Module 2 – Part 2 – Klein's BabyCore Coping / Defensive Maneuvers

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Section 1 - Self-Regulatory Maneuvers for Infants: A Brief Introduction to Barry Brazelton, M.D.

A Brief Introduction to Barry Brazelton, M.D.:

Barry Brazelton was a developmental pediatrician who did mother-infant research starting in the late 1940's and 1950's. He often described the infant as having a very small array of mechanisms for coping with distress in life. This array of maneuvers included, most notably: Crying, pooping, peeing, spitting up, sneezing, staring fixedly at something, and going to sleep. It is interesting to note that these are all visible reactions of the infant that can be observed in response to noxious stimuli.

Underneath each of these behaviors, one can imagine a psychic component, a phantasy in the infant regarding what he is achieving by the physical, bodily action. For the most part, these actions seem to be 'evacuative' in nature. Therefore, they suggest an underlying phantasy of putting the noxious experience outside oneself. The final two maneuvers, staring fixedly and going to sleep, seem to suggest a phantasy of escaping the distressing experience, perhaps even trying to deny his existence.

I mention Brazelton's observations because they seem to be the same as Klein's core defensive maneuvers of projection and denial, and also hint at the operation of the "organ of attention." The primary difference is that, as a pediatrician, Brazelton is describing observable behaviors of infants, while Klein is suggesting the unconscious phantasies of the infant attendant to the behaviors.

Section 2 - The Organ of Attention and Denial of Experience

Introduction:

Infants start out life in an utterly helpless state, understanding next to nothing of what is happening and completely dependent on the surrounding environment to keep them alive. They begin life after birth with almost no maneuvers for coping with distress except to try to escape it. Consequently, they will usually try to avoid having the experience, and failing that, they will try to rid themselves of it by evacuation. Avoiding it usually means not "taking in" the experience in the first place. To achieve this, all the infant needs to do is direct his 'organ of attention' in some direction other than at the unwanted experience so as to effectively "deny" the existence of the potentially distressing experience.

What is the Organ of Attention?

Essentially, the organ of attention is the totality of each sense of perception: sight, sound, touch, smell and taste. Although they are linked to deep brain functions, some part of the personality comes to be increasingly "in charge" of them. Thus, we refer to the totality of these organs of perception and the part of the personality in control of their direction and use at a given moment as the 'organ of attention.'

For instance, a baby who does not want to see that mom is not paying attention to him may simply stare intently at something else, ignoring mom's existence at that moment. Another common example occurs when he has been left at day care for several hours. When mom comes to pick him up, he may stare away at first and refuse to look at her. The pain of having been left in the morning was likely "turned away from" and denied until mom came back, finally compelling the infant to face that he had lost someone of great importance, possibly permanently.

I once met a very kindly, older woman who did not like rude or vulgar behavior and had a capacity to literally hallucinate out of existence off color jokes told at the dinner table. Her relatives described this as a lifelong behavior. She was literally unaware that such an activity had just taken place in her presence, probably achieving this by unconsciously anticipating when such an act was forthcoming and turning her 'organ of attention' away from that area in advance.

Summary:

The idea of an 'organ of attention' is a very useful construct as infants have so few maneuvers available to them. The "denial" of the existence of something an infant doesn't want to see, by effectively looking away, is perhaps the most rudimentary maneuver available and therefore, quite commonplace in the life of a baby.

Melanie Klein ranks denial as one of the most fundamental of psychological defensive maneuvers because it is so elemental and available to the infant. Denial is ranked alongside the concrete phantasies of "taking something in" and "putting something out." In psychological terms these maneuvers involve phantasies of "introjection" and "projection."

[Note: See Module Five for a detailed elaboration on the "Organ of Attention."]

Section 3 - Being An Unborn Inside Baby

Introduction:

This section on being an "unborn, inside baby" and the next section on the "death instinct" are essentially two versions of the same issue, one of which is more extreme than the other. Both have to do with attitudes about birth and life in the outside world. The first focuses on a solution that undoes the problems attendant to being born by simply reversing the process and imagining being unborn back to the inside of mom. Sort

of like Punxsatawney Phil, the groundhog who, according to the legend, if he sees his shadow when he comes out in spring simply goes back into his hole for another six weeks.

The death instinct is essentially the same attitude but with a more violent response as I will outline in the next section.

The Experience of Birth:

It seems reasonable to assume that birth is one of the most dramatic and distressing events that an infant has yet experienced. After nine months of what is hopefully a boring constancy, there is a sudden, unexpected violent event with literally crushing sensations that takes place, after which everything is permanently different. Some babies are quick to move on and explore this new universe that requires breathing and subjects one to all of their inadequacies. Other babies are not and become the subjects of the two concepts – being an "unborn, inside baby" and the "death instinct."

Alessandra Piontelli is an Italian psychoanalyst whose book "Backwards in Time" describes infants she had studied before birth (by echo sonogram) and after birth (by infant observation). Piontelli also made a point of studying twins in utero. She describes a situation in which a light was shown on the mother's abdomen and the infants' reaction to this novel stimulus was then observed. The female fetus moved toward the light, as if curious about it, while the male buried his head in the placenta, as if to get away from the unwanted intrusion.

I think this highlights the variability of the experience of infants regarding any big stimulus, and birth is a very big stimulus! The issues at hand include the infant's ability to cope with sudden novel stimuli and whether he feels fragmented by the stimulus. We could put this variable more in the "nature" camp of genetic predispositions. On the other hand, the response of the environment must also be of extreme importance.

If things get off to a shaky start between mom and infant, some infants will keep on chugging along, and others will be quick to get off the train and give up. This variability is readily obvious when one studies breast feeding. It usually takes an effort from both parties to make it work, and a Herculean effort by one if the other is not trying very hard.

The most difficult circumstance for mother and infant is premature birth when the infant is literally not ready to come out, and the typically extended hospitalization adds insult to injury. Whenever I get a whiff of ambivalence about life in the behavioral history of a patient of any age I immediately wonder about prematurity as a possible contributing element.

The Relationship to Mental Pain in Early Infancy:

If all babies must decide after birth whether or not they feel that being born and out in the world is "worth it," the environment's regulation of the infant's physical and emotional distress is a huge variable in the equation. Anything that interferes with the mother and infant quickly making a good connection has the potential to tip the balance toward life in the outside world not being worth it. Illness immediately after birth, failure to establish a successful feeding relationship, excessive anxiety or ambivalence on the part of the mother, a baby who can't get comfortable and regulated and is easily overwhelmed by stimuli, etc. can all add to the feeling that being born and out in the world is more pain than it is worth.

Manifestations of Ambivalence about Being Born:

If one observes small children at play or recalls one's own childhood, there is endless delight in making houses, forts, and creating all sorts of small, tight places to crawl inside. I had a woman patient who, whenever distressed, would take a bath for one or two hours to gain relaxation and retreat from her distress.

These are all manifestations of a phantasy of being unborn or joined up to someone else. This is human and universal. But it can, like everything in life, be carried to an excessive or extreme degree, and that is what we are aiming to explore.

The most obvious manifestation of ambivalence about being born is a baby who does not want to wake up and take in the new reality of being in the outside world. Since birth is primarily about separation, a lesser version can sometimes be seen in the infant who wants to held all the time, as in being carried around in a "snuggly pouch" on the mother's or father's chest. Infants tend to like consistency, but some are more intensely affected negatively by any alteration in whatever pattern they have come to expect. This is one of the reasons why I don't particularly encourage mothers to leave their babies overnight during the early months after birth.

Sometimes the manifestation of ambivalence is more psychosomatic in expression. Asthma, for example, always brings to mind the problem of taking one's first breath after birth, the terror that one may not be able to breathe, and then any later separation from mother reminding one unconsciously of that initial anxiety at birth. I suspect that whatever physiologic reactions to which the infant has inherited a predisposition have the potential to become the "target zone" for these deeply unconscious reactions to the initial separation at birth.

Later in childhood, and on into adult life, these manifestations morph into patterns that typically center on the issue of "separateness." Anything from never wanting to have a sleepover at another child's house, to having a serious struggle over leaving home to go away to college, to having a breakdown after breaking up with a boyfriend or girlfriend, to a divorce, etc. can reawaken these baby anxieties that originated with birth. In all of these situations, there is a telltale phantasy embedded in the reaction that is about "dying," often expressed in the form of "I can't live without …"

People with these unconscious anxieties about separateness tend to form very "attached" relationships. They may never leave home and their parents, they may "fuse" with a partner in life, or they may do the opposite and never risk any attachment that could lead to another birth-like catastrophe, preferring attachment living inside their own rectum, an organization like the military, or whatever provides unchanging consistency and a "guarantee" of insider status on a permanent basis.

Manifestations in the Consulting Room:

I once had a patient who had been put back into the hospital at one month of age to see if he had neurologic damage because he refused to wake up or stay awake. He had been born about four weeks prematurely, had no neurologic defects, but demonstrated throughout his childhood and young adult life that he was extremely ambivalent about living on the "outside." In treatment, he wanted me to think for him and regularly dreamed of living inside my office, interior stairways, and in the room across the hall from my office. He was permanently manifesting the 'unborn, inside baby' condition, only tolerating separateness to the degree necessary to keep from irritating his "host."

Every therapist has few patients in practice like the one just described for whom being an unborn inside baby is a central feature of his lifestyle as a patient. They are not in treatment to gain independence. Rather, they use the therapeutic relationship as an end in itself, i.e. being joined up with the therapist is their primary unconscious goal. They often idealize the therapist's ideas and do little thinking of their own. If the therapist does not have a "model" for this, then they will not recognize this deeply unconscious motive in their patient. These patients are usually agreeable, appreciative of the therapy, even pay early, but they never "grow" commensurate with the insight and knowledge gained.

