she felt and it would grow over several days, especially weekend breaks, to the point that it would feel like a momentous injury. Completely unavailable to the patient was her feeling that I was so much more colorful as a person, and that I wouldn't want to see her more often because she would just be a drag on my happiness. From one frame of reference, the frequency of twice a week was woefully inadequate for what she needed. I was iatrogenically making matters worse, in the sense that it was my responsibility to see that the frequency was adequate to the task. I had allowed her protests of financial anxiety to put me off what I would ordinarily suggest. When I pointed all this out to her, she was able to recognize the merit of my points, that she was treating me as she treated her internal mother, never giving me the chance to become a better mother who more adequately met her needs. This of course also allowed her to evade the experience of any envious feelings toward me as I remained chronically marginal as a mother. Shortly thereafter we were able to arrange a compromise fee that allowed us to increase to three times per week. The flow of the work improved considerably, and she began to truly dissect and own what she did to her mother and me.

In this example, I hope it comes through that what I was doing was analysis of an issue, essentially no differently than I would if the patient were in five day a week analysis, but that we would never be able to get to an analytic level without work on those negative transference elements. My primary point being that it is precisely those types of elements that, unaddressed, prevent a psychotherapy from ever growing to an analysis. It is even conceivable to me that nearly every psychotherapy with a patient who has significant characterological difficulties and does not progress to analysis, is breaking down because some aspect of the patient's omnipotence and negative feelings, often an envious reaction to the treatment, is not being addressed.

Concluding Summary:
In summary, I would like to suggest that at least here in the my region of the U.S., psychoanalytic patients are made, not born. That every psychotherapy has the potential to progress to the level of a psychoanalysis. That progression is as much or more a function of the therapist's mind set and expectation as it is the patient's availability. The therapist who can demonstrate the existence of an unconscious inner world that informs and determines how the patient lives his or her life is then in a position to suggest that the patient has no choice but to learn about that inner world as it is the only game in town. Once that patient comes to the realization that they neglect that inner world at their own peril, then the therapist has a patient who can see the logic, if not necessity, for coming as frequently as is needed to do justice to exploring and modifying that inner world.

Section 11 - 25 Axioms Every Mental Health Professional Must Understand

Introduction:
1 – This is a list of 25 topics and corollaries that I think are particularly useful for a mental health professional in their everyday clinical work. Additionally, I am highlighting topics many of which can be explored at greater length in other areas of "Minnick's Klein Academy" – MKA for short. References to those additional readings will be made at the end of some of the Axioms.

[Note: I think it is fair to say that I learned most of these axioms either from reading the works of Melanie Klein and her students and colleagues, or from Dr. Albert Mason. I owe a debt of gratitude to all of them.]

2 – I have arbitrarily divided the Axioms into 7 broad categories following a rather loosely organized developmental sequence from infancy to adolescence. The 7 major headings are:

– Neuroscience, Early Psychological Development, and the Elaboration of Unconscious Phantasy [Axioms 1 – 3]

– Life Outside the Womb, Mental Pain, and Coping/Defensive Maneuvers [Axioms 4 – 8]

– Core Emotions in the Relationship to Mother in Infancy [Axiom 9]

– The Role of Destructive States of Mind in Development [Axioms 10 – 13]

– Adolescence, Development, and the Baby Core of the Personality [Axioms 14 – 15]

– Marriage and the Baby Core of the Personality [Axioms 16 – 20]

– Being a Therapist and Doing Therapy [Axioms 21 – 25]

3 – There is purposeful repetition of many of the ideas in this seminar in the hope the repetition will clarify and connect ideas and cement the readers understanding of them.

Neuroscience, Early Psychological Development, and The Elaboration of Unconscious Phantasy

[Note: My main premise here is that "neuroscience" provides a "neurophysiological" explanation for what Melanie Klein saw and intuited from her clinical experience with infants and very small children.

Axiom #1 – The Amygdala is the Infant's First Memory System and the Location of the "Baby Core":

– Arguably the most important concept that neuroscience has to offer psychoanalysis is that the "amygdala" is the primary memory storage area of the brain for the first two years of life. In effect, it seems to be the source of what can be referred to as the "baby core" of the personality. Its two most important characteristics are that it: (1) stores "memories as feelings", rather than concepts or ideas; and (2) these "emotional memories" cannot be recalled through "conscious introspection". They can, however, be "relived" in the outside world, thus forming the foundation of the "repetition compulsion" [See Corollary 3].

Corollary 1: The amygdala is at the heart of "mental health and illness", as the primary location of the "baby core" of the personality, thus making an understanding of its significance invaluable.

– Most mental health professionals recognize that very early life experiences seem to disproportionately set the stage for such things as (1) a person's attitudes about his or her life, 2) approaches to the management of emotions and stress, (3) ways of experiencing others and relating to them, etc.

Interestingly, these earliest attitudes about life and coping strategies often seem to be all that is left at the end of life, in old age, as one increasingly faces the reality of one's ultimate mortality.

– To put it in summary form, the "baby core" of the personality dominates in infancy, resurges to the forefront at puberty and into early and mid-adolescence, and seems to be all that is left for many in old age. We have all had patients for whom infancy was difficult and traumatic, and who seemed to "constitutionally" bring coping strategies that did not lend themselves to evolution and modification in later childhood. They often seem unable and/or unwilling to change to any significant degree, even with the aid of the insights that their therapy experiences offer them.

– The punchline is that it behooves all therapists to recognize and develop models for conceptualizing the "creation" and "operation" of the "baby core" of their patient's personality. It may rule even with understanding, but it will surely dominate if not recognized for its infantile origin and nature!

Corollary 2: If "memories as feelings", stored in the amygdala, are the "origin" of the "baby core" of the personality, then I find it extremely useful to picture these "memories as feelings" as being stored as a "PAIRED RELATIONSHIP" between a "part of self" and a "primitive version of mom or dad". This is probably originally at a "part object level" (i.e. consisting of a "bodily part" of mom or dad, performing some "function" as in, for example, the "feeding breast" or "toilet breast").

– It is helpful to think of the emotions connected with this "paired relationship" as a very primitive precursor to what will be later referred to as "UNCONSCIOUS PHANTASY". This pairing will be "externalized" and "recreated" throughout the lifespan, whenever the opportunity arises.

– The "parent" half of these "paired relationships", i.e. a primitive version of mom and/or dad, represent what is referred to in psychoanalytic literature as the "super-ego". The negative versions of mom or dad become what can be referred to as a "harsh super-ego".

The positive versions of mom or dad can grow to become, over the course of childhood, "inspirational" figures. This means that the more restrictive "early super-ego" can be "grown" in the course of childhood into a more mature version that is predominantly positive, and that one "aspires" to be like, thus becoming what Donald Meltzer refers to as the "SUPER-EGO IDEAL".

Corollary 3: Because these primitive memories as feelings are stored as the link to a "relationship between self and object", and because they cannot be "consciously recalled", only relived in a relationship, these two facts are at the heart of the "repetition compulsion" and its therapeutic sibling, the "transference". In essence, if a person can only recreate these internal paired relationships in the outside world, then the outside world is the only place in which these stored "memories as feelings" can be brought into awareness, as they are being "externalized and recreated" with someone in the here and now.

– This is at the root of Bion's idea that "true psychological development and change" only takes place in the context of an "intimate relationship". In other words, an "intimate relationship" is one in which the "baby core" of both individual's "inner worlds" is engaged. This means that "casual" and "contractual" relationships are unlikely to "evoke the baby core" in a manner that has a high likelihood of opportunity for recognition and change of a "baby" pattern of "viewing and relating to the world".

Thus the "baby core" is most commonly engaged in: (1) a relationship to parents and siblings, (2) dating and marital relationships, and (3) therapy conducted to maximize the opportunity for its operation and recognition (i.e. analytically oriented therapy). It need not ever be engaged with acquaintances (i.e." casual" relationships) and workplace interactions (i.e. "contractual" relationships).

Corollary 4: Because the "amygdala" level "memories as feelings" cannot be consciously recollected, but can be "relived", it becomes an ironic fact that to "access" these "primitive relationships" one must recreate them with another person of emotional significance. This leads to an explanation of Bion's idea that true structural "PSYCHIC CHANGE" is most likely to occur only in the context of an "intimate relationship", not intimate in a "sexual sense" but intimate in an "emotional sense".

– The "most primitive versions" of these stored emotional states (i.e. from the first hours, days and weeks of infancy) seem to remain only accessible through recreation in the outside world as a very "primitive" object relationship (i.e. the "repetition compulsion"). Because these states of mind, as emotional reactions, are so early, vague and yet global, and because they are so "beyond verbal thought and abstraction", it is an absolute necessity to have "models" for these very "primitive" experiences, or they will never be recognized and understood. It is inconceivable that one can do this without working with a therapist who has been trained to recognize such primitive states of mind.

Corollary 5: It may well turn out to be that it is at this level of the amygdala that the "most primitive psychological maneuvers" operate. I have particularly in mind "denial", "introjective processes", and "projective processes". This idea would contribute to an understanding of why these processes can occur completely outside of conscious awareness, even in an individual whose mental functioning is both reasonable and realistic in most areas of life.

Corollary 6: It has to be that the "memories stored as feelings", at the level of the amygdala, are very much connected to what is "evoked" by later traumatic experiences, as now seen so commonly in our young adults suffering from "post-traumatic stress disorder", after serving in military combat situations.

Even though medications and behavioral maneuvers are successful in alleviating the symptoms in some individuals, it is worth noting that for some, it probably must also require an understanding of very primitive experiences, left over from infancy, which were never recognized, abstracted out as an issue, and understood at a more logical, cognitive level.

Axiom #2 – The Hippocampus is the Second Memory System, Only Fully Operative After Age Two:

– The “hippocampus” is at the heart of a “more elaborated and sophisticated memory storage system” that only comes online around the end of the second year of life. It (1) increasingly takes over for the amygdala, (2) can make use of “verbal thought” because language became operative in the middle of the first year as a more advanced method of communication, (3) enhances the development of the use of “symbols” and “symbolic thought”, and (4) makes more elaborate connections to other areas of the cerebral cortex, perhaps most importantly for emotional development, the “frontal lobes”.

Corollary 1: It is very likely that it is at this level of the “hippocampal memory system” that “unconscious phantasies” become more elaborated and achieve their ultimate form, suitable for expression in “dream life” and “verbalized symbolic expression”.

– This might help explain why “primitive versions of unconscious phantasies” that were stored in the “amygdala” (i.e. as “memories as feelings”) in the first two years of life, and which could only be “relived” but not “thought” about, can later, when “elaborated at the level of the hippocampus” not only be relived and re-experienced, but there is now the added possibility of giving a more “elaborate meaning” to a stored “memory as a feeling”.