The evidence of their ambivalence about being separate can be seen in their life choices, as I mentioned earlier, but will inevitably be most manifest in their dreams. They will tend to be on the "inside" of structures, aspects of their identity will be co-mingled with other's identities, separateness will be avoided,

there may be hints at living inside someone's anus as seen in dreams living in dirty caves, sewers, and the like, and there is typically no evidence of exploring new and novel places or ideas.

Differences from the Death Instinct:

While the initial situation of feeling that being born and out in the world is not worth it is the same in both of these sections, there are some key differences. While these are overlapping circles, I will treat them as more distinct for the sake of clarity of exposition.

The key difference as I conceptualize it based on my clinical experience is the degree of violence in the emotional response to the trauma of being born. To put it starkly, it is as if the babies who have a less violent reaction are saying "I can fix this here and now. I will refuse to go on any further. I am going on a sit down strike, become passively immobile, and go back to where I started."

Babies who manifest the death instinct, on the other hand, act as if outraged by their birth, hate every aspect of being separate, and even hate their sensory apparatus for making them vulnerable to the experience of the pain of separation and life outside the womb. This makes a perfect segue to the the death instinct.

Section 4 - The Death Instinct: How Alive To Be, How Much Life To Live?

Background Introduction:
This is historically one of the most controversial concepts in psychoanalysis, going back to Freud's original formal declaration of the life and death instincts in his classic 1920 paper, "Beyond the Pleasure Principle." The difficulty lies in part with the natural human wish to see infants, and infancy, as a period of innocence. That infancy is a period of maximal distress, that things can go horribly wrong despite the caregivers best intentions, and stamp a life permanently in a negative way, is too much for some to accept.

Melanie Klein's student, the extraordinary British psychoanalyst Hanna Segal, makes mention of Klein's idea that the infant's need to deflect the 'death instinct' to the outside world and take a posture against it. I could never, as a young analyst, quite wrap me mind around that idea until Dr. Segal came to Los Angeles to lecture, and I was able to briefly get a response that redirected my thinking. I realized at that point that I was taking the "death" aspect, in an infant who seemed unlikely to be able to abstract out such a concept, too literally.

What I came to realize was that this had much more to do with an extreme reaction to being born, and was thus more fundamentally related to the concept of being an 'unborn, inside baby' than to "death" as an adult might conceptualize it.

The Concept of the Death Instinct:
1 – I can't see how infants have the conceptual capacity to understand life and death as concepts. I doubt that they know what death means. Having said that, I do think they can have a concept of the terrors of feeling like one is dying even if they don't understand how that will end.

When you are born you have to do something for the first time that I imagine can be really terrifying even if you don't know what it is about. I am of course referring to taking one's first breath. You may be literally drowning in fluids, suffocating, and then finally cold air rushes into your lungs for the first time. Frankly, it

sounds terrifying to me. It is that terror and any others that a newborn infant can suffer that can make life after birth a potentially really frightening and awful experience.

2 – But not all infant's seem to have the same reaction to these traumas. Some seem to avoid dwelling on the situation, if you will, and quickly direct their 'organ of attention' on mom and getting things on a positive foothold. For others, I have the impression that looking for the "silver lining" to birth is not so easy. For whatever combination of constitutional predispositions and environmental difficulties, these infants have a much more intense, violent even, reaction to those insults attendant to birth.

3 – What seems to set these babies apart from others is a "hatred" of this state of affairs. This hatred includes hating being in pain, hating being helpless and totally dependent, and even hatred of their organs of perception and their mind for being able to experience such painful realities.

My clinical experience suggests that these intense reactions seem to correlate with individuals who will later in life seem to be intensly predisposed to problematic levels of "unconscious envy". I cannot give a definitive explanation for this correlation. I can say that it makes sense to me that this hatred of being a helpless baby could be linked to the reactions that some babies seem to have of being outraged that mom gets to be the "big fancy mom" and they have to be the "shitted-up baby". Whether this hatred means that these are babies that will turn out to be highly envious adults, or whether it indicates the pains of infancy will promote the development of envy, perhaps only future research will tell.

<u>Manifestations of the Death Instinct in Adolescence and Adulthood</u>:
1 – I find it useful to picture these babies as having very intense, violent reactions to the pains of infancy. Later this will often manifest in behaviors, like alcohol and drug use in adolescence, to evade any experience of the baby level mental pains that resurface at puberty. In the most extreme situations, it will manifest in psychotic breakdown with violent attacks on the mental apparatus that can perceive reality and its attendant mental pains.

2 – Any baby who cannot decide if being born has sufficient goodness to warrant staying alive in the outside world is highly likely, without treatment, to remain ambivalent about living for their entire life. This ambivalence may be very unconscious, but it will usually be in evidence somewhere in the individuals behavior and attitudes.

I think of this situation as one of being chronically, unconsciously, "characterologically suicidal". This is not necessarily someone who ever thinks consciously of suicide. But a careful review of their life history will include episodes of risk taking or actual events that could have, or even should have been lethal. These events will have occurred at times when stresses and mental pains suggest circumstantially that the death instinct was operative.

At minimum, the individual may unconsciously make life choices including career, marital partner, having children, etc. that represents an "attenuation" of how much of the experience of being a separate, living human being in the outside world, vulnerable to mental pain, they will tolerate. The imagery of literature is replete with spinsters, accountants with humdrum lives, etc. Careers in the military, government service, and even large corporations may represent living inside a mental space where nothing changes and everything is prescribed in life.

If the above represent compromises with the death instinct, it will commonly resurface in a more recognizable form when the slings and arrows of life come home to roost in the form of illness or death around the individual. Serious illness in the individual may bring to the surface a lack of desire to confront the situation and a reaction of seemingly "just giving up".

3 – In the circumstance of suicide, the behavior itself is prima facie evidence of the death instinct in operation. Even if the person didn't intend to die, it was still evidence of the ambivalence about life that is part and parcel of the death instinct.

4 – Most commonly, the concept of the death instinct seems to match its expected manifestations in a range of more subtle ways. These are in the realm of risk taking behaviors that would suggest ambivalence about preserving life. In this day and age I would certainly wonder about anyone who persists in smoking cigarettes past adolescence or their twenties, where they could still rationalize that they will stop before it could do any harm.

In general, risk taking behaviors exist on a continuum. At the least obvious end of the spectrum, they take the form of behaviors that have a low level of danger but are clearly not healthful. At the increasingly more obvious end, the behaviors start to look like Russian Roulette.

At the lower end, the behaviors have a low level of danger when done responsibly, but become more dangerous under certain circumstances. So for example, snow skiing and scuba diving can be safe and sane activities. They stop being safe and sane if you are drunk, there is an avalanche warning, or you try diving deeper than is recommended, or you go without a buddy diver just in case something goes wrong.

At the other extreme, free hand mountain climbing, hang gliding, and auto racing seem to be on the ragged edge of playing Russian Roulette. The television show "60 Minutes" filmed an episode of men sky diving in body suits and the main diver died in an accident between episodes. You cannot convince me that that man did not have a very intensely active death instinct.

While it may be impossible to say for certain how much the death instinct was operative in a given lethal event, there is a bit of circumstantial evidence that one can obtain fairly readily. That is to ask the following question. "When was that person's birthday?" You may be astonished at the number of life ending events that occur around someone's birthday. I always assume the death instinct was in operation under such circumstances because the coincidence with the anniversary of their birth seems too predictable to be a complete accident.

Summary:
At birth, all babies must decide whether or not they feel that being born and out in the world is "worth it". If they feel that being outside in the world, separate from mom, is more pain than it is worth, then they will want to be unborn back inside mom. For some, this means an attenuation of that distress and any further vulnerability to the distress of being separate.

For others, in particular those infants who have a particularly violent reaction to birth and its attendant pains to life out in the world, the urge to stop living, having a mind, and feeling any pain is much greater. It then has the potential later in life to lead to potentially life ending behavior, or stamps the personality with a "characterological suicidal" predisposition.

[Parenthetically, if violent criminal behavior is a manifestation of the death instinct in an individual, it seems obvious that the death penalty is no deterrent to someone who does not care about life.]

Section 5 - Splitting-and-Idealization

Overview:
We introduced this topic in our discussion of the paranoid-schizoid position as an essential component maneuver for the infant to bring order to its world. the infant would endeavor to hold on to all that is pleasurable and therefore "good", while simultaneously evacuating anything that is distressing and therefore "bad" into the outside world. This dividing of the world into good and bad is the process of "splitting-and-idealization" and the evacuating of the bad half into the outside world is the process of "splitting-and-projective identification". [Note: I have borrowed both hyphenated terms from Donald Meltzer.]

Since I have described this term in detail in the section on the paranoid-schizoid position and its attendant maneuvers for normal development earlier in this module, I will now speak about "idealization" more generally in later development and in daily life .

Idealization in Development and Daily Life:
To begin I would like to highlight some ideas that I find useful:
1 – Idealization is an essential and necessary aspect of early infancy and should gradually give way to a more mature version of reality testing during childhood and adolescence. By adulthood it should be clear that there is no good evidence that magic exists, perfection should be seen as impossible, the world should be seen as more grey than black and white, and everything choice in life should be recognized as a "trade-off".

Whenever one sees an adult who is holding on to unrealistic, magical, idealized attitudes about life in the real world, it should be recognized as coming from the "baby core" of the personality. To the extent that these attitudes dominate the person and their functioning in life, the potential for these attitudes to become problematic goes up exponentially.