– Thus the original “primitive memory” can be expanded, making it possible to contemplate and create an answer to such questions as “who” is doing “what”, to “whom”, and “why” are they doing it. It is very likely that each “unconscious phantasy” has a very “primitive” interaction at its foundation, left over from very early infancy.

Put in other words, the “primitive paired relationship” between a “part of self” and a version of “mom” or “dad”, stored at the level of the amygdala, probably gets “reworked” later in early childhood to become storable at the level of the “hippocampus”, with a more “elaborated meaning” given to it. Thus the earliest “unthinkable” primitive relationship moves into the realm of a potentially “thinkable” and “dream-able” state of mind. It has been given a more sophisticated “meaning” as to what the “part of self” and “version of mom or dad” are “DOING TO EACH OTHER” and “WHY THEY ARE DOING IT”.

Corollary 2: It is therefore likely that the more “elaborated psychological defensive maneuvers”, and I have in mind particularly Klein’s “manic defenses”, are operative at this level of mental functioning at an unconscious level, i.e the level of the “hippocampus”.

This contrasts with very early infancy. While I cannot prove it, it seems logical to me that the earliest defensive maneuvers (i.e. “denial” and “evacuative/projective processes”) are operational at the level of the “amygdala”, and remain so throughout the lifespan at that level. This makes them among the “MOST UNCONSCIOUS” of mental maneuvers, along with the operations of primitive, “unconscious envy”.

Corollary 3: It is fascinating to consider the implications of these two memory systems, one that is not “retrievable” via “conscious introspection”, and one that is potentially “recallable”.

– I have observed over my career, often to my own amazement, that a human being can be “projecting” massively, all over the place, and be “completely unaware of” and “oblivious” to that fact. Additionally, I have constantly observed people to be responding, “powerfully and destructively”, to their own unconscious feelings of intense “unconscious envy”, with absolutely “no awareness”. This can at times be astonishing.

For example, I once had a brilliant university professor who consistently used obscure, highly sophisticated words to express himself, ones that I often did not recognize. After many months I finally inquired as to whether he was aware of this use of his vocabulary, and to my amazement, he was utterly unaware of it. He literally stopped doing it that day and never did it again over the ensuing years of treatment.

– These repeated experiences have led me to the conclusion that of all really important psychological issues, the two “most ubiquitous” and simultaneously “least available” to conscious awareness are (1) the

operation of "PROJECTIVE PROCESSES" and (2) the vicissitudes of "UNCONSCIOUS ENVY". This fact is perhaps at least partially explained by their inception in early infancy, when the "amygdala" is the dominant memory system at the center of the "processing" and "management" of emotional states of mind.

Axiom #3 – The Frontal Lobes, as the Most Mature Integrator of Mental Life, Fully Mature in the Mid 20's:

– The most advanced parts of the brain, used for "reasoning" and "emotional judgment", are the "frontal lobes". Because they are not fully formed until the mid-twenties and beyond, the lack of sound judgement, so common in adolescents through their late teens and early twenties, can be partially explained by this brain development timetable.

While I do not believe in denying the need to "take responsibility" for one's actions, this fact of development does have significant implications for many areas of life including the criminal justice system, making life choices such as selecting a marital partner or a career, etc. Clearly the insurance industry recognizes this implicitly, if not explicitly, by putting drivers in a different risk class prior to the age of 25 years.

Summary of Neuroscience Implications: Brain "developmental timetables" have huge implications for human "coping mechanisms" used to manage mental pain. I find it helpful to consider the possibility that the most primitive, bodily linked, defensive maneuvers are "amygdala" based. These probably include "DENIAL", "SPLITTING-AND-IDEALIZATION", and "SPLITTING-AND-PROJECTIVE IDENTIFICATION".

– The more "elaborated" and "sophisticated" "coping maneuvers" would be linked to the "hippocampal" memory system. These coping/defensive maneuvers would move beyond the "bodily linked" maneuvers to more "language based", elaborated "psychological defenses". I have particularly in mind the constellation of defensive postures that Klein referred to as "manic defenses" which are particularly aimed, in the broadest sense, at denying the "psychic reality" of events taking place in the unconscious inner world, which are leading to mental pains, particularly those pains linked to the "depressive position".

Life Outside the Womb, Mental Pain, and Coping/Defensive Maneuvers

Axiom #4 – The Life Instinct, Projective Processes, and the "Work" of Coping with Mental Pain:

– The essence of the "life instinct", and "life" itself, is "work". The foundation of that "work" is the "facing and modifying" of "mental pain", beginning in infancy. This is certainly an arbitrary set of definitions, taken from a psychoanalytic perspective, but very useful in thinking in broad brush strokes about a given individual's approach to their life and the implications of that approach. First we need some simple, useful, and clearly arbitrary definitions.

Definitions:

– "Life Instinct": For discussions sake, I will arbitrarily define the "life instinct" as a desire to be "alive", be "born" into the outside world, and have "relationships and experience" in that outside world. For this to dominate, the infant must essentially presume that the "pleasure" and "goodness" in life outweighs the "pain of life". Despite the simple words and concepts, that definition gives one a tremendous amount to contemplate. The idea of the "life instinct" may be easier to think about if we immediately contrast it with an arbitrary definition of the "death instinct".

– "Death Instinct": I find it particularly helpful to think of the "death instinct" as linked to the "hatred of mental pain", combined with a feeling that the "pain of being born and out in the world" is much worse than whatever "pleasure" or "goodness" is available there.

The result seems to be a desire to "return" to the relative peace and steadiness of being "unborn, back inside the womb", i.e. to return to being an "unborn, inside baby". This "hatred of mental pain" consequent to being born and out in the world immediately extends, in some infants, to a hatred of the "organs of perception" that allow one to be aware of mental pain. In addition, the emotions of "love" and "caring", that make one susceptible to most all of the emotional pains of life, are also viewed with "hatred and contempt". In effect, "love" is viewed as a "one way ticket" to vulnerability to the mental pains" of "disappointment, rejection, loss, etc."

Background Assumptions Regarding Mental Pain:

– Putting these two contrasting views of "life after birth" side by side, and arbitrarily ignoring the reality that these attitudes "may commence in the womb" before birth, we can come to the problem of quantifying how much "mental pain" an infant is experiencing, and how he or she responding to that experience.

Klein's sense of an infant's coping mechanisms suggested that "DENIAL", "SPLITTING-AND-IDEALIZATION", and "SPLITTING-AND-PROJECTIVE PROCESSES" were the primary things available to the baby in earliest infancy. Put in layman's terms, the infant could (1) ignore that something existed, i.e. use "denial"; (2) it could try to separate the "good" stuff from the "bad" stuff, i.e. "splitting-an-idealization"; and (3) then hold on to the "good", and try to get rid of the "bad" stuff via all "methods of evacuation" available to it (i.e. "cry", "spit up", "poop", "pee"," sneeze", "go to sleep", etc.).

– This suggests that we can create a "natural history" of the use of available maneuvers for "coping" with "emotional pain" in infancy. Furthermore, we can suggest that if that "mental pain" is not excessive or too constant, that these maneuvers will allow for "loving relationships" to still predominate.

– However, if the pain is "too continuous" or "severe in intensity", then these maneuvers (perhaps most particularly projective processes) will become preferred and used more massively, thus "interfering" with the development of "healthy loving relationships" to caregiving figures.

We could then think of these necessary and ordinary means for "coping" with life as having shifted into the realm of "defensive postures" that are "too extensively" used in "too extreme a manner" to allow for "ordinary development" to proceed.

Thus, when we see an adolescent or adult "excessively relying on projective processes", and "turning away" from relationships to parental figures, we can surmise that the infancy of that individual had more "emotional distress" than would allow for "ordinary loving object relationships" to be the foundation of the personality.

Background Assumptions Regarding Defensive Maneuvers:

– If the "life instinct" can be summarized as requiring the "facing of mental pain", and the "death instinct" involves the "evasion of mental pain", how are we to think of the "evolution" of the "psychological coping maneuvers" that we ultimately refer to as "defenses"?

– I would like to suggest that we think of them as "necessary" to the infant and small child, for survival, in the face of varying degrees of "helplessness', "dependence", "not understanding" (including "confusional" states of mind), etc. In other words, everything "painful" about infancy and early childhood, by necessity, requires some form of coping/defensive maneuver.

But I would like to suggest that while every "defense" has its "day of usefulness", gradually over time every defense has the potential to be "out of date", i.e. no longer necessary, and an "impediment" to further "mental and emotional growth".

For example, an infant might close its eyes in the face of something scary or upsetting, and even go to sleep on the spot to evade the experience. However, later in childhood this would no longer be necessary or helpful when faced with, for example, a difficult school assignment. Similarly, as an adult, when an ominous envelope arrives from the IRS, or you fear your spouse may be having an affair, it is usually not constructive to ignore or run away from those distressing aspects of external relatity. For example, staying in your room and playing video games in response to the assignment, or never opening up the letter from the IRS and denying it ever arrived, or going on a long binge of alcohol usage in response to the suspicion of infidelity, are not going to lead to any constructive "work" on the problem at hand.

An infant may have had "denying" the existence of the distress as its only available "coping" maneuver, but that approach is almost always out of date and a "problem" later in life.

Work versus Omnipotence:

– I hope it is becoming apparent that I am suggesting that an individual human being's life is only as good as the "skills" he or she develops to "cope with mental pain". He or she ideally begins developing these in early childhood, based on "good experiences with loving parents", who themselves are skilled at coping with the "slings and arrows" of life in the outside world (as exemplified by "Murphy's Law", i.e. things can and will go wrong in the worst way at the most inopportune time).

The infant and child needs to feel that on balance, "good/pleasure" can outweigh the "bad/painful" in life. It needs to learn that it takes "effort" to cope with the "bad/pains" of life, in order to have a "happy existence" in the outside world and "internal harmony" in its inner world.

– It further must come to recognize that this "effort", to "grow one's capacities to cope with the pains of life", requires the passage of "time" to develop these skills. I am suggesting that these two ingredients combined, i.e. "effort" over "time", come to be experienced as what is meant by the word "WORK".

This concept of "work" requiring "effort over time" can be contrasted by the child's conception of "magic", which is imagined to produce the "desired result" with "very little effort or time". At their essence, "OMNIPOTENT STATES OF MIND" are meant to "magically evade" the "work" of "tolerating mental pain'', in order to "face and modify" that pain, so that "proper" psychological growth and development can take place.

At this point we can begin to tackle the concepts of "omnipotence" and the "evasion of work", in its proper sense, by moving on to axiom number five.