The continuation of such thought processes later in life is often evidence of a unconscious attempt to avoid deep seated confusion about what is good and what is not. The fear that something is going to be ruined by a little bit of "bad" creeping in is typical of the thinking of a small child, but should not be dominant later in life. The juice from the peas touching the hamburger patty or a broken piece missing from a cookie, may feel like the calamitous ruin of something to a small child, but they should not be an issue to an adult.

2 – Idealization amounts to removing any imperfections or impurities to the point that what is left is perfect. This is a serious problem in ways that may not be immediately obvious at first blush. It poses several problems.

– If something is perfect, it is very hard to keep from spoiling it. Everything done in relation to it must be kept perfect as well.

– If a parent is idealized, they will at some level be imagined to expect perfection from everyone around them. Picture a stage mother or little league father constantly hovering over their small child's performance and effectively demanding perfection of their child from the child's point of view. This is why "idealized Gods" are so hard to please in the sense of a religion dominated by baby core thinking. [Note: See Module Four for a discussion of this aspect in "The Baby Core in Religion and Religious Thought".]

3 – When under stress, people often find it difficult to "think" or they literally stop thinking. They tend then to resort to very limited, concrete approaches in which everything is black or white because the complexity that shades of grey require one to ponder through simply seem too daunting at that moment of stress. It is in these states of mind that people return to the idea that there must be a bad guy who can be blamed, or a causal explanation that seems obvious, the "where there is smoke there is fire" type of limited logic.

It is probably obvious that this type of thinking relies on prejudices as preconceived background assumptions. It also tends to create a desire for an "all knowing" savior who can fix the problem at hand. That savior would have originally have been mommy, but she morphs later in adult life into some version of a god. As the saying goes, "there are no athiests in a foxhole".

Summary:
Splitting-and-idealization as a normal infantile process necessary to bring order to the confusion, chaos, and helplessness that is infancy, must give way over development to more mature ways of thinking that involve a more sophisticated level of reality testing.

Where idealization remains excessively prominent in one's thinking processes later in life, it is evidence that development has gone awry and poses potential serious problems. It leads to rigid, concrete, simplistic thinking and often overlays much more confused, troubled thinking and phantasies left over from infancy.

Section 6 - Splitting-and-Projective Identification

Overview:
Melanie Klein wrote a paper in 1946 called "Notes on Some Schizoid Mechanisms" in which she first mentioned the phrase "projective identification". With that paper she simultaneously unleashed two huge trends that have been central in psychoanalytic discussions ever since. The first is the psychoanalytic exploration of the ubiquitous, deeply unconscious psychological maneuvers that could be subsumed under the rubric of "projective processes". The second trend is one of confusion as to what is exactly referred to by the term "projective identification".

I could make an argument that "projective identification" is simultaneously the single most important concept in all of psychoanalysis and simultaneously the most confusing and misunderstood. It is an unfortunate term but one that can be made sense of so that people can use its underlying phenomena to add to their understanding of normal development and mental functioning in health and extreme mental illness.

A psychiatrist friend of mine summed it up when I told him some twenty years ago that I was going to teach a course on projective identification and his instant response was "Okay, I get the projective part, but where does the identification come in?" In response to that question I would like to propose a way of thinking about projective processes that is useful and infinitely less confusing. After sharing that model, I will revisit the terminology and try to briefly unpack how the confusion ensued from Klein's classic 1946 paper, "Notes on Some Schizoid Mechanisms".

Some Helpful Assumptions About Infants:
It is impossible to adequately appreciate the ubiquitous scope of projective processes at the level of the baby core of the personality without a few essential assumptions:

1 – Babies are fundamentally "concrete" in their mental functions at the beginning of life. They probably make no distinction between physical and mental states, which implies they make no distinction between physical and mental distress. It also seems highly likely that they make no distinction between physical and mental maneuvers for coping with distress.

2 – It is universally human to consciously wish as a child that there be "magic", and to have that wish persist into adulthood at an unconscious, baby core level, even if it is not acknowledged as such, cognitively, as the individual grows up. This is to say that adults use "projective processes" just as much as they did when young, they are simply very unaware that projections are taking place.

3 – When under emotional and/or physical stress, humans have a resurgence of "baby level" coping maneuvers. This means that "projective processes" become more extensive, violent, and problematic during times of emotional and physical distress, often in proportion to the degree of distress.

Before I move on to a model for making unconscious projective processes more logical, I would like to illustrate the points I just made with an example that I find useful. It has to do with the seemingly universal appeal of cigarette smoking and the difficulty in giving it up. If cigarettes were not unhealthful, and did not leave an odor on clothing, etc., I suspect there are few among us who would not occasionally smoke. If that is true, what is the appeal?

I would like you to consider that smoking is a very primitive, powerful, reinforcement of the idea that one can have a magical capacity to "take in" anything one wishes that is good, and concretely "expel" anything that is felt to be unwanted. This reassurance of a magical capacity is evident in the common need for

someone to have a cigarette before they face something difficult or anxiety producing. Likewise, smoking is often used for the restoration of magical resources after working on something for a period of time, in the form of a "cigarette break". Maybe we could even reference the cigarette after lovemaking, actually an odd juxtaposition of intimate contact and self-sufficiency when you think about it. I suspect that for some it is a reassurance that any anxieties that might result from the increase in emotional vulnerability, attendant to making intimate contact with another, can be hedged by a reassurance that they can be evacuated out of self as needed to preserve a feeling of being safely in control of everything.

Let us now address "projective process" by breaking the issue down into the two broad areas. The first area involves the building block elements that make up projective processes, namely "content", "motive", and "consequence". The second area involves the clinical relevance of projective processes in relation to the issues of identification (including the location of the sense of identity) , confusional states, paranoid anxieties, etc.

Infancy and Projective Processes:
If we start by going back to infancy, it is useful to picture the alimentary tract as a model for projective processes. Simply put, the infant imagines it can take anything into itself that it wishes to have and can expel outside itself anything of which it wishes to rid itself. This means that it can imagine taking things in with its mouth, eyes, ears, nose, anus, etc. and evacuate anything through its mouth, anus, urethra, eyes, nose, etc.

The "content" available to these processes can be anything physical or mental since infants appear to make no distinction between them in early life. In the later months of the first year of life we can make assumptions about "projective processes" that will hold up as models for the rest of the lifespan, but in the beginning these processes are more amorphous and global. It is important to remember that we are talking about the basic mechanisms by which the personality and mental apparatus are constructed. [See Bion's "Mother-Infant" Model at the Beginning of Module Two]. Only later in this discussion will we be concerned with faulty personality construction and problematic use of these mechanisms.

However, in the beginning of life they do essentially represent the core means by which human mental structure is achieved. In other words, 'introjective' and 'projective' processes represent the essential maneuvers by which the complex and beautiful human mental apparatus and personality are created. These two processes are not themselves pathological, they are simply analogous to brick and mortar in construction. That is to say that how they are used matters, but in and of themselves they are simply construction and maintenance maneuvers with no inherent emotional valence.

With all of this as a backdrop, let's arbitrarily begin our discussion of "projective processes" around the second year of life. I find it useful to make a model of them in the form of an algebraic equation:

'CONTENT' + 'MOTIVE' = 'CONSEQUENCE'

1 – The 'content' of projective processes can in theory be anything. In practical fact it can be distilled down to four primary classes, with the first two being more easily recognized that the second two. The first would be "parts of self" including both "good" and/or "bad" baby parts of self. The second group would be "good" and/or "bad" versions of mom or dad, including primitive 'part object' versions of them. The third area of content for projective processes would be "states of mind" and fourth would be "mental capacities".

The area of 'states of mind' gets a bit tricky as it is usually a state of mind that tends to be chronically attached to a part of self or internal version of mom or dad (i.e. the "internal objects" of Kleinian literature) and thus gives that element of someone's internal world its unique meaning or value. So, for instance, a baby feeling of being small, helpless, stupid, left out, unwanted, frustrated, enraged, jealous, envious, alone, guilty, depressed, cruel, shamed, humiliated, etc., are all states of mind that could be attached to a part of self or a version of mom or dad. They could even be a central, defining component of the states of mind attached to that part of self or parent.

However, I do think that it is also possible to project a state of mind without it being attached to a structure from one's internal world. This is perhaps more common when the motive for the projection is in the realm of communication and the projector is not necessarily trying to rid himself of something.

When it comes to our fourth area, the projecting "mental capacities", we are in the realm of maneuvers that almost always represent significant developmental problems. I am referring primarily to the projection of such developmentally important capacities as the ability to "think", or to "feel", or to "face mental pain" with a goal of modifying it rather than wholesale evasion of it. Also the ability or willingness to "care" about life and relationships, etc. can be a mental capacity that is jettisoned, often into someone in that person's family.

The projection of any of these capacities into someone else, or even outer space, immediately gives a serious limitation to developmental progression in life, eventuating in handicaps that are often obvious, but sometimes more subtle. At the extreme, they take us into the realm of severe character problems and psychosis.

2 – The realm of "motive" for projective processes takes us back to the basic issues of mental pain and the core emotions related to mother as outlined earlier in this module. For example, the motives often can be distilled down to some basic emotional desires:
– (1) to rid oneself of something felt to be undesirable or distressing,
– (2) to communicate something via "song and dance",
– (3) to hurt or harm someone,
– (4) to reverse roles with someone (i.e. simultaneous introjection and projection),
– (5) to get inside the object and obliterate separateness.

These are arbitrary categories and represent overlapping circles in real life. Much of the work of the practicing therapist involves the patient evacuating something that is felt to be undesirable into the therapist, sometimes for communication, but also often just to rid himself. The therapist's job is to make sense of it so that it can be converted into a communication. This latter point is key – in life, POTENTIALLY ANY PROJECTION CAN BE CONVERTED INTO A COMMUNICATION. This amounts to the container performing what I described as Bion's model of mother/infant interaction for building a mental apparatus.

The fifth category, namely getting inside the object is hugely important in life and therapy and represents an entire book in itself. Its key variables are its "reversibility" and "extensiveness". Temporary, reversible fusion is a key element in "empathy" (putting oneself in someone else's shoes) and "intimacy". On the other hand, "massive" projection parts of one's internal world into another represent a key dynamic in psychotic states.

3 – The "consequences" that result from a specific projection follow relatively straight forwardly as a result of what was projected and what the motive for the projection was. If the content was felt by the projector to be something that he didn't want, then he will expect the recipient to feel the same way. If what was projected was felt to be valuable, the projector will expect that the container will hold on to it.

Likewise, if the "motive" was hostile, then the recipient's response to the projection will be expected to contain a negative, hostile component in the response or reaction to the projection. If the motive was loving, then the projection will not be expected to generate a negative reaction.

The uncertainty about a projector's motive is one of the reasons why 'sarcasm' in humor is a double edged sword. The perpetrator of the comment or joke can never know for sure how it will be taken by the recipient. Quite often, a bit of sarcasm of the "it was just a joke, chill out" type stirs up something painful in the recipient at a baby level that is not recognized by the projector and resented by the recipient.

When we add the issues of "center of gravity of sense of identity", "reversibility", and "quantity" of what is projected, we will then be in a position to discuss another crucial consequence of projective processes, namely the generation of "confusional states".

At bare minimum, the projector will have some confusion about the state of mind of the recipient, whose feelings may not be congruent with what the projector might imagine and expect, all unconsciously, to be the reaction of the container to the projection. This can be exemplified in the mundane example of "you look sick", "no I am feeling fine".

Where the projection is of a larger part of self or of an internal object, then the resultant distortion of the projector's "perception of the container" can be much greater. Where the "sense of identity" of the projector goes with the projection, the resultant confusion about identity can be very great and is commonly problematic.

I am aware that at this point the reader is probably feeling overwhelmed with this array of components to "projective Processes". Hang in there, it all takes some re-reading and digesting.

Unpacking the Confusion about "Identification":
Melanie Klein was a gifted clinician, and arrived at a number of extraordinarily useful clinical observations about deeply unconscious processes. But a careful reader of Klein comes away with an impression that she was never overly concerned with contradictions and inconsistencies in the models she was creating. It is as if she was moving from one inspired realization to the next and defending her clinical observations and their implications, but she was not the detailed theoretician that was Freud.

For us to make sense of this lack of precision, we have to add some after the fact, so here goes.
1 – If we have 'content', 'motive', and 'consequence' as key variables in projective processes, we must now add a fourth element, the recipient of the projection, for whom we will use Bion's useful nomenclature, "container". The word 'consequence' of our little algebraic equation is then actually a reference to what is imagined to happen to this recipient (i.e. "container") of the projection.

From the point of view of the projector, the "container" will now be imagined to be significantly influenced by what has been put into it. Put in different words, the container is now at least partially "identified" with the projected content, and maybe even imagined to be completely "taken over" by what has been put into it. We could think of this as the first potential meaning of 'identification' in Klein's term, 'projective identification'.

2 – We can add a second potential meaning to 'identification' that has to do with the projector now feeling that he is no longer separate from the 'container', because the container now possesses a part of the projector. The result is that projector and container are now "fused and confused", as the Kleinian psychoanalyst Jim Grotstein likes to say.

Put in other words, the identity of the projector has gone with the projection into the container and the projector's identity is now equated with that of the container. This is more likely to happen when the projector unconsciously feels it would be desirable to get inside the container to take possession and control of the container or even to live inside it and become an "unborn, inside baby". This state of mind is probably universally common with infants in relation to their mom.

3 – The third potential meaning of identification really adds to the confusion with the terminology. This is in circumstances where envy is involved, and the projector's unconscious motive has a large component of a desire to exchange positions in life with the container, as is also so common in infancy with mom.

In this envy driven "role reversal" (or 'envious reversal' for shorthand), two processes take place instantaneously and simultaneously. The first is that the projector rids himself of the unwanted baby state,

by projecting it into the 'container'. Simultaneously, the projector steals the desirable state of affairs (i.e. some aspect of the "container's" identity) from the container and takes it in for himself.

A stark, somewhat unpleasant prototype of this process could be envisioned in the idea of the envious baby imagining devouring the breast to have it for himself and simultaneously shitting (evacuating) into the cavity left behind all of the baby's hated states of "babyness". The result of this 'envious reversal' is that the baby feels "big and fancy" and mom is felt to be "shitted up and small".

To summarize the confusion linked to the word 'identification', it can refer to: (1) the container being equated with what was put into it by the projection, or (2) it can represent the state of the projector and container now being linked by a shared component of identity because a part of the projector is now lodged in the container, or (3) it can be more global than # 2 because complete identities have been swapped, as in an envious reversal.

With this in mind, it is observable in Klein's 1946 paper that her first example of "projective identification" is not simply one of "content" being projected into an object and the object being becoming equated with what was projected into it, but rather it is an example of the more extreme, global example of the identity swapping that takes place in an envious reversal. The word identification in that situation is really a result of the two simultaneous processes, a "projection" and an "introjection".

If the readers head is again spinning at this point, let's try to break the processes in this last example down into more digestible units by looking at some of the elements involved in what is totally simple and straight forward to the infant – "I don't want this, you take it" or "I want to be you, and you can be me".

<u>The Center of Gravity of the Sense of Identity</u>:
Donald Meltzer, in his extraordinarily useful but difficult book "Sexual States of Mind", makes the observation that in trying to evaluate projective and introjective processes in a given situation, one must look for the "center of gravity of the sense of identity". His point is that at a given moment the sense of identity that someone unconsciously is operating with may be lodged in a particular part of self or object (i.e. person), and in turn, that entire projective process may at that moment be taking place inside oneself, or it may be taking place inside someone else.

This becomes a crucial issue when trying to clinically understand what a patient is feeling at a given moment.
If, for example, the patient is getting rid of something undesirable by projecting it outside, their sense of identity is going to stay behind because they don't want to be connected with the undesirable element being projected. On the other hand, if the projection is going into a desirable container, they may wish to go with it so as to be "inside" the desirable place.

The key issue becomes: Where is the primary sense of identity after a projection has taken place? [It must be noted that this is different from the minor note of a small aspect of unconscious feeling that the container now contains something of oneself in it and so there is a small, more subtle sense of identification with the container based on that fact.]

Let's use as an example sexual intercourse where one is literally physically "joined up" with another briefly. If the female and male love each other, and wish to feel joined up more permanently, they may literally feel fused and connected, and may imagine that have to do everything together, think the same way, etc. The center of gravity of each individual's sense of identity may be temporarily, reversible lodged inside the other.

Contrast that with a "rape", where the male is getting inside the woman and, if you will, simultaneously robbing her of her desirable state of femaleness, while depositing his hated state of being a left out, needy, soiled baby. With this model in mind, one could argue that seen in this light, most forcible rapes are an unconscious act of a "violent envious reversal". The center of gravity of each person's identity in that awful

example stays largely separate on purpose, consciously and unconsciously, as neither wants to be the other after the act.

As a side note, if you take those two extremes, joining up or violent envious reversal, then you can see why adolescent sex is so often contaminated by confusion between the two. After having sex, the two parties are not sure if what they did was a loving act or a criminal theft of their parents' sexuality. The resulting uncertainty leads to anxiety and guilt that typically wins the day and ruins the relationship.

In the consulting room, recognizing where the "center of gravity of the sense of identity" is lodged from moment to moment is crucial to making sense of what a patient is feeling. If a patient is complaining of feeling controlled by the therapy or you, or is acting as if you are supposed to think for them, then you have to consider that the patient's sense of identity is lodged inside you. This the point where dreams often become crucial in helping to clarify what is taking place unconsciously.

To site an extreme example, I had a patient whose dreams endlessly involved her being in my office building after hours, roaming the halls, coming in to assist me during sessions, and at one point even having her own room in the building adjacent to mine. We came to recognize these as an expression of her overwhelming baby level desire, now entirely unconscious, to return to being an unborn, baby back inside mom.

Confusional States:
It follows naturally and inevitably that if even a small part of oneself is projected into another, that there must inevitably be at least a small resultant confusion, regarding both the container's identity and what the container will do in response to the projection. Here are a few of the possible responses on the part of the container, as imagined by the projector.

1 – The most common expectation is that the container will in some way "sense or feel" the projection and will have a reaction according to what was projected and the motive of the projection. The container will retain much of their identity with the projection only adding a minor alteration to that state.

This represents the situation when the average person projects something. They usually project "into reality" which is to say the container tends to already be that way so that the projection "fits" the container and is not particularly obvious. If, for example, you put a small sack of trash in a large dumpster filled with trash, you won't imagine it will have much impact.

Nonetheless, there will be a small resultant confusion on the part of the projector about the object. To take a benign example, if the projector sneezed and was afraid they were coming down with a cold, and then saw someone blow their nose, they might ask "Do you have a cold?" The other person might say that they were having a bit of an allergy that day but the projector might not feel sure that the other isn't in fact coming down with the cold the projector does not want to have.

To summarize this first area of confusion, all projections, no matter how small, have a subtle component of resultant confusion between self and object, and an additional uncertainty as to how much the container has been affected by the projection now residing in them.