Axiom #5 – The Death Instinct and the Evasion of Mental Pain:

– I find it clinically useful and helpful to think of the essence of the "death instinct" as the "evasion of the work of coping with mental pain" by the use of "omnipotent defensive maneuvers". These maneuvers have a natural developmental course from infancy into adulthood.

The Background to Omnipotence, versus Work, in Early Infancy:

– Beginning in infancy, it becomes apparent that to have "love for" and "care about" mom or dad, and any others, subjects one to the "vulnerability" of experiencing "separation"," loss", "envy", "jealousy", and "guilt", to name some of the most important emotions in early life. For some infants and small children, this seems like it is a "risk" they are "unwilling to tolerate". The "evasion of mental pain", and its potential, becomes more "paramount" than the "experience of pleasure".

– This intolerance of the "potential for mental pain" can even extend to a hatred of the "vulnerability" inherent in "caring emotional relationships", and even to a hatred of the "mental apparatus" that makes

"perception" of these emotions possible. This hatred can lead to what Bion referred to as "attacks on linking". While this is a reference to a more severe level of emotional disturbance, we should consider the more mundane uses of the "organs of perception", and the "mental apparatus" in control of their use, as central to ordinary mental functioning. We might refer collectively to the "perceptual apparatus" and its "use" in life as "THE ORGAN OF ATTENTION".

Corollary: The most destructive of those "omnipotent maneuvers" can be said to involve "projective processes" under the sway of the emotion of "unconscious envy" at a baby level in an individual's personality.

– Projections are made unconsciously for many reasons or "motives", many of which do not have particularly destructive consequences. But when "baby states of mind" are "hated" by an individual, and "envious hatred" of the people who are felt to have all of the "good, desirable qualities and possessions" (e.g. mom and/or dad) is added to the mix, one has a very potently destructive state of mind.

The common result is that the "hated baby qualities" are "projected into the object", while the "desirable qualities" or "possessions" are "taken from the object", creating an "envious reversal" of identities. This situation is particularly destructive because there is an unconscious desire to "ruin" and "deprive" the imagined happiness of the object. It creates a deep seated hopelessness about life ever being "good" because "good figures" are being spoiled and thus unavailable to that person.

Axiom #6 – The "Organ of Attention" and Early Coping Maneuvers:

– I find it very useful to highlight the way in which human beings use their "five senses" to manage what is allowed "into their mind". We can refer to this function of the human brain as the "ORGAN OF ATTENTION". This idea of managing one's relationship to the outside world by the "direction of the focus" of one's "perceptual apparatus" can be seen to be powerfully operative in infancy, and then throughout the lifespan. A considerable number of the infant's modes of coping with mental pain, that will become the basis for psychological "defensive maneuvers" later in infancy and childhood, have their origin in the infant's "manipulation of its five senses", by this "organ of attention".

– The most obvious, and perhaps earliest manifestation of the use of the "organ of attention", is in the defensive maneuver of "DENIAL". Quite literally, an infant "turning its gaze away" from something upsetting or scary, can be thought of as using the "organ of attention", in this case vision, to "deny and escape" the existence of the upsetting and distressing element in its life.

For example, a mother returning to pick up her infant at day care, after an eight hour separation, is likely to be met with an infant, in the arms of the day care individual, who at first "averts its gaze" and "turns away" from mom, as if to say "I don't want to be reminded of all the pain you caused me by leaving". This can be thought of as a momentary use of the "organ of attention" to avoid the recurrence of the emotional pain of mother leaving earlier in the day.

– More extreme uses of the "organ of attention" can be seen when a non-psychotic individual, for whatever unconscious reason, "hallucinates out of existence", something that might otherwise be available to the five senses. This might occur, as I mentioned earlier in the example of "denial" of evidence that one's spouse is having an extramarital affair, by failing, for example, to see that he or she is not wearing their wedding ring when he or she comes home from being out for the evening.

– I find the concept of the "organ of attention" useful to me as a clinician as I observe what patients (including myself) choose to "attend to" or choose "not to attend to", and thus what they (or I) are unconsciously simultaneously avoiding. Patterns can be seen in one's current focus that suggest possible early patterns of coping left over from infancy. For example, some patients are hyper aware of evidence in my office of the existence of other patients, or my life outside the office. Other patients go way out of their way to avoid seeing obvious, virtually unavoidable evidence of their analytic siblings or my outside life.

Patients who obsess about small things beyond their control can be thought of as having their "organ of attention" hijacked by some baby part of their personality. "Meditation" can be thought of as an activity particularly oriented toward managing this sort of problematic misuse of the "organ of attention".

Axiom #7 – Innocent Misconceptions versus Misperception and Perversion of Reality:

– This differentiation is particularly useful to a practicing mental health professional. It allows for the distinction to be made between an idea that is "erroneous" but held by a patient in an "innocent, non-defensive" manner. This would contrast with an idea that is both "incorrect" and selected with a conscious or unconscious "motive" of "denying or attacking reality" or even "spoiling" anyone's enjoyment of reality.

The first idea, which might be referred to as an "innocent misconception" (a concept originally proposed by the English Kleinian psychoanalyst Roger Money-Kyrle), is not so much created for defensive or even spoiling purposes, but was arrived at based on a natural extrapolation from one's childhood experiences, without realizing the childhood experience was a distorted of version of how life is for most people. This can be seen commonly in the expectation of how relationships work, based on experiences with parents who are perhaps not typical in their attitudes or behaviors.

– These "innocent misconceptions", ubiquitous in infancy and childhood, should be differentiated from "omnipotence" based "distortions" and "misperceptions". The latter two categories are a function of (1) "unconscious defensive maneuvers", (2) the inevitable product of "projective processes", and (3) where "unconscious envy" is intense, "perversions of reality" and the "truth".

– The "innocent misconceptions" generally lead to a distortion of reality, but not with a motive of doing harm, and they are usually amendable to alteration when new experiences come along that allow for a recognition of the inaccuracy of the childhood experience based "misconception".

– This contrasts with more "omnipotence" and "defensively based" and/or "envy based" distortions of reality that lead to "misperceptions". These are usually much less amenable to alteration, as additional versions of reality are understood, because of the "defensive" motives for holding on to these distortions of reality. These distortions become consistently destructive when unconscious "envious hatred" is added to the motivation, because of the unconscious urge to "spoil" or "ruin" the envied individual's life (in terms of a quality, capacity, or possession).

Axiom #8: Internal Harmony is a Human Being's Most Precious Possession:

– To have a life that is worth living, one must be able to (1) enjoy the fact of being born and out in the world, (2) use one's five senses fully, (3) have human relationships to the fullest extent possible, and (4) fully do the "work" of managing the mental pain that exists in the context of those relationships. If a person does all of this successfully, even if that person's physical health is subpar, then he or she can have a sense that "live is worth living", and that "life is good". In essence, that individual has "internal harmony".

– The rub is that while what makes for "internal harmony" is relatively easy to describe, what makes it deteriorate can be much more difficult to ferret out, often because the "perturbing factors" can be very "unconscious". This is probably because internal harmony begins in infancy, in relationship to mother and/or one's caregivers, and is thus most likely intimately tied to what is stored unconsciously as "memories as feelings" in the "amygdala".

– Melanie Klein said that the earliest relationship to the "breast" (meaning the very earliest relationship to mother after birth, at a "feeding" and "comforting" and thus "part object" level) formed the foundation of emotional stability. When this earliest relationship goes well, the infant creates a loving version of a relationship to mother internally as what Klein called "a good breast", and thus also developing what the psychologist Eric Ericson would refer to as "basic trust" about "life and its goodness".

– With her concepts of the "paranoid schizoid position" and "depressive position", Klein formulated, from her observations of infants and small children, the idea that early infancy (i.e. at the level of the amygdala) required certain types of primitive mental maneuvers to preserve this "basic trust" in the "goodness" of the relationship to mother. In effect, as the infant moved developmentally to greater "integration" of experiences and states of mind, it also moved to a state of "internal harmony" more closely resembling that of an adult.

– With her concept of the "depressive position" as a constructive response to the psychic reality of how one is "treating ones good figures" externally and internally, she was then able to elaborate the rather broad category of "manic defenses" against "psychic reality". With this idea of "manic defenses" she was also outlining on of the most common "disruptors of internal harmony".

In effect, "turning away" from the "work" of maintaining a good relationship to one's "internal versions of a good parent", in the face of mental pain, is at the root of most disruptions of internal harmony and a common cause of "depression". One of the most common reasons for this is the failure to acknowledge "guilt", often treating it as a bad emotion because it can be unbearably painful. This results in a failure to recognize that experiencing guilt it is a message that one needs to address a problem, and do the "work" of "make proper amends" to repair the causes of that guilt.

– "Omnipotence", when defined as the "magical evasion of reality", and the "work" that is required to preserve "internal harmony", by definition then precludes the possibility of real internal harmony. In its place, "omnipotent approaches" typically substitute "manic excitement", which is never sustainable.

Carried to a more extreme level of character difficulty, the "turning away" from one's "good internal objects" to create a "narcissistic personality organization" (i.e. where the "bad" part of self has the "good baby parts of self" under it control) guarantees that "internal harmony" will never see the light of day. When "unconscious envy" is excessively "spoiling" one's internal good relationships," omnipotence" and "narcissistic personality organization" will effectively stamp the personality as "ill" and very likely preclude life from ever being all it can be.

– In summary, "internal harmony" still comes down to doing the "work" required to preserve one's good internal relationships, most likely at the level of the amygdala. Failure to do this "work" puts all that makes "life worth living" in peril. This fact makes the preservation of internal harmony such an inexpensive priority when one considers that the entire happiness and value of life is at stake!

Core Emotions in the Relationship to Mother in Infancy

Axiom #9: "Separation", "Envy", and "Jealousy" are Key Emotions to Understand, with "Guilt" Close Behind:

Definitions:

I would like to define these key emotions first and then we can discuss their operation in relation to mother.

"Separation" = Birth ushers in the infant's introduction to awareness of its "smallness", "helplessness", and utter "dependency" on mother (and caregivers). Because the "separation" is frightening, and all of the above feelings can be very much linked to great distress, particularly if the caregivers are unavailable or inadequate, "separateness" is often thoroughly disliked or even "hated", because it is associated with mental pain. This pain is usually encompassed by the general term "separation anxiety", and probably linked to the infant's emotional state of "nameless dread" (Bion's term) that it may "die".

"Envy" = It is perhaps the oldest of the "categorical emotions" (i.e. emotions with a very specific, definable nature, in contrast say to the "bodily, physiologic state" that we refer to as "anxiety") and appears to be

"inherited" in a predisposition to its intensity. It can be defined as a "two party" situation, at a "part object level", more linked to hatred that love, in which a person compares themselves to another in terms of a (1) "quality", (2) "capacity", or (3) possession". The comparison leads to a painful feeling that one "is inferior to or has less" than the other. Awareness of this discrepancy is the pain that we call envy.

It is of crucial importance to see that envy commences at birth with the infant's perception of the discrepancy between itself and mom. She is seen as "having everything, knowing everything, and being able to do anything" while the infant clearly recognizes it has none of those wonderful qualities or capacities.

"Envy" itself is "very painful", but not inherently "destructive". It is the "defenses" against any experience of this pain that lead to envy's "destructive" aspect. This is because the defenses against envy, first and foremost, involve some form of "spoiling" the object of the envy. One can alternately, (1) "reverse roles" with the envied person, (2) "deny" that one has any envy, (3) regularly make others "feel envious of you" (the Trump/Kardashian approach), (4) project your "capacity" to feel envy into someone else, or the road least traveled, (5) acknowledge and "live with" your envy. This last approach is the only one that has a constructive possibility of "growing yourself into an adult" who need no longer "envy" mom and dad.

As an example of envy's destructiveness, Shakespeare said, and I paraphrase, "envy is the green-eyed monster that doth bite the hand that feeds it". Mark Twain also noted that the "principal difference" between "man and dog" is that a "dog won't bite you" when you "pick it up and make it prosperous".

"Jealousy" = In contrast to envy, jealousy always a "triangular" situation in that by definition it involves three persons, at a "whole object" (i.e. person) level, and is more fundamentally linked to "love" than "hate". In jealousy, one loves one person, and wants that person to give their love exclusively back to oneself, and not to a third person.

It is worth noting that at an unconscious level, people rather universally understand this distinction between envy and jealousy. Because jealous is more based on love than hate, one constantly sees people refer to situations of envy with the word "jealousy", as in "I am so jealous that you got that new job" (or car, house, etc.).
It is also worth noting that the further back into infancy one traces "jealousy", the more it shades into and becomes indistinguishable from "envy". The earliest form of "jealousy" seems to be the infant's potential phantasy that the two breasts go off together and feed each other. That form of three party relationship contains the feeling of envy of having the "capacity" to do the feeding, as well as the infant feeling left out of the "banquet".

Overview of Core, Early Emotions:

– The three most important, emotionally "painful" states, in the "infant's" initial relationship to its "mother", are (1) "reactions to separation", and the categorical emotions of (2) "envy", and (3) "jealousy". Since the infant's life begins with mother at the center of its existence, the emotions it has toward mother are of paramount importance at the "core" of the personality. I have found it of profound value to create a "hierarchy" of these earliest important emotions or issues for an infant, that are most useful for the mental health professional to highlight in their clinical work. At the top of this list are the "core emotions" of "envy" and "jealousy", and what might be described as the emotional "reactions to separation".

– These very specific emotions and situations are intimately connected to the even broader fundamental emotional states of "love" and "hate". When a "loving" relationship is established with mom, that feeling of "love" for her is paradoxically both a mitigating element, in relationship to emotional pain, and also the source of much of the emotional pain of life, and certainly infancy.

In other words, if you have a well-established feeling of "loving mom" and feeling "loved by her", for example, then it makes many pains in life more bearable. But because you love and need mom, it also

makes separations, envy, and jealousy potentially more intense. This of course leads some infants to "attenuate their love" for mom, in order to be less vulnerable to these other, painful emotions.

– "GUILT" is also key, but somewhat more elaborate and neuro-developmentally more sophisticated, and probably not clearly operative until the second half of the first year of life. I would simply define it as the painful feeling than one has in some way "injured" or done "harm" to someone one loves or cares about. It can be among the most painful of all human emotions.

Although guilt is more likely to be naturally in evidence in the second half of the first year of life, it is useful to also think of situations in which guilt is thrust "prematurely", if you will, on an infant. We might think of such a situation as one of "CATASTROPHIC PREMATURE GUILT". Examples might include the death of the mother in childbirth or death of a twin before or at birth, severe depression in the mother in the first half of the first year, severe illness in a sibling or parent in the first months after birth, etc.

Corollary on Premature, Overwhelming Guilt:

– Because guilt is among the most important emotions in relation to mother in later infancy, the "capacity to tolerate guilt", will profoundly affect the capacity to cope with situations evoked later in life, and will be of particular importance in coping with conflict in relationships, and perhaps most importantly in marriage. The main point is that it is useful to have a model of "overwhelming and/or unbearable guilt" at birth, and the first few months thereafter. This model allows one to be on the lookout for "guilt" that has been "denied" or "split off and projected" and is thus going unrecognized, yet exerting a powerful unconscious influence on the individual's life.

A common clue to early guilt, manifesting later in life, can be the inability to say "I am sorry", for example in one's marriage. Alternately, it may be seen in a predisposition to project guilt and always suggest that someone else is "at fault and to blame". The incapacity to constructively face guilt, when there are early issues underlying this inability, predisposes that individual to "episodic depression", whenever anything goes very wrong in life.

The Unique Problem of Defining "Anxiety":

– This leads us to the extremely confusing issue of what is meant by the word "anxiety". I would like to argue that it is not a "categorical emotion" per se, like for instance "envy", "jealousy", and "guilt". I have struggled for years to find a useful way to define it and have come to the conclusion that it is perhaps best defined as the "bodily" or "physical" concomitant to a categorical emotion.

My hunch is that it can be most usefully thought of as emanating from the "baby core" of the personality, probably at the level of the "amygdala". That partly explains why it is often, as Freud said, a "signal" that something distressing is going on at an unconscious level in the mind.

– Kleinian's have tended to describe the issue of "anxiety" as linked to either (1) a feeling that one is under attack because something "unwanted or bad" was "projected" into the outside world, and is now retaliating; or (2) 'feeling sorry" that one has, or may have, harmed a "loved or valued figure". They refer to the "retaliatory" fantasy version (1) as "persecutory (or paranoid) anxiety", and the more "guilt" like feeling related to (2) as "depressive anxiety".

– It is of interest to note that "guilt" itself can also be usefully separated into "persecutory guilt" and "depressive guilt". The "persecutory" form suggests the individual is not really able to take responsibility for their behavior, and is feeling "blamed" from an outside source. "Depressive guilt" suggests the person is more fully taking responsibility for the "damage" or "harm" imagined to have been done to the loved or valued object, and is therefore feeling a more genuine wish to make repairs. In contrast, "persecutory guilt" is more likely to lead to "manic repair" where one tries to fix the problem without ever taking full "psychic responsibility" for having done the damage.

Discussion of Emotions in a Broader Sense:

– Wilfred Bion summarized human "emotional states of mind" in the broadest of brush strokes, referring to them as the "passions". He defined these "passions" as "love" (i.e. the "life instinct"), "hate" (i.e. the "death instinct"), and "curiosity" or "knowing" (i.e. the "epistemophilic instinct"), "L, H, and K" for shorthand.

The difficulty with these almost "philosophical abstractions" is that they are too broad to be clinically useful in a specific life situation. It is also somewhat confusing to emphasize "love" or "hate" because while love has everything to do with mental stability, it is also the root cause of most of the emotional pain in life, in the sense that if you "care" about someone, then you can feel "pained" at their loss or having to share them. And while "hatred" is an extremely powerful emotion, it is often most powerfully evoked by the specific categorical emotion of "envy". In fact, "envy" is often most usefully used as a modifier when referred to as "envious hatred".

– This brings us to the broad array of emotions confronting the beginning mental health professional being introduced to human development. Charles Darwin in 1872, examining "facial expressions" across different species, thought he could see evidence of "happiness or joy", "surprise", "fear", "disgust", "anger", and "sadness". In addition, there are many mental health professionals who would think of "shame" as a central emotion in human development. How is one to decide which emotions are central to development in infancy, and where to place the others in the course of psychological development?

I think the answer lies in the concept of memories as feelings stored in early infancy in the amygdala. Those emotional states will take "developmental precedence" over ones that occur later in infancy and childhood. Furthermore, the earliest emotions, i.e. related to "envy, jealousy, separation, and guilt" will be linked to the earliest coping/defensive maneuvers available to the infant.

Emotions, Defenses, and the "Baby Core" of the Personality:

– I find it useful to assume that every potentially "painful emotion" necessarily requires some means of coping with it so that one can live life without being in continual "emotional anguish". This suggests that the human mind requires an array of "defensive/coping maneuvers", typically performed automatically, and therefore "unconsciously".

– Anna Freud, in her seminal 1936 book, "The Ego and the Mechanisms of Defense", defined more than fifteen "mechanisms of defense". These included such maneuvers as "introjection", "projection", "denial", "repression"," suppression", "idealization", "sublimation", "displacement", "identification", "intellectualization", "rationalization", "reaction formation", "sublimation", "identification with the aggressor", etc.

– Contrast that list with Donald Meltzer's summary of Melanie Klein's core "defensive/coping maneuvers". Her primary maneuvers, operative at birth or shortly thereafter, are "denial", "introjection", "splitting-and-idealization", and "splitting-and-projective identification". Later in the first few years of life, she suggests the infant will add the "triad of manic defenses", i.e. "control", "contempt", and "triumph". These are used primarily to deny "psychic reality" and especially the "guilt" of the "depressive position".

– So what happened to all of Anna Freud's defensive mechanisms? For me, the answer lies in Klein's emphasis on the first days, weeks, and months after birth, when the "amygdala" is the dominant memory storage system. As she followed those earliest emotional states forward longitudinally, she placed those earliest emotional experiences as being at the "root or foundation" of all emotional and mental life, throughout the lifespan. Therefore, she felt that all human beings are dominated by very early emotional reactions, to early experiences with caregivers, and therefore use their earliest "coping maneuvers" to deal with those primitive emotions.

Many of Anna Freud's defensive mechanisms are more "sophisticated". Similarly, the emotion of "shame" can be seen as more developmentally sophisticated. Melanie Klein traced all emotional reactions throughout the lifespan back to more basic, underlying "root causes" and "primitive, prototypic states of mind", before language had developed. "Shame" would not yet be operative as an emotion state, "introjective and projective processes" would be dominant instead at that early point in time.

– In effect, Klein felt that there were more "primal" emotional states and defensive maneuvers in play. Because these underlay later, more sophisticated maneuvers, these "prototype, primitive, root causes" ultimately needed understanding if the personality was to truly change "structurally".