2 – If we increase the forcefulness of the projection, and its size, then we will have an increase of the feeling of the projection altering the recipient's identity, even if the center of gravity of the sense of identity of the projector remains outside the container. In effect, the projection is now felt to take over the container and has therefore become much more the primary "new identity" of the container.

Take as an example a situation where I was felt to be helpful all week to a patient, but I then bring up that they have not paid me for a bill given to them three weeks ago. If their instant reaction is to feel that I am angry, and they simultaneously become angrily defensive, we can assume that something has altered my identity at that moment. What often underlays such a situation is that the patient unconsciously felt a desire

to withhold my money, keep it for themselves, so that I have become the "poor, hungry baby" and they have become the "rich, fancy parent/therapist".

This would be an example of an envious reversal, but for our purposes, the primary point is that the patient's projection has resulted in some confusion. My identity has been "taken over" by their projection into me of an unwanted baby aspect of themselves and I am imagined to have momentarily become dominated by that projected part of themselves and therefore imagined to be angry and retaliatory.

3 – To get to situations where confusion becomes a major component of the alteration of the identity of both the projector and the recipient, we need to add the desire of the projector to "get inside" the container. In other words, the "center of gravity of the sense of identity" of the projector is attached at that moment to the projected element so that the result is the projector is now imagining himself to be inside the object. If this state is temporary and reversible, then it may not be a problem. It could represent the aforementioned state of empathy often described as putting oneself in another's shoes. This is probably what happens when we see a well done movie and feel impacted by it.

When the sense of identity resides more permanently inside the object, then we have an entirely different situation. If the motive is more permanent possession and control of the object, then the confusions that result will have a more hostile, controlling quality for both parties. If the motive is more to join up and obliterate separateness, then the confusions will have a more "Who is thinking what?" and "Where are the boundaries?" type of quality. If the motive is more to be a passive, unborn, inside baby then the confusional qualities will likely involve passivity on the part of the projector and ultimately feelings of being parasitized on the part of the recipient.

In summary, the possibilities for confusion are as myriad as are the possibilities of what is projected and why. I cannot possible do justice to their breadth, but the reading of any literature on pathological states of mind will be permeated by examples of confusional states, large and small, that result from projective processes.

Summary of Confusional States

I hope it is obvious that the topic of confusional states attendant to projective processes is huge, it varies from subtle to massive, can be seen on various continuums like neurotic versus psychotic, benign versus extremely problematic, temporary versus characterological and permanent, etc. In any of these situations, it still boils down to alteration of the container's identity, which is now comingled to a variable degree with something that once belonged to the projector's internal world. Both of their identities have been altered, and that alteration leads to confusion in the projector's mind.

To put it from another frame of reference, the identity of the projector is depleted by a projection and the identity of the recipient is increased and altered by the addition of the projected element. The fact that one is now residing in part in another must inevitably alter both identities and lead to some element of confusion. This resultant confusion will increase with the size of the projection, forcefulness of the projection, and movement of the sense of identity into the object with the projection.

Paranoid Anxieties:

Much of our discussion has involved the impact of projective processes on the sense of identity of self and object. The altered senses of identity result inevitably in confusional states of varying degrees of seriousness. But now we need to look more specifically at the anxieties that result from projective process.

The confusional states are related to some aspect of one person being inside another person. The anxieties that result would logically be expected to follow on that state of affairs. For example, the fear that one cannot get back out of the object entered by the projective process would lead to something akin to "claustrophobic anxiety". A feeling of being "controlled" by another might be another, additional anxiety resulting from being inside another in unconscious phantasy.

To explore this area in greater depth we need to focus more intensely on the issue of "motive" for the projection in the first place. In particular, whenever the motive had an element of "hostility" toward what is being projected or toward the object receiving the projection. With a hostile motive, it will it will follow that the projection will be expected to engender hostility, in the recipient, back toward the projector. Infants just love Hammurabi's Law, "Eye for an Eye, Tooth for a Tooth".

This is so often in the form of an unconscious expectation on the part of the projector that if they don't want what they have projected, then the recipient will not want it either. If the projector hates baby feelings, for example, then recipient won't want them either and will project them back, in triplicate. This is the most common cause of the paranoid anxieties attendant to projective processes.

Now let's add an order of magnitude to the hostility involved in the motive of the projections taking place. This is especially common where "unconscious envy" is at the center of the motive for the projection. The spoiling, hateful urges in such projections lead to instant intense paranoid expectation of retaliation, even if it is entirely unconscious.

For example, a very disturbed five year old child patient, threw a wadded up piece of paper at me at the end of the last session of the week, saying it was a "doo doo bomb", and ran out the door. His anxiety that he had destroyed me with the projection led him to have to be carried into the building of my office by his mother, with him kicking and screaming, to his Monday session. For me that represented his expectation that in retaliation I would blow him up when he came back and he was terrified.

We can make an almost axiomatic assumption about projective processes and paranoid anxieties. The more hostility there is in the motive, which very often has unconscious envy at its root, the more paranoid and intense will be anxieties about retaliation. The rub is that so often these states of mind are held in areas of the mind that are separated off from one's conscious awareness and are thus often subtle even though they are influential. Again the key is to have a model of projective processes and their consequences available. This makes it possible to have an understanding of such pervasive unconscious activities that are usually impenetrable by the use of just ordinary common sense.

Fixed Chronic Projections Versus Acute Destabilizing Projections

This is an extremely helpful differentiation to make, especially when evaluating families and marriages. There is more detailed reference to the marital context of projections in Module Three. The essential idea is that human beings, beginning in infancy, have projective processes taking place in all relationships. These projective processes exist on several continuums: content, motive, size, intensity and violence, reversibility, and now we are adding "acute" versus "chronic".

"Acute projections" arise in a given situation based on that momentary state of mind with specific emotions dominant. They will follow the algebraic equation of "content + motive = consequence". This implies that they will be destabilizing of a relationship when the content or motive is more in a negative realm. It is not as likely to problematic or destabilizing when the projection is of a more positive or communicative nature.

The key point is that acute projections will be inevitable when any intense, painful baby state of mind is aroused. As a result, since the motive is usually to get rid of something painful or distressing, the projection may aim to bring relief but will usually lead to a destabilization of the internal harmony of everyone involved, at least momentarily or temporarily, and in proportion to the degree of mental pain involved. The degree to which the "adult part" of either party can come one the scene and make sense of what, is going on is usually the degree to which order can be restored and internal harmony re-established.

Chronic projections in contrast are a part of a longer term relationship during which certain patterns of interacting and attendant states of mind have led to a more ongoing, continuous set of specific projections that functionally become "fixed" until some a acute situation destabilizes these projections.

Childhood interactions within the family occur over many years and accrue certain patterns of treating each other that have ongoing projections embedded in these interactions. Structurally speaking, it is as if the projector places certain projections into their object ("container") and then treats that person as if they can always be expected to be that way. Parents who want their child to be an extension of their own idealized baby self might be unable to see their child's limitations based on that chronic projection of their own wishful idealization. The same could be said of a parent who projects an unwanted aspect of their baby self and can't help themselves from seeing their child in that negative light.

The key point is that the parent is not just imagining that some past historical element will be recreated in the present. I am saying that they are actually projecting a "part of self" into the other, their child in these examples, and these projections are on an "ongoing, chronic nature". Take for instance a father who is a little league coach and has projected his own idealized "future Hall of Famer" aspect of self into his son, and insists on putting him in as the starting pitcher when another boy on the team is clearly a better pitcher. Or the mother who keeps fretting that her daughter will "turn away" from her (the same way the mother turned away from her own mother) even though the daughter shows no evidence of having significant underlying or unconscious hostility toward the mother.

These examples may seem more benign but these chronic fixed projections are often quite problematic and potentially destructive. A parent or grandparent who decides that one of the grandchildren is inherently "bad", stupid, a loser, worthless, etc. is invariably projecting a hated part of self into the child. Similarly, a parent who projects a neglected, abandoned, unwanted part of self into the child will behave in a fashion dominated by the projection rather than by the actual unique qualities of the child. The result might be that the parent is actually neglectful or abandoning. What is more common is that the parent will go to the opposite extreme of never separating from the child, even in a reasonable manner so that the child can develop a sense of autonomy and independence.

Marriages are also long term relationships, analogous to families. Marriages begin via an unconscious marital selection process requires that individuals find a partner that has the same quality and type of "internal paired relationships" making up their unconscious inner worlds. If they do not have these similar internal situations they will have nothing in common and speak entirely foreign tongues. But this leads inevitably, and almost entirely unconsciously, to the couple dividing up these internal paired situations and assigning each other various roles and states of mind.

One partner may make it clear that they like to be in control, and so they take on the role of the good parent who takes care of everything, while the other gets to be the baby who is taken care of by the good parent. Or one spouse might "contain" the part of self that is always afraid something bad is about to happen and the other gets to be the confident, grown-up, reassuring parent who is optimistic.

In each of these situations one person is projecting one half of a paired relationship into the other, usually the child/baby element or the parent element, while adopting and holding on to the corresponding other half of the relationship. This division of the pairing can remain unchanged for the course of a marriage or it may evolve over time. In happy marriages, these divisions stabilize and harmonize the relationship. But as with all projections, the more mental pain attached to them, the greater the likelihood is that they will become problematic at some point. [These are very large topics and are covered in greater detail in Module Three.]

In summary, it is very useful to make a distinction between acute projections and chronic projections. Acute projections are usually attendant to some momentary situation that has arisen, one that may be painful, problematic, or just require communication. They can be small or massive, gentle or violent, a momentary shift or massively destabilizing, and are usually reversible and/or will pass. Chronic projections involve ongoing, semi-permanent structural elements in both personalities involved and tend to stabilize the relationship when loving and stamp the relationship as problematic when negative.