While I cannot prove it, I suspect this is why "shame" is relatively neglected in the Kleinian literature. It was taken up by John Steiner more recently. But he is not highlighting it, as a primitive state of mind, as much he is suggesting that it can be an important element in later "characterological patterns", as for example seen in certain individuals with "psychic retreats".

Corollary on "Sibling Rivalry" and the "Oedipus Complex":

– It is useful to remind oneself that "SIBLING RIVALRY" is no more that an amalgam of "envy" and "jealousy" in relationship to one's siblings, in terms of how much attention they are getting from mom and/or dad. Furthermore, the same idea applies to the concept of the "OEDIPUS COMPLEX". It too is just "envy" and "jealousy" related to mom and dad's relationship to each other, and one's feeling of being left out.

This is why I am always amazed when I hear someone say that the "Oedipus Complex" is outdated. That is equivalent to saying that infant's no longer have the human emotions of "envy" and "jealousy". That suggests to me that those individuals who would say the Oedipus Complex no longer exists do not understand "baby states of mind" very well and have not had an adequate personal analysis.

The Role of Destructive States of Mind in Development

Axiom #10: Two Key Reactions to the Distress of Birth into the Outside World:

– There are two variables that almost always come to my mind when I think about a given patient's possible reaction to a difficult infancy. They are: (1) What degree of "mental pain" did that particular infant experience in his or her early infancy; and (2) What was the relative strength of that individual's "death instinct" at birth? The first question relates to the infant's reactions to its environment, and the second relates to the strength of the infant's "constitutional" reaction to emotional distress. These are broad questions and immediately lead me to two very specific questions.

The first is to what degree did that individual wish to remain "unborn" in the face of the pain of early life outside the womb? To put that question in shorthand, to what degree have they wanted to remain an "unborn, inside baby" and have someone else "think and feel" for them?

The second question is linked, in my mind, more to the "constitutional strength" of "envious hatred", at a baby level, in the personality. Put in operative terms, how much did they "hate" being a "helpless, needy, utterly dependent baby" and "resent" mother being the "big fancy person" who "has everything, knows everything, and can do anything"? If those feelings were intense, one commonly sees an infant who's reaction is a desire to reverse the situation, and make mother the "shitted up, small, needy baby", while simultaneously taking over her role of the "big, fancy, grown-up" – in effect, an "ENVIOUS ROLE REVERSAL". I tend to surmise or suspect this, as having been a baby state of mind in a patient, when I see intense "envious arrogance" or "know-it-all behavior" in a person later in life.

– To summarize, two of the key components of the "death instinct", as a reaction to being born and out in the world, are (1) a wish to be "unborn back inside mom", and (2) "envious hatred" of all of the mental pain to which one is subjected by being born (i.e. the smallness and helplessness of infancy).

While I cannot prove it, the totality of my decades of clinical experience suggests to me that "envy" is more of an "innate, constitutional reaction", than it is an "environmental response to deprivation". I particularly say that because I have seen a generational thread of "envy" in many family trees (i.e. in grandparents, parents, and children". This is contrasted with "family trees" where their predisposition was less intense, and the response to early disturbance and deprivation was less envious in nature, even though the generations were "unconsciously recreating" their own difficult infancies with their children.

– As an interesting side note to these reactions to birth, it would be possible to create a Cartesian coordinate system or graph with the horizontal axis having "unborn" on the left and "born" on the right side, and the vertical axis having "loving engagement in life" at the top and "envious hatred of life" at the bottom. An individual's personality functioning at a given moment in time could then be charted in terms of its potential for positive engagement in life or, conversely, its potential for destructive behavior to self and object at that point in time, or a retreat from life.

Corollary on Criminality and Mental Illness:

– I also find it helpful to consider the possibility that the more "severe the emotional disturbance" in an individual, the more likely it is that "envious hatred" and "emotional violence" are central features of their unconscious inner worlds and therefore their degree of disturbance. This is the reason why it is useful to think of "criminality" as a "serious emotional disturbance", independent of whether it is manifested as "physical violence" in the poor part of town, or "white collar crime" on Wall Street, that defrauds people of their life savings.

The difficulty in thinking about the link between criminality and mental illness/emotional disturbance is twofold. The first problem is that the "most disturbed individuals" in the criminal justice system learned in infancy to use "physicality" to cope with painful states of mind. In effect they turned their brain into one big "muscle", using it to go from "impulse to action without intervening thought". This is the same as saying they are unable to contain any "painful states of mind" and are driven to immediately "evacuate/project" the painful state of mind into the outside world.

– This predisposition to "action" means that "containment" of their "physical destructiveness" becomes the overriding priority. I saw this problem over and over in my years at LA's Central Juvenile Hall. Thirteen or fourteen year old children who were "acting out", but who were physically diminutive, were sent to the "mental health system" for treatment. By contrast, those physically precocious 13 or 14 year olds, who "frightened" the staff because of their larger physical stature, were consistently treated inappropriately as a menace to society, and sent to the "criminal justice system".

– The take home lesson is that if we send violent "psychotic" patients to locked mental wards, why shouldn't the jails and prisons be skewed toward mental health rehabilitation, more like a mental hospital, instead of simply reinforcing the very abuse that has contributed to their emotional disturbance, and inability to use their minds, in the first place?

Axiom #11: Everyone Has An "Envious, Omnipotent, Know-It-All, Destructive, Self-Sufficient" – "Bad Part of Self"!

– It is useful to assume that in the early development of all human beings, there is a "part of self" that is the primary user of omnipotent maneuvers to evade painful states of mind that occur in infancy. If effect, all babies must "turn away" from both mental pain, and the loving relationships that are felt to be the primary source of that emotional pain, when the pain is felt to be too great to bear.

Gradually, the "part of self", that "turns away" from mom/caregiver, and "sucks its thumb" for example, develops a life of its own, and becomes "the me who does not need anyone else". Over time, reacting to many different painful life circumstances and various painful emotions, this part of self develops a constellation of "preferred maneuvers" under the sway of various "core painful emotions". To summarize these pains and maneuvers in a very compact manner, I have given this part of self the descriptive name of "the envious, omnipotent, know-it-all, destructive, self-sufficient part of self", or "bad self" for ultra-shorthand.

– I put "envy" as the first painful emotion because it is so central in causing the spoiling of a primal good object, in personalities destined to have serious emotional disturbance. "Omnipotence" (i.e. I can do anything I need to do for myself) and "omniscience" (i.e. the "know-it-all", or more accurately, "I know all I need to know"), as favored psychic postures or maneuvers, come second and third in the name, as core elements of the "bad part of self", in its claim to not need the mom or dad as "good objects". Thus, these maneuvers are both in service of being "self sufficient", but they do not necessarily have to link to "destructiveness" as a part of getting along without the need of the parents.

It is where "envy" is particularly prominent, in the states of mind of the infant who is "turning away" from good objects, that "destructiveness" also becomes a prominent aspect of the operation of the "bad part" of self. Psychoanalytic literature and literature in general is replete with descriptions of the operation of a "bad part of self" that is particularly destructive under the sway of "unconscious envious hatred".

Milton's "Dante's Inferno" is a good place to start, as well as the biblical myths surrounding "Lucifer", who's "envious hatred of God" made him prefer "ruling in Hell" than playing second fiddle in Heaven ("serving" behind mother's breast as represented by God).

Axiom #12: Emotional violence is at the Heart of Severe Emotional Disturbance:

– As I have spent decades with patients of all stripes and persuasions, and tried to aid them in being happier and more adaptive in life, I have come to the conclusion that "emotional violence" in one's reactions to birth, infancy, relationships, and life in general, seems to correlate better than any other personality element with "severity of emotional disturbance". Put in simple terms, if you want to be borderline, psychotic, or criminal, it really helps to have a constitutional predisposition to "violent emotional reactions" to life and experience.

– I got my first confirmation of this possibility relatively early in my career as a psychoanalyst when I gave a lecture on "unconscious envy". A psychiatrist, who had spent decades working at a state psychiatric hospital, came up to me after the talk. She said she was so "relieved" to hear my talk because she had always thought that if there were a "gene', that determined a predisposition for "schizophrenia", it would be a gene for "excessive envy". The population of her state hospital, all chronically institutionalized, seemed to have been destroyed by their "extreme envy" of everyone and everything.

– In summary, after my decades of work with patients, I would be inclined to suggest that the emotional violence in a given individual is probably an amalgam of: (1) their predisposition to "intense unconscious envy" (which I take to be constitutionally passed on and inherited), (2) the degree of "violently intense " emotional experiences they had in infancy (colic being a prime example of such an experience), and (3) the quantity of "violent emotional reactions" they experienced from the caregivers and siblings in infancy and childhood. The latter does not seem to be as much "causal" but rather more "reinforcing" of the first two issues. In summary, the harsher their natural reactions to infancy, and the more distressing their infancy was by happenstance or design, the more their "violent emotional states of mind" predispose them to serious emotional disturbance.

– An additional correlation is observable with "emotional violence", and that is a predisposition to "violent" and often massive use of "projective" processes. This functionally potentiates the emotional violence, perpetuates the infantile levels of paranoid anxiety, and interferes with the possibility of the

lessoning of “unconscious envy”, because the individual can never find a “good object” from which to receive something good.

Axiom #13: Unconscious Envy, Early Emotional Deprivation, and Narcissistic Personality Organization:

This is really an extension of Axioms 11 and 12, with a slightly different focus. The combination of extensive “unconscious envy” at a baby level, and significant “emotional deprivation” in infancy and childhood, are at the root of the development of a “narcissistic personality organization”. All babies need “love and attention” from their parents, which is obvious. Babies who are given “things” in the form of wealth and material goods, instead of an “emotional expression” of love, are at high risk to grow up “extremely self-centered”. They look “spoiled”, but they are actually “deprived”. This underlying deprivation predisposes them to believe that “things” can be a substitute for “love” in a relationship. The punch line – great “emotional deprivation” can and often does occur just as easily in Beverly Hills as in the poor part of town.

Corollary #1: The degree to which the “good baby parts of self” were felt to be left in mental pain, and “let down” by the absence of “good parental figures”, is the degree to which they (i.e. the good baby parts of self) are vulnerable to “turning away” from the good family, both internally and externally. They are then susceptible to turning to the “bad part of self”, and forming a “delinquent gang”, that can be referred to as a “narcissistic personality organization”.

Corollary #2: When therapy is successful in dismantling a “narcissistic personality organization”, it is of extreme importance to recognize that the “bad part of self” feels it is being “MURDERED OFF”, and is therefore “fighting for its life”. This is important as one faces the “seemingly intractable” nature of work to give up the omnipotent maneuvers of the “bad part of self”.