<u>Overall Summary Regarding the Concept of Projective Identification</u>:
The term projective identification is a reference to a myriad of concrete phantasies that originate infancy

and carry on ubiquitously in all human beings on an hourly basis throughout the lifespan. Because they seem rooted in our phylogenetic inheritance as a remnant of preverbal "song and dance" forms of communication, by species without a cerebral cortex and frontal lobes to create and process verbal thought and communication, they remain active even though they are illogical to our "rational" adult selves. They literally operate on a different level and manner, unavailable to our conscious awareness, for the most part.

Melanie Klein's unfortunate term is too confusing to be useful, and should be replaced, as far as I am concerned, with the more general and straightforward term of "projective processes". It would be sensible to add a parallel general term "introjective processes" to describe the same concrete quality of phantasies going into oneself instead of out of oneself.

These phantasies remain almost completely unavailable to conscious, rational "common sense". Once one sees them, it all seems so obvious that one wonders why they have only been accurately defined and explored in the last one hundred or so years. But the recognition of having an unconscious inner world is such an amazing paradox. It is like having and using two arms and two legs and yet never noticing their existence.

My hope is that the reader of this section will use the components of projector, content, motive, consequence, and container to think about these processes without confusing jargon. I believe one can then begin to make sense of many things that are otherwise illogical, paradoxical, hypocritical, etc.

Needless to say, it helps to have had personal experience, in treatment, with the nature and scope of one's own projective activities.

Section 7 - The Manic Defense

Introduction:
It is easy to have the mistaken notion that if one is not manic depressive then the 'manic defense' is a not applicable in our lives. WRONG! You, me, and everyone else uses manic defenses daily, if not hourly. They may not be clinically problematic versions, but they are fundamentally from the same family. Every time you say to yourself, I really should pay the bills, mow the lawn, wash the car, or call my relative who I haven't spoken with for three months, but instead watch TV, go shopping, play with my hobby, smoke some dope, or masturbate, you are manifesting a manic defense in that you are turning away from a caring voice in your psychic reality.

Let's up the ante a bit. Every time you 'forget' to tell your spouse that you broke their whatever, or lie about where you really are going as you leave the house, or steal your neighbors newspaper because you think they make have taken yours once, or tell your boss you are sick when you are not because they pissed you off yesterday, or cheat on your spouse because they haven't been nice to you recently, you are using a manic defense.

In each case there is some bit of psychic reality or mental pain that you are evading. In each case you have a rationalization or justification for your action. As H. L. Menken said, "Conscience is the inner voice which warns us that somebody may be looking". This implies that everyone would use manic defenses if they are not caught because they are not listening to their internal harmony about what is fair, just, and right. In effect, they are using a manic defense to evade what otherwise should cause guilt, and the only potential deterrent is fear of punishment, They manage somehow to justify their actions if they think no one will catch them. From this point of view, almost all criminal action must be a product, among other things, of a manic defense.

So where do these ubiquitous maneuvers originate? Clearly they are more advanced, with their rationalizations and justifications, than the simplistic use of denial and splitting processes that are prominent in the paranoid-schizoid position. It turns out that they are a product of the advancing brain

development ushering in the depressive position. If the depressive position is the "ying", then manic defenses are its "yang".

The Depressive Position and Manic Defenses:
As the infant moves into the middle and latter part of its first year of life it has really begun to get with the program. It recognizes that mom is separate, that it loves her and really needs her, and that she has her own life that includes other people. None of this would necessarily be a problem if it were not for the infant's developing capacity to feel guilty when it is frustrated and angry with mom. When it began life and had the world divided into the good guys and the bad guys, it could do whatever it felt like to the bad mom and its own bad self. But it is beginning to see that there are no bad guys, only "good guys behaving badly" to paraphrase the English Kleinian analyst Ron Britton.

So this is where manic defenses come into the picture. The infant is getting cleverer by the day and realizes that it is possible to bypass guilt using a bunch of maneuvers. It even begins to see that these same maneuvers can be used to avoid dependence and obliterate separation. It realizes it has stumbled onto a veritable "gold mine" of ways to avoid the mental pains of the depressive position!

Definition:
Manic defenses represent a group of maneuvers whose use begins to develop in the latter half of the first year of life and continue with great prominence in many people throughout the lifespan. Their central feature is that they are aimed at evading the pains attendant to loving and needing an object who also makes you angry and want to hurt them. In other words, they aim to evade the pains of the depressive position, and most particularly guilt, and thus effectively denying some aspect of psychic reality.

These maneuvers extend beyond just the evasion of depressive anxieties, i.e. guilt and the fear of losing the person you need and love. This is because the infant soon realizes they also turn out to be pretty effective at denying many of the other pains of infancy such as feeling small, dependent, envious, etc.

Melanie Klein emphasize a triad of maneuvers that are key: control, contempt, and triumph. These three words highlight the underlying attitudes of the infant that can be expressed in a myriad of behaviors.

"Control" aims to obliterate any awareness of separateness because the object does whatever you wish so you can deny that it has a mind and life of its own. It also diminishes envy and jealousy because effectively you have all the benefits of the object's capacities and attention available to your every whim. It is the least guilt producing because it is easy to deny that the object may have needs of its own that are being thwarted. After all, mom's were only put on earth to serve the baby, or at least the baby's party line.

"Contempt" is more aimed at guilt about how you treat the object. If the object is spoiled, made less than human, etc. then it is "good riddance to bad rubbish", you need not feel badly for hurting what was once your good object.

"Triumph" is an extension of contempt, but especially when envious hatred of the good object's qualities is added to the desire to evade guilt, risk of loss, and dependence. Then one is not just satisfied to spoil the object, but the desire to triumphantly reverse the situation of who is small, and who is big and controls all the wealth.

Manifestations in Infancy:
An infant does not display much beyond turning away, refusing to open its mouth, pushing away or hitting at something, generally refusing to cooperate, and crying. This is due substantially the infant not yet having language capabilities which makes it more difficult to infer what it is thinking. But just wait a few more months and the attitudes and thoughts that are beginning in the first year are easily represented in recognizable form as language skills are added to increasing mobility.

Every possible way of denying smallness, dependency, love and guilt for bad behavior, envy of what the grown-ups have and can do, etc. can be put into use. For example, smallness and dependence are readily countered by grandiose overestimation of one's capacities when augmented by a healthy dose of denial of reality.

Every toddler wants to do whatever the grown-ups do, clearly ignoring the realities of the size, strength, knowledge, etc. needed for the task at hand. Furthermore, if they insist the grown-up behave in lock-step with their every command, they can ignore that the grown-up is separate and not really under the toddler's control. When I was a small child and would tell my mom to stay exactly where I wanted her, and then proceed to ignore her, I was manifesting a component of a potential manic defense.

It is important to note that any behavior of the small child that overestimates its ability may be a product of either or both of two processes. One is simple denial of the differences between the child and the grown-up. But it may also represent the child actually getting inside the grown-up, in unconscious phantasy, and taking possession and control of the parent's capacities.

If the child also seems to treat the grown up as incompetent, then one can assume an "envious reversal" has taken place. In that circumstance, the child has simultaneously stolen the grown-ups capacities while deposited their own hated smallness and incapacity into the grown-up.

Any guilt that is potentially generated over some misbehavior is then easily denied, blamed on someone else, or the ultimate trump card, make the object of the guilt bad and so then who cares if you hurt it. Toddlers will say things to a parent like "your stupid and I hate you". This instantly renders the object contemptible and because the object is no longer worthy of love, caring about how you treat it, etc., there is no reason to feel guilt.

If you are feeling an extra dose of envious hatred at that moment, all you have to do is hold on to that contemptuous attitude that the parent or whomever is so thoroughly bad and reprehensible that you are justified in holding them permanently in a state of contempt.

One sees this tragically in cases of divorce where a child sides with one parent and makes the other all bad, functionally ignoring or spoiling all of the things the child once loved and needed from that parent. This is manic behavior but it also exploits the quality of thinking of the paranoid-schizoid position where things are all or none, black or white, etc. In this situation it allows the child to take jealous possession of one parent, especially if the child fears the loss of that parent more than the loss of the one who has been made all bad.

Relationship to Omnipotence and Particularly Anal Omnipotence:
Smallness, dependence, separateness, feeling you have injured your good object, are all fairly obvious to the eye and not easily denied if one is facing reality. But reality is pretty painful much of the time in childhood, even when you have an intact family that is living harmoniously. Most children naturally gravitate to wishful ideas, the most fundamental of all being the idea that there is magic, and you can have it and instantly erase all of the pains I just outlined.

Every area of life that lends itself to the possibility that there might be magic will be seized for the use as magic. If I put on mom's bra, it will magically give me breasts and I can feed myself. If I pick up daddy's cordless drill, I will be able to do anything he can do, maybe even marry mom and be her husband.

Those are all pretty fancy and obvious, but the average baby will do something more elemental and basic like imagine that whatever comes out of its own body, and was once food, may have changed into a special food that it can now make for itself. What a wonderful idea, because if it works, one will be self-sufficient forever and never again have to depend on mom for food. With that wishful desire in mind, all bodily products are worth a try.

So omnipotence, in the form of having magic, is a universal component of manic defenses. Its corollary of turning to one's own body for comfort and sustenance, is an additional huge augmenter of all of the phantasies used in manic defenses. We can go back to our joking paraphrase of the rather perverse saying used earlier, "when the going gets tough, the tough go masturbate".

Impact on Development:
Every child needs to learn to modulate mental pain by facing it first, then modifying it in a constructive, growth promoting manner. Learning to feel sorry, is the only way you can say you are sorry and mean it. One needs to learn to do things properly and grow up in a slow, step-wise fashion. One must rely on others to teach you what is necessary to end up a competent adult. All manic defenses potentially interfere with this requisite necessity of tolerance of smallness, not knowing, dependence on others to learn, taking responsibility for one's mistakes, etc.

Imagine a world where everyone projects blame, many people claim competence but have never learned the basics, where there is heavy reliance on magical solutions that deny reality, where guilt is evaded by saying the other is all bad or not worthy of caring, etc. That is a recipe for disaster when it comes to proper growth and development. It has all the hallmarks of manic defenses! No wonder politicians are easy to despise, especially if we ourselves manically deny that we elected them because they promised a magical solution.

Relationship of Mania to Depression:
As can be inferred from the discussion so far, manic defenses have their root in infancy in relation to mom, and represent a desire to evade all of the pains of the baby's reality. These maneuvers invariably have a large dose of magic in them, so as to make one self physically larger and more capable, completely independent, and invulnerable to pain in relationship to one's objects.

Those pains include dependence on a loved object that could go away, guilt for how one is treating that person, and all of that is in addition to the already extant pains of jealousy and envy.

As long as one is a child, one is still not really fully separate from the parent and usually not emotionally independent, even in bad family situations, where there is always hope no matter how unrealistic, that something will change for the better. Turning to one's own body and bodily products for comfort, or altering one's identity into a more grandiose one, will typically evolve in form during childhood, into progressively more disguised and derivative equivalents.

Any hobby that involves collecting or making things, becoming passionate about reading books where one individual conquers or saves the world, constantly daydreaming about being someone talented or famous, starting to use substances as a teenager to alter one's mind and experience, etc. are all potentially manifestations of an urge toward a manic, magical denial of some painful aspect of the reality that one lives.

If a human beings most precious commodity in life is their "internal harmony" then all of the manic defenses are likely to cause an erosion of it. If guilt and fear of punishment are the main things that make a human behave in a civilized manner, denial of caring and guilt removes half of the motivation for doing the right thing with others. If you make the other person less than human, then you can mistreat them any way you wish.

But in "heart of hearts" of people behaving manically, they know that what they are doing is wrong in the sense of the Golden Rule of how you treat others. Simultaneously they are ruining the world in which they live so that there are no longer any good people in it. They have created an "every man for himself" type of universe that no longer has proper, caring relationships. They are damaging their internal good figures, depriving them of life, and it is a guaranteed ticket to depression at some later point in life.

If a person is going to avoid his depression, he will have to ever increasingly ramp up his manic maneuvers to stay a step ahead. And since one can't ramp them up forever without ultimately flaming out, sooner or later one's internal world with its damaged objects will catch up with the person and they will get depressed. In case you doubt this, call the hedge fund – ponsey scheme manager Bernie Madoff in prison and ask how it worked out for him.

Sadly, most people never fully face their manic activities until something goes drastically wrong and they come crashing down to earth. This is in part because of the very denial of reality that is so part and parcel of manic defenses, literally by definition.

"Life is full of surprises, mostly bad", as Bion is purported to have said. When those bad surprises happen, like divorce, death of a friend or loved one, a severe career downturn, or just plain old aging so that one's beauty and youth are gone, that painful event is often the straw that breaks the proverbial manic camel's back. Icarus crashes for flying too close to the sun, Michael Jackson dies of a drug overdose, Tiger Woods get caught having affairs, Magic Johnson contracts Aids, and the list goes on and on. If you don't preserve your internally harmony, sooner or later you will pay in the form of depression, or worse.

Manifestations in the Consulting Room:
Albert Mason, who pioneered Kleinian analysis on the West Coast of the US when he came from London to Los Angeles with Bion, in the late 1960's, says that analysis of manic defenses represents as much of 75% of the work that analysts do with their patients.

Any person who is a mental health professional could probably write a large novel cataloguing their experiences with manic defensive maneuvers in the consulting room, even if they didn't recognize them as being what Klein would call manic defenses.

Patients who don't come on time or pay on time, who constantly denigrate therapy and the therapist in a million different ways, both small and large, who quit therapy to save money, who deny they have an unconscious inner world, who confuse the acquisition of knowledge with the proper application of that knowledge, who think occasionally saying something nice is the same as actually treating your internal and external objects decently, who forget to tell you their bad dream from last night, etc. all are manifesting various versions of a manic defense.

The key point is that the patient who turned away from their original good objects in infancy and childhood will recreate that in the transference. If they did not, there would be no opportunity to explore in the here and now what they have don't internally their entire lives.

We therapists suffer this recreation of these manic defensive maneuvers so that the patient may one day have a true capacity to have a whole loving relationship and tolerate the precarious uncertainty that the loved object will go on living. When we fail to confront these manic maneuvers, we effectively allow the patient to go insane in the form of spoiling our good work, and it will ultimately lead to a failed treatment or worse.

Conclusion:
Manic defenses are central psychological defenses used to cope with the pains of infancy. Like all defensive maneuvers they have a time in development when they may help the infant survive how difficult it is to be small and dependent. But like most developmental phases, it is also possible to overuse or continue to us something that now has the potential to overshoot the mark and interfere with further emotional growth and development.
Since these maneuvers are particularly aimed at altering reality and diminishing one's love for one's good object, they have the potential for a particularly pernicious effect on development and internal harmony. They me be human, but that does not mean that they are not also a very big problem in life.
When the going gets tough, the tough should go into analysis, rather than go shopping!

[Note: For an expanded lecture on Manic Defenses see Module Five.]

Section 8 - Narcissistic Personality Organization (à la Herbert Rosenfeld and Donald Meltzer)

Introduction and Overview:

Herbert Rosenfeld, in his book "Psychotic States," published in the 1960's, made a point of the need for neurotic and psychotic patients to turn away from their analyst in the same fashion that they turned away from their primary love objects in infancy. That idea highlighted for me the importance in life of turning toward or turning away from one's good objects as a key variable in mental health and mental illness.

Early in my career, I always assumed that babies would turn away from their primary objects because they had let the infant down. It took me years to see how envy in infancy of one's good objects' goodness could be an even greater source of turning away. Narcissistic personality organization has turning away from one's good objects as a central feature of it, literally by definition.

Definition of a Narcissistic Personality Organization:
A personality configuration in which the good baby parts of self, because of emotional pain that they can or will not tolerate, have turned away from the good parents internally and externally. The bad part of self has offered them refuge from the pain, and they are now under its influence instead of the good parents. This situation may be temporary or permanent.

It is a personality configuration analogous the relationship between a pimp and a prostitute or a drug pusher and an addict. As Meltzer describes it in his book "Sexual States of Mind," the bad part of self offers refuge from pain, caters to the vanity and sensuality of the good baby parts, but coercion and brute force are never far behind lest the good baby parts start longing for the good parents.

This configuration is dominant in all situations of substance abuse, narcissistic personalities, most character disorders including sociopathy, most borderline personality disorders, and probably most psychoses.

It is important for the reader to note that this is a configuration of unconscious inner world relationships. When thinking of narcissistic individuals, one tends to associate to the Kardashian or Donald Trump type figure who craves the spotlight and wears a perennial tee shirt saying "Narcissisus Is My Idol". I am describing a narcissism that is potentially entirely internal and not easily recognized as such. This configuration is often so well hidden that when it breaks out in the open people say "I had no idea that so and so was an alcoholic, suicidal, etc."

Origin in Infancy in Relation to Mental Pain and Particularly Envy:
All human beings identify with babies who have been mistreated. In prison, child molesters are in great danger of being murdered by fellow prisoners, perhaps on the basis of this identification with the baby victim. It is a fact that mistreatment at the hands of adults in infancy will greatly warp development and often generate serious emotional disturbance.

Melanie Klein added some additional models of development going awry that are hard for most of us to take. We want our babies to be sweet little innocent things, all sugar and spice and everything nice. Klein's small child patients included some very disturbed ones who had a lot of really violent thoughts, sometimes quite out of proportion to anything done to them. These children often experienced the world as filled with violence, could never integrate their feelings of hatred with their loving feelings, so that they regularly went back and forth between extremes of love and violence.

Living in such a universe, where the good baby parts of the personality are so often in pain, and where there is a part of self that has such violently intense feelings of frustration and hatred, skews personality development. It become difficult to hold on to or trust in the goodness of your objects, and subjects one to a feeling that it is a necessity to be able to be self-sufficient in case you have no good object to turn toward.

One can see a milder version of this in the infant who is in distress, doesn't feel contained, if you will, by a good object, and takes matters into its own hands literally in the form of sucking its thumb or finger. While this may begin as an expression of a need to comfort and soothe oneself in the beginning, it tends gradually to accrue the significance turning away from the object to self-sufficiency. It is as if the infant or toddler is saying "I don't need your stupid old poopy breasts, I can feed myself, the hell with you!"

What then gradually develops, in all infant's, is one part of the self that claims it can get along without needing anybody else. This can be helpful when mom and dad are not available, but it can easily become a problem if it is relied on too often. Clearly, parents who are inadequate, harsh, or regularly unavailable will promote the growth and dominance of this part of self.

What is not clear to most is that intense unconscious envy in an infant can promote the growth of this part of self even when the parents are adequate. Some babies seem to come out of the womb filled with a grievance that they have to be the small, helpless, dependent, shitted-up baby who doesn't understand anything and mom get to be the big, fancy person who has everything, knows everything, and can do anything. The only justice that seems fair is that mom be the baby and they get to be the mom. Needless to say, this attitude on the baby's part makes it hard to take in good stuff from the resented mother (who may even be referred to by her first name, rather than give her the credit of getting to be called mom).