Adolescence, Development, and the Baby Core of the Personality:

Axiom #14: Puberty and the Resurgence of the Baby Core of the Personality:

It is always the case, in normal development, that the “baby core of the personality” comes back to the forefront of emotional life at “puberty”. This “rebirth” of the “baby core” offers, on one hand, an opportunity for emotional growth, and on the other hand, the opportunity to “go to hell in a handbasket”. In ordinary development, this preeminence of the “baby core” emotional states will last for at least three years. This leaves the average teenager at his or her “most chaotic” from approximately the age of 12 through the age of 15. Most adolescents will begin to show evidence of moving into young adulthood at the age of 16 or 17. [See Axiom #15]

– This resurgence of the baby core of the personality confers a period of intense mental suffering, typically only second to the suffering of infancy.

Corollary: Psychological growth requires a “balanced relationship to mental pain”, in the “context of good objects”, or else the risk of excessive ongoing use of “omnipotent maneuvers” will retard or distort psychological growth (I immediately think of excessive marijuana smoking or obsessional computer gaming).

Alternately, the pubertal child may retreat to the relative calm of “latency age” psychological states, with its “excessive, obsessional splitting of emotions apart from thoughts” and “object relationships”. Such a retreat leads to further emotional development and object relationships both becoming distorted and/or impoverished.

Axiom #15: Ages 13 to 15 are Commonly the Most Confused, Unstable Years After Infancy:

– In my first decade of private practice I consulted to Los Angeles County Juvenile Hall where I had the good fortune to evaluate almost 900 adolescent boys for the court. Their ages ranged from 11 to 17 years, with the bulk being in the 13 to 16 age range. They were detained in those days from such minor offenses as "running away" from home, or habitual truancy, to such major crimes as robbery and murder. Each had a detailed history taken by a social worker. I interviewed each adolescent and occasionally their parents. It was an extraordinary opportunity to see a museum of teenagers, with a childhood history attached to add to my impressions of the adolescent.

– I came away with two ideas that are pertinent to this discussion and one additional observation. The first idea is that the "baby core" of the personality is clearly "reborn" back to the surface of emotional experience at "puberty". I am thinking of "puberty" as commencing with the "hormonal changes" that occur typically with the first menstruation, or ejaculation. For girls this is commonly at ages 11 to 13, and for boys ages 12 to 14, although these ages seem to be trending earlier in recent decades for whatever reasons.
Attendant to this "rebirth of the baby core" of the personality is a tremendous amount of "confusion" and "anxiety" surrounding the questions of: (1) Am I a child or an adult?; and (2) Do I want to grow up and leave the relative peace and safety of childhood?

– The second take home lesson I learned was that the period of maximal instability and chaos seems to be from about the ages of 13 to 15. Commonly, during the latter part of the fifteenth year and into the sixteenth, the teenager begins to "settle into" what will become their "adult " sense of identity and the early versions of their "adult" personality structure.

– During my decade long stint at LAC Juvenile Hall, I longed to understand what correlations from these adolescent's childhoods I might observe that would allow me to predict "delinquent" behavior in a reasonably reliable manner. It seemed only logical to me that it would correlate reliably with divorce, violence, alcoholism, too many children in the family, etc. Frustratingly, although all of those were regularly present, I found none that were predictive in the sense of always leading to delinquency! But I did make one observation – almost every child began to be "truant" from school, before they got in trouble.

Implications for the Therapist:

– The first take home lesson from these experiences for me is that one "CANNOT PREDICT" how a young person will turn out later in life as an adult, based on their behavior during ages 13 to 15, as so many parents are afraid is the case. I find myself explaining over and over to parents that the "rebirth of the baby core" is an opportunity to "rework" difficulties remaining from infancy, providing the potential for a better understanding and outcome if things were rough in infancy.

The parents need to be patient with their "impossible teenager", recognizing that he or she is in the "eye of the tornado/hurricane" that is "early adolescence", and things will "begin settle down", typically in the second half of the fifteenth year or into the sixteenth. It is no accident that one is not allowed by society to drive a car until the age of 16, and insurance companies do not take you off the high risk pool until the age of 25, when the "frontal lobes of the cerebral cortex are finally fully developed.

– The second implication is that one cannot make a "reliable diagnosis that will hold up in adulthood" of any child or teenager before the age of 16, and realistically really before the ages of about 18 to 20. One can only describe "symptoms" or "behaviors". The personality is still too fluid in its development to represent "adult" structure.

If I had been diagnosed by my teenage behavior, I might been thought to display elements of psychosis, perversion, sociopathy and criminality, addiction, and psychosomatic illness. In this day and age, every teenager seems to display "gender identity and object choice confusion", much less commonly on open display in my day. I assume this is mainly because society is much more accepting of these issues now than it was when I was pubertal in the late 1950's.

Marriage and The Baby Core of the Personality

Axiom #16: A Good Marriage Requires Love, Compatibility, and Commitment:

– To have a proper marriage (i.e. happy, satisfying, and enduring), it can be said to require "love, compatibility, and commitment". "Love" is a function of the baby core of the personality, "compatibility" is a function of genetics and environmental experience, and "commitment" is a function of the adult part of the personality.

It is almost counter-intuitive that "love" is in fact the easiest to achieve. Babies can fall in love with any good mother, and by extension, the "baby core" of any adult can do the same. Arguably, this so called "love" can be put on a continuum. At one end is "infatuation" that is based mostly on "idealized projections" into the other person, i.e. making them what you "wish" they would be. At the other end of the spectrum would be a more reality based "romantic love" that is by my arbitrary definition an amalgam of "baby level" and "adult level" attractions (i.e. more realistic in the accuracy of the appraisal of the other). The "baby level" portion of this attraction seems to very commonly go on mostly, or entirely, at an unconsciously.

– In contrast to the deeply unconscious elements involved in "falling in love" with someone, "compatibility" is much more recognizable at a "conscious level". For example, someone who wants to live on a boat and sail around the world does not fit with someone who cannot swim, is afraid of water, and gets horribly seasick. They would recognize that "incompatibility".

– It has been my impression, and I still have been unable to find an exception to it, that all couple who have (1) a proper courtship,(2) get to know each other fully, and (3)fall in love and have that love as a major reason for marrying, are "amazingly compatible" at both conscious and unconscious levels in their personalities. They may seem to have different styles in coping with these commonalities, at an unconscious level, but they "fit" nonetheless. This leads to a powerful implication for the marital therapist as outlined in the Axiom 17.

– "Commitment" is actually the most difficult of the three key elements of a good marriage to achieve. This is because it is predominantly an "adult capacity", although it is born of one's earliest baby states of mind. That is to say, that if the infant "turned away" from its "good objects" in infancy, it is at high risk to do the same in marriage to a spouse during times of stress and emotional pain.
This is where the "adult part of self" comes into play, both in "managing mental pain" and "preserving a loving relationship" to one's spouse. Remember that marriage vows always mention "through thick and through thin", in one's commitment to one's spouse. It is harder to actually do in real life, as witnessed by a 50% divorce rate in the US.

Corollary: There are "no sides to be taken" in marital therapy because both parties have unconsciously co-created their marital difficulties. This began at the inception of the relationship, based on how they "unconsciously" divvied up" who was going to "contain" which of the parts of their personalities (i.e. unconscious inner worlds). This divvying up of internal structures might include the "needy", or "angry", or "depressed", or "crazy", etc. aspect of both of their personalities. I will elaborate in the next Axiom on this point.

Axiom #17: All Couples Who Courted and Married for Love, "Fit" at Unconscious Levels:

– When speaking of marriage, it is often said that "opposites attract". I have been looking my entire career for an example of a couple who were so "opposite" in their personality structures that they did not "fit together" and I have "NEVER" seen one. In fact, all of my experience with individuals and couples suggests that only "sames", to coin a word, are attracted to each other.

That is to say that for a couple to be even mildly attracted to each other, they must have a very great deal in common. The confusing aspect of this commonality is that what they have most importantly in common are usually structural elements at a deeply unconscious level, about which they may be entirely unaware. As a patient described once on a first date, "the guys seemed really boring for the first hour, and then he said something that sounded pretty crazy and I instantly felt more attracted to him". Needless to say, she had no clue why that was so.

– I am not discounting "conscious attitudes" as unimportant. Things like appearance, attitudes about intimacy, family, politics, religion, children, hobbies, travel, food, etc. are all very real and play a significant part in attraction and conscious choice. But the truly "deal making or breaking commonalities" are always at a "deeply unconscious, baby core level". Most people can describe some "manifestations" of these "baby level" unconscious elements but cannot abstract out the details at that primitive level.

Perhaps most importantly these baby level commonalities might include such things as: (1) the level "emotional intimacy" expected in the relationship,(2) how "dependent" on each other they feel is safe, (3) how "appearance oriented or materialistic" they are, (4) how "narcissistic" they are, (5) how "cruel" or "grudge full" they can be, (6) how "paranoid" or "idealizing" they prefer to be, etc.

For example, one partner might have been adopted, and the other lost a parent to cancer in infancy. Or maybe both had parents who were alcoholics, or parents who divorced, or families without much emotional contact, etc. The basic point is that they both have "parts of self" and/or "versions of mom or dad" in common, at a deeply unconscious "baby core" level.

– What actually happens then, in the "unconscious marital contract", is that they in effect "divvy up" these various unconsciously shared parts, deciding who will contain which parts. So for example, one partner might hate feeling "small and helpless", and the other partner always wanted to be "taken care of" by a good parent. So they might choose that one will be the "good parent", in control of the relationship much of the time, and the other will be taken "care of" like a baby, in effect meeting each partner's unconscious preferences.

Alternately, they both might share a "fear of dependence" at a baby level, and agree they should both have careers, meet their own needs that way, and then "share life together" on an absolutely equal footing. This is very common in marriages that resemble two "siblings" who have chosen to "band together".

– The degree to which the baby core of each individual's personality has "problematic" elements, and this is a key idea for the marital therapist, is the degree to which the marital relationship has the "potential" for difficulty. In turn, this potential for difficulty can be said to correlate with the degree to which the "omnipotent maneuvers" are used to evade mental pain.

Axiom #18: All Marital Difficulties are a Function of the "Baby Core" of the Personality:

– It can be said that the degree to which the "fit" between two partners at a baby level contains potentially "problematic" elements, is the degree to which the marital relationship has the "potential for difficulty" during the marriage. This tends to be particularly the case when "stressful situations" arise in the course of the marriage and aggravate these baby level difficulties.

Perhaps the most common aggravator of underlying baby level difficulties is the "birth" of a child. While it is often the first child's birth that stirs up "baby level" issues in one or both partners, occasionally it is not until a second, or even third child is born, that these difficulties are recreated. This is especially true where the first baby is "identified with" as having possession of both mom and dad all to his or her self, and the underlying "sibling rivalry" that is problematic is not stirred up until the second child is born.

– Any emotionally stressful event, that disrupts the normal flow of the marriage, is likely to evoke baby level issues. A move, job change or loss, serious illness, death in the family, infidelity, birth of a

handicapped child, etc. are all likely to stir up underlying issues. The degree to which these elements are "problematic" for either individual, is the degree to which they will then become problematic for the marriage.

The inability to manage these elements typically then requires marital or individual therapy, otherwise the risk of divorce becomes very high. One not infrequently sees couples who have remained together, but never really addressed the underlying issues in their marital relationship, and have lost intimacy and love over an extended period of time. Invariably, they have recreated and become just like their views of their own parents, who were seen as an unhappy couple, stuck with each other in a lifeless, sexless, sterile relationship. While tragic at one level, it is oddly "safe" at another level because "nothing is left to lose".

Corollary: Because all couples fit together at an unconscious level, their marriage is potentially "savable" if they are both willing to do the work to rebuild it. Even if they have "fallen out of love", the marriage may be salvaged by understanding the baby level elements that have caused the disruption of their relationship.

The main exception is perhaps when they married without ever having "love" for each other. This is sometimes seen when marriage occurred as a matter of convenience (e.g. to look respectable or to have a child). It may also occur when there is an unconscious or conscious fear that no one could "ever want or love" them. Those situations seem more common later in life, when desperation sets in, and the individuals are probably too scarred or damaged to be able to be married (i.e. without first having a personal analysis).

Axiom #19: It is Essential for All Individuals and Couples to be Able to Differentiate "Adult" from "Baby" States of Mind:

– In the early Kleinian literature, this idea was referred to as proper, or mature, "horizontal splitting". I understood this to imply that a mature personality had "baby level" states of mind differentiated from "adult, more realistic" states of mind. In effect, the work of analysis was to distinguish "invalid", "distorted", and thus "unrealistic unconscious phantasies", and "innocent misconceptions", from more "adult, realistic" views of oneself in the world.

An example of this distinction occurred when a patient of mine, years ago, was in the early phase of his analysis and came to his Monday session announcing that I would be "proud of him" because he had purchased three suits with vests, just like the ones I wore. He genuinely confused his attire and external appearance with internal, structural personality change. He thought if he "dressed like an adult" it meant that he had "become adult". I would have categorized this as an "innocent misconception", that was a product in part of how concrete this man's thinking was, early in his treatment. He really did not yet recognize the scope of his "unconscious inner world".

– In summary, what I wish to suggest is that it is very human to have "baby states of mind" completely comingled with, and undifferentiated from, "adult states" of mind and behavior. It often takes some years to make significant separations and distinctions between them, in a given individual or couple. But it is a distinction that is critical to the long term improvement and stability of the personality and relationships.

This axiom is nearly the same as saying that a patient in individual therapy does not truly recognize their need for therapy until they have a conviction that they have an unconscious inner world. The difference with a couple is that their partner is telling them constantly that they do problematic things of which they are unaware and need to be aware of that fact. This is tantamount to saying "you have an unconscious inner world and better start working on it" or our marriage life is in peril.

Corollary:

– The "hallmark" of the differentiation of a baby state of mind, from an adult state of mind, is that "baby" states of mind are almost always "INAPPROPRIATE IN THEIR INTENSITY" to the situation at hand. That is to say that they are most often "too intense" and "exaggerated" for that situation, but they can also

be “too minimal or even absent”, for the reality at hand. As an obvious example of the latter, the inability to have any “feeling” at all, when someone close dies, is a common example of a “baby level” predominating in this paradoxical manner. It may be an unconscious reaction to the possibility that if one allowed feelings to exist at all, they would completely take over and that one would “fall apart”.

Until someone is aware that they are “over” or “under” reacting to a situation, they do not necessarily recognize that something in their reaction “needs to be understood and modified”. Spouses that routinely “blow up” or “scream” at each other may believe they are justified and being and “constructive”, when in reality I have never seen any relationship that is enhanced by “shouting” at each other.

– When “baby parts” of the personality predominate during times of loss, disturbance, conflict, etc., one often sees anger, blaming, defensiveness, etc. in a marital relationship (or life in general). . When these sorts of emotions are predominating, and the individuals do not realize that their reactions are not “adult” in nature, then they have no way of knowing that they need assistance. They are likely to just make a mess of their relationships and life.

– When “adult” states of mind predominate during those same times, the predominant emotion is more likely to “GUILT” or “SADNESS”. This is a “sane”, realistic reaction. The problem is that because sadness and guilt can be very painful, it is not uncommon for the individual to have an “innocent misconception” that they should not have the feeling. It may also be a more problematic “affront to their omnipotence” that they would be “losing control” of their emotions or appearing to be “childish”.

In summary, it is the therapist’s job, as I see it, to begin to make the differentiations between “adult” and “infantile” states of mind, from the first time a patient enters the office. Needless to say, the therapist needs to be clear about these differentiations, his or herself, and that requires having had analytically oriented treatment.

Axiom #20: Emotional Development Tends to Only Occur in the Context of an Intimate Relationship

– Another way of saying this is that for emotional development to take place, the “baby core” of the personality must be “engaged” in the relationship. Bion suggested that one can usefully divide relationships into three categories according to the “depth of emotional intimacy” involved. He did NOT mean to imply intimate as in “sexual” intimacy.
His three categories of depth of the emotional link in a relationship are “casual”, “contractual”, and “intimate”.

– As I think of it, “casual” implies someone you recognize, maybe even know their name, but with whom you do not actually socialize. A neighbor you see when walking your dog in the morning might fit this description.

– Similarly, a “contractual” relationship is one in which some form of “contractual” situation brings you together regularly, but it is still not someone with whom you have an emotionally personal relationship. Relationships to co-workers and superiors at work most commonly exemplify this level of relationship.

– By contrast, it is usually only with (1) family, (2) close friends, or (3) dating or marital partners, that one has a truly emotionally “intimate” relationship, in Bion’s sense of the word. And it is most commonly only in that sort of relationship that the “baby core” of the personality is routinely engaged. This makes for a circular, but useful, definition of an “intimate relationship”. It is one in which the engagement of the “baby core” of each person makes it “intimate”, and it is only “intimate” if the “baby core” is engaged.

– The main implication of this idea is that for a change to take place in someone’s personality, in a manner that is truly “structural” in nature, as opposed to “superficial”, “intellectual”, or “contrived”, it must occur in the realm of “real emotional significance” to that individual uniquely.

For me, with my current thinking, it seems to imply that this "emotional contact or resonance" occurs at the level of the "amygdala". This is not to say that higher level cognitive functions are not involved, they clearly are involved. But they must ultimately have an impact on the emotional relationships stored at the level of the amygdala if any real growth and development is to take place.

– Take for example an infant whose mother went back to work full time in the infant's second month of life, or who was given up for adoption at birth because the biological mother was a single student, and did not feel ready to have a child. In either situation, the infant might develop an "innocent misconception" that it was "not lovable" and therefore "bad". If that "unconscious phantasy" is carried into adulthood, despite in reality having loving parents and a husband or wife, that individual is still likely to be predisposed to periods of mild depression, whenever he or she is not fully successful at something.

Let's imagine that person sees a psychiatrist for medication, during an episode of depression, and recovers adequately. He or she is still subject to the same reaction in future situations. In contrast, let's say that individual goes into a more ongoing therapy relationship, after a subsequent bout of depression. They are likely to gradually recreate with the therapist, in the "transference", that same "feeling that they are unloved and bad". The therapist recognizes the historic link, and they gradually over time, see this same quality of "negative transference" from multiple angles. If they continue their "constructive interactions", the very quality of their emotional relationship is gradually altered. This represents an actual "structural change", based on many elements of the "emotionally intimate relationship" to the therapist.

– I find it useful to distinguish this quality of change from one in which an aspect of the personality is "split off and projected", but the underlying "paired relationship" (between a baby level part of self and a version of mom or day) goes on at the level of the "amygdala", unaltered.

This can be seen in therapies where the therapist and patient engage in a mutually supported attack on someone, often a parent, sibling or spouse, creating a "folie au deux", that encourages the projection of a "bad", and thus unwanted part of self or internal parental figure, into someone in the outside world. This amounts to the unconscious use of a "manic defense". It does not lead to "structural change", even if the individual "feels better". Instead, it usually increases personality "rigidity" and "paranoid anxiety", not to mention ruining the relationship to the recipient of the projections .

– In summary, because true "structural change" in the personality seems to only take place in the context of an "emotionally intimate" relationship, such changes later in life typically require an intensive therapy situation, and are most commonly and readily created by an "analytic level" of intensity of therapy. This level of intensity and intimacy allows the "baby core" of the personality to be engaged in an ongoing manner, without resorting to excessive defensive maneuvers to evade the pain that the relationship allows to be recreated.

Being a Therapist and Doing Therapy

Axiom #21: Being a "Good" Therapist Requires Extensive Training, Emotional Balance, Curiosity, and Imagination

– It is the "kiss of death" as a therapist to be prone to: (1) "narcissism", (2) "sitting-in-moral judgment", (3) "omnipotent" and "omniscient" states of mind, and/or (4) have difficulty in "setting limits" and "preserving boundaries". Unfortunately, most of us start with our fair share of these characteristics or predispositions.

Most of these correlate with (1)the activity of "unconscious envy", (2) a predisposition to the excessive unconscious use of "projective processes" to get away from experiencing baby states of mind, (3)and whatever "innocent misconceptions" or "distortions" we have about life, boundaries, and intimacy, left over from our infancies and childhoods.

– This means that even the most potentially "talented" young therapist still has an "amygdala", and an abundance of things they do not know about themselves. "Talent" for therapy requires (1) liking

"interaction" with people, (2) an active "curiosity" about the workings of the unconscious inner world in self and other, (3) a general familiarity and comfort operating in the realm of "emotional experience" that we might arbitrarily call "psychological mindedness", (4) all rounded out with a readily available "imagination" that can creatively think about and verbalize emotional states, including recognizing the use of "symbols" particularly as conveyed by dreams, that represent baby states of mind.

Axiom #22: All Therapists Need a "Personal Analysis" to "Calibrate" Their Instrument

– Every therapist was once a baby! He or she had experiences stored in their amygdala during those early weeks and months, and WILL RECREATE them with their patients, whether they are aware of it or not. Thus, just like in a marriage, or any emotionally intimate relationship, what they do not understand about themselves will, inevitable produce difficulties in the therapy relationship.