I am describing the development of the "bad self". If we were to catalogue its various primary characteristics, we could refer to it as "the envious, omnipotent, know-it-all, destructive, self-sufficient bad part of self".

<u>The Narcissistic Personality Organization and Its Relationship to Good Objects</u>:
If everyone has a bad part of self, is it equally problematic for growth and development in all children? The answer is obviously no, but then we have to explain what is different in some compared to others. Let's try to make a list of distinctive features.

1 – The primary variable is always the infant's tolerance of mental pain. We can arbitrarily make a definition that it is the good baby parts of self that feel the pain in relation to the good mom and dad. These good baby parts will turn, by this definition toward the good parents if they are available.

2 – The bad part of self, by definition, always is devoted to self-sufficiency and therefore lives forever and permanently outside the sphere of the good objects. To put it in different words, it refuses to ever enter into the sphere of influence of the good objects. This is because to do so would subject it to it envy of them, undermine its feeling of omnipotent self-sufficiency, and subject it potentially to a multitude of emotional pains that it has dedicated its existence to evading.

3 – The sphere of influence of the bad part of self in a given person's personality is largely determined by the good baby parts' relationship to the good parental figures, externally and internally. As mentioned earlier, where the good parental figures are inadequate or felt to be unavailable, the good baby parts of self are more likely to listen to the propaganda of the bad self. Where the parents are flawed to the point of being bad parents, then the bad part of self will dominate. This is partly because the good baby parts have nowhere to turn, and partly because the bad self is offering something that is familiar because it is similar to what the flawed parents offer, so who can say one offering is worse than the other.

4 – Where unconscious envy is intense, the bad part of self can offer irresistible solutions in the form of magic and grandiosity. This is the situation in malignant narcissism and is commonly part of the core dynamics of severy narcissistic personality organizations.

Manifestations of Narcissistic Personality Organization in Ordinary Life:
Once again we have to look to a combination of mental pain and the availability of good objects to see when the bad part of self has any chance of getting the good baby parts to turn to it instead of good parental figures. If the good parents are unavailable, even the ordinarily loving child is at risk to temporarily turn away. Who hasn't as an adolescent, when the parents were our for the night or away for the weekend, turned to the parents liquor cabinet, snuck out in their car, or worse.

Marital relationships are forever being plagued by this configuration being replayed as the mental pains of life, most commonly some form of separation, recreate the mental pains of infancy. It is typical, for example, for the birth of a child to provoke the jealousy and feeling of abandonment in the husband that originally was attendant to the birth of a sibling in early childhood. It is probably not much less common for a wife that stays at home while the husband gets to go away everyday to work, recreating feeling alone and left out, to provoking any number of activities that represent turning away from him to some form of self-sufficiency, thus no longer needing him as a source of love and security.

Think of nearly any situation in life that leads to a sudden resurgence of baby pains, death loss of a job, divorce, etc. Any of those pains have a potential to provoke a turning away from caring, life, and good objects, with a goal of unconsciously trying to be self-sufficient and no longer vulnerable to the pains that love and caring inherently make one subject to experiencing.

Implications of Narcissistic Personality Organization in the Therapy Setting :
This is always the personality configuration that is the most difficult to treat successfully because there are always separations, loneliness, jealousy and envy, to provoke a feeling that the good parent is not adequately available, 24/7, to keep the pain of the good baby parts contained sufficiently such that they won't go back to their tried and true magical solutions to mental pain.

Lack of availability of a good object, when the good baby parts are so intolerant of separation and aloneness is some individuals, is the primary reason that the only successful program for treating substance abuse is Alcoholics Anonymous. They offer the only seven day a week family support, in every city, and a free parent/sponsor to boot!

These patients tend to treat all relationships, and the people in them, as "things" to be used as needed, and discarded like trash when no longer needed. In effect they are treating the other personas an extension of themselves which is taken for granted, rather than as a separate, unique, irreplaceable human being.

For the therapist, it is not easy or pleasant to be treated in a manner that takes him or her for granted and utterly ignores his feelings or needs. What do you say when the patient says "tomorrow's time is not convenient, do you have something in the early morning or late in the evening?" It won't help to say "No you self-centered jerk, I have a life too!"

Finally, there is one point that needs to be made here that is crucial for the therapist to understand when treating a patient with an underlying narcissistic personality configuration. That point is that progress in treatment, which when you think about it is threatening, if successful, to put the bad part of self permanently out of business, will lead to a violent reaction from the bad part of self. It will feel that you are trying to murder it out of existence and will be fighting for its life. This needs to be anticipated, recognized, and explained to the patient who will often feel caught in the crossfire.

This was graphically depicted in the dream of a patient after some seven arduous years of analysis struggling to dismantle his anal omnipotent attachment to smoking marijuana as a potent stimulator of his feeling of omnipotent self-sufficiency. In the dream, which was right before Valentine's Day, he pulled his car up in front of a flower shop to get flowers for his wife. Thinking he would put the arrangement in the back of his car, he opened the trunk to clean it out and found an old marijuana joint wrapped in aluminum foil. He said to himself "I don't need that anymore" and threw it into the trash can on the curb near him.

Instantly a black man appeared from out of nowhere across the street and started shooting a gun at the patient who started to run for his life. He awoke in a panic at that moment.

For me, the dream was an unusually vivid depiction of the good baby part of self, caught in the crossfire of caring relationship and omnipotent self-sufficiency. The black man was feeling that the abandonment of the addiction to marijuana usage was threatening to kill it off and it was fighting for its life. The patient felt considerable relief to see the meaning of the dream.

Long Term Prognosis:
Narcissistic personality organizations, when severe, are very difficult to dismantle. Because of the inherent intolerance of mental pain, the therapy setting needs to offer a considerable amount of support in terms of frequency of sessions, ideally five day a week analysis. Since this is often unrealistic, a multifaceted team approach can be of benefit including significant others, parents and other relatives, etc.

Relapse is always a byproduct of mental pain becoming greater than the background support can contain. It is often possible to anticipate such situations in advance and make arrangements accordingly.

Summary:
I would like to review the points made about of this difficult personality configuration and end with a quote from Herbert Rosenfeld.

1 – Where being a baby was excessively painful, for external or internal reasons, the resorting to magical (i.e. omnipotent) thinking is inevitable. This omnipotence will develop into a complete set of characterological maneuvers whose purpose is to deny need, smallness, helplessness, dependency, etc. These usually prominently includes a projection of these hated baby states of mind into someone else, sibling, child, spouse, coworker, parent, etc.

2 – Because it is felt to be a source of pain more than pleasure to turn toward other humans for love, attention, or need, unless they are completely under your control, this type of character does not enter into proper object relations, but instead thinks of others as “things”, to be used as an extension of self when suited to one’s needs, and to be discarded and forgotten when no longer usable.

3 – In the unconscious inner world of such individuals, the bad part of self has hypertrophied to a point of complete, permanent dominance over the good baby parts because they have given up hope for any good parental figures to exist who would care about and meet their needs.

4 – The consequence of this narcissisitic personality organization, where the bad part of self has gotten the good baby parts to turn away from good parental figures both externally and internally, is that the individual is no longer governed by love, concern for the other, depressive guilt, etc. In effect, they are not operating by the rules that ordinarily should govern behavior. They may not even have fear of punishment as a deterrent. This sense of self-sufficiency is commonly augmented by substance abuse and sexual perversion.

5 – I find it useful to refer to this bad self as the “envious, omnipotent, know-it-all, destructive, self-sufficient” part of self in order to keep its primary characteristics in mind.

6 – Herbert Rosenfeld depicts the mind being controlled by perverse thinking under the sway of the death instinct : “The destructive narcissism of these patients appears often highly organized, as if one were dealing with a powerful gang dominated by a leader, who controls all of the gang to see that they support one another
in making the criminal destructive work more effective and powerful. However, the narcissistic organization not only increases the strength of destructive narcissism, but it has a defensive purpose to keep itself in power and so maintain the status quo. The main aim seems to be to prevent the weakening of the organization and to control the members of the gang so that they will not desert the destructive organization

and join the positive parts of the self or betray the secrets of the gang to the police, the protecting superego, standing for the helpful analyst, who might be able to save the patient. … The narcissistic organization is in my experience not primarily directed against guilt and anxiety, but seems to have the purpose of maintaining the idealization and superior power of destructive narcissism."]

Rosenfeld's comments have huge implications for treatment where such a personality organization dominates an individual sent for rehabilitation, privately or institutionally.

Section 9 - Omnipotence and Omniscience to Augment Defensive Maneuvers

Introduction and Overview:
As the saying goes about life, everything has its time and place. This is especially true of this topic. Infancy is really hard, what with utter helplessness, not understanding anything, being totally at the mercy of other, etc. A baby needs all the help it can get and magic sure would be a nice addition. Whenever the adults are not measuring up, one can simply rub one's magic lantern, click the heels together of our red shoes, wish upon a star, or as my close friend's four year old daughter once said about being afraid of the dark, "I just turn my magic tooth and then its light".

Finding ways to cope with the pains of infancy is human and hardly seems like a crime. Many of the ways include making oneself feel more in control, more powerful, more knowledgeable, more special, etc. These are often age appropriate and perhaps necessary for survival at a young age. The rub is that they need to be relinquished as time goes on, development proceeds, and the need for proper apprehension of reality becomes overwhelmingly desirable. For most of us that occurs as long as the pains of life are modulated adequately by good parental figures, etc. In