Therefore, everyone who does therapy should have their own personal treatment to understand the major "baby elements" in their own personality. Otherwise, they will "project" problematic elements into patients, and/or they will have "problematic reactions" to the "baby aspects" of their patients, that are being "projected" into the therapist.

Corollary:

– "Negative transferences" are the most commonly avoided transferences by therapists and patients alike. Ideally, a therapist needs to "anticipate", and bring up the possibility of a negative reaction that a patient may have in the future or is currently having unconsciously, long before it is in "full bloom". Most therapies that are "interrupted prematurely" are "ruined by unanalyzed negative transferences", something I learned early on in doing therapy.

Perhaps the single best hint or clue that such an issue might come up is whether or not the patient "turned away" from their "good objects" at any point in infancy. For example, sucking one's thumb throughout much of childhood, serious adolescent rejection of the parents, history of significant drug and alcohol usage, serial infidelity, etc. all suggest that the patient does not remain in the relationship to a "good object", but instead "turns away" in the face of excessive mental pain, often including "envy of the goodness" of the object.

The latter idea is of particular importance because occasionally a therapy is making "good progress", and then comes unexpectedly to a screeching halt, and the patient quits seemingly out of the blue for no apparent reason. If the therapist had seen the correlation from the patient's earlier history, they might have anticipated this "negative transference reaction".

– It has been my repeated experience that I need to point out to a patient in the early sessions that based on their history, they will "unconsciously" need to "recreate" their negative reaction they had in their infancy or childhood, with me in the therapy, in order for it to get analyzed, instead of repeated through "action".

When that "negative transference" finally comes to fruition, patients will often say to me, "you said I was going to feel this way, back when we first met". This gives us both more time to explore the "origin of the negative reaction", without the patient "acting" on it without awareness of its unconscious origin. It is as if the "anticipation" of it makes the idea more likely to have significance that needs to be "thought about" rather than "acted upon".

Corollary: If the therapist and patient are "too scared" or "unaware" of the negative element, and wish to preserve an "idealized" view of their work together, an extremely common situation, then there is an almost inevitable risk of projecting the "negative unconscious element" into someone outside the therapeutic relationship. This nearly always is a spouse, parent, sibling, or co-worker who does not deserve the full blame for whatever is wrong.

Axiom #23: The Therapist's Problematic Infantile Countertransference versus Normal Countertransference:

– This has always been a difficult topic for psychoanalysis, as seen from Freud's and Klein's time, to current day. The crux of the problem might be framed by the two questions. First, is it possible for a therapist to be an impartial judge of a patient, without reacting "problematically or neurotically"? And second, would it be "desirable" even if it were possible to not react to the patient?

– If it were true that patients could use "words alone" to convey their "states of mind", it might be possible to be "impartial". But the problem is that damn "amygdala" again! Some of the most important and early states of mind, stored at the level of the amygdala as "memories as feelings", can only be "lived out" through unconsciously performed "song and dance" on the patient's part. Furthermore, they must inevitably be "received at a primitive level" by the therapist's mind, as a "feeling", and then converted into "thoughts" that can be expressed in "words".

This process corresponds to Bion's notion of very primitive, unthinkable states of mind (which he arbitrarily referred to as "beta elements") requiring the infant's mother to take them into herself, and convert them to "thinkable, usable states of mind". Bion arbitrarily gave the mother's "reverie", about the "infant's raw states of mind", the name "alpha process", and the products of the mother's mental work were referred to as "alpha elements".

– This points the way to the core issues that are involved in the problem of "countertransference" (which I will call CT for short). Let's presume a patient manages to convey something to the therapist by non-verbal communication, that is very important. How can the therapist "DISTINGUISH" his or her own "baby level" reaction to the matter at hand, from the patient's unconscious communication through pre-verbal or non-verbal means?

– For example, what if my patient is critical of their mother, and I am also in a mood to be critical of my own mother. I might collude with the patient in their urge to blame their parent, and both of us are not taking responsibility for our own contribution to the issue at hand.

What if the real issue is that the patient is recreating, with me, an early, very primitive difficulty with their mother. What if the issue is that the mother was unwilling to consider her own "problematic" failure to "take in" the infant's states of mind, when those states of mind were painful to the mother?

What if, by complaining about his or her own mother, the patient is trying to recreate a situation with me, where I am the mother who is "failing to see" that I am the person about whom the patient is complaining. In effect, my own CT reaction of not wanting to be "to blame" for anything, and my willingness to make mother the "bad guy", is leading me to fail to receive an important, but primitive, song and dance recreation of an early version of mother in the patient's unconscious inner world.

– I see this type of CT difficulty regularly in less well trained people doing therapy. They are often colluding with their patient to project everything bad, and put all the blame for their marital woes, into their spouse. The therapist agrees with, and thus colludes with their patient's projections into their spouse, not infrequently ruining the marriage. By failing to aid their patient in "taking back projections", which were they recognized and stopped, would greatly improve the marriage, the therapist is actually doing harm. Furthermore, the patient's projections into the spouse, not infrequently, represent criticisms the patient would need to direct at the therapist in the transference, if the therapist were willing to allow "negative transferences" to exist.

– In summary, we can arbitrarily divide CT into two categories. The first would be the "expectable human reaction" that most of a group of therapists would have, when a patient conveyed a certain state of mind by non-verbal song and dance, with or without the use of words.

The second is the therapist's own "baby level" reactions, which may be both entirely "unconscious" and "irrational". This has a lot to do with why it is usually wise to keep strong reactions to a patient to oneself. These reactions are often the therapist's own issues, thus something to be kept private to the therapist. They represent useful material for his or her formal therapy, or later ongoing self-analysis. This is one of the main reasons why candidates in psychoanalytic training are required to be in a personal analysis for much of their training.

Since much of the communication in therapy goes on at this "pre-verbal/non-verbal" level, it requires the therapist to be able to differentiate their own "reasonable reactions" to their patient's communications, from their own "baby level, neurotic, irrational, unanalyzed reactions and unconscious phantasies". This links back to Axiom 22, with the necessity for all therapists to have their own personal treatment, and it anticipates Axiom 24.

Axiom #24: The therapist should never "take sides" in marital therapy!

– As I mentioned earlier, I see this over and over in therapists doing either individual therapy, or in doing marital therapy. This is not restricted to spouses as the therapist may side with the patient against a parent, sibling, boss, etc. The underlying issue is the same in all of the situations, i.e. "bad stuff" and "blame" are being "projected" instead of "owned".

This is probably most commonly a product of the therapist's inadequate training, with the result that they do not have the concept of "projective processes" understood in anything more that the most rudimentary sense.

However, it is also very commonly a product of more problematic, neurotic CT reactions and prejudices. As I said earlier, mothers, fathers, and spouses come in for the lion's share of such collusions between therapist and patient to project "bad stuff" into them, and spare the therapist and patient the arduous task taking responsibility for one's own problematic reactions and behavior.

Axiom #25: The Gift of Sharing an Exploration of the Workings of Another Human's Mind Should Be Cherished

– I once had a boy in treatment who was fascinated with the workings of "planets and outer space", when he clearly really wanted to understand what had happened in the womb, and infancy, with regard to himself and his twin sister. He could not bear the pain of a tragedy that occurred at birth, his mother's subsequent depression, and the harm it did to his entire childhood. He projected the problem as far away from himself as possible, and attempted to work on it at great distance from the actual humans involved, who themselves could not face it.

– As therapists, having calibrated our own minds to do the work of exploring the unconscious "inner space" of "psychic reality", we are doing work that is even more fascinating that that of the astro-physicist, but also one hell of a lot "scarier". It is also quite "amazingly fascinating" stuff, and potentially never the same from day to day. As I like to say, even when a patient is extremely "boring to the point of being soporific", there is still the "fascinating" question of what it is that he or she doing to render life "so empty of emotion", or seemingly "devoid of meaning"?

– I regularly hear young therapists lament about the difficulty of doing the work with patients. It always reminds me of the pain I felt in the first five years of practicing as a mental health professional, when I had patients bring in their struggles with painful thoughts, their dreams, etc. and I had little or no real in-depth understanding of what it all meant. It was hard to wait years, with personal analysis and supervision in the meantime, before I reached a point of having a modicum of understanding of what might be going on in my patient's unconscious inner worlds, and in my own.

– Because I ultimately wished to understand myself, and felt propelled to do the "work" of facing my mental pain, despite my own narcissistic personality organization and unconscious use of omnipotent maneuvers and manic defenses, I managed to come out on the other side with a more constructive and productive approach to life.

– I wanted my patients to feel able to face their own mental pain, with me at their side, and not evade it with medication or magic. As a result, even though probably half of all my patients during my career have come to me on medication, or have been on medication prescribed by someone else during treatment with me, I myself am still on my first "prescription pad", when it comes to my doing the prescribing of medication.

Furthermore, were it not for the fear of being sued, I rather doubt that very many patients really require medication, if one is willing to see them frequently enough that the patient can bear to "stay in contact" with his or her unconscious inner world between sessions (meaning it often requires seeing a really distressed patient three to five times per week).

[Note: I am not suggesting that a patient who is acutely psychotic does not require hospitalization and medication, but I am suggesting that medication is very "over prescribed". This amounts to saying to a patient, "let's see if we can make your pesky inner world go away, so I don't have to do the hard work of learning to understand the workings of my own inner world, in order to be able to understand the workings of your unconscious inner world". Children as patients are particularly susceptible to this feeling that the "grown-ups" just want their minds to "go away".]

– It is my impression that all psychotropic medications essentially do the same thing, they make it harder to "feel one's feelings". When a patient is in a treatment that can manage that patient's feelings and states of mind, all patients will come to the conclusion, sooner or later, that they are missing out on a portion of life by being unable to "feel" themselves fully.

I have NEVER had a patient who has not ultimately wanted to stop their medication, because they thought they could get along without out it, and they wanted to be able to completely feel the "good" aspects of life, This is usually because they are no longer afraid of their painful states of mind. [Again, chronically psychotic and schizophrenic patients, who are not a part of my practice, would be exceptions to this rule].

– Whenever I really think about it, I feel that it is such an "honor and privilege" to have a human being come into my office and expose the most intimate and detailed "workings of their mind" to me. There is nothing more interesting in the universe, and nothing to be cherished more, save perhaps "life" itself. I go to work every day expecting interesting, new things to occur, and I feel so fortunate to have a career that I enjoy, even love!

In summary, this leads me to want to paraphrase the saying of early American history, "Go West Young Man (or Woman)". I would like to say "Calibrate Thy Instrument, and Go Deeper – You'll Never Have a Boring Day in Your Life!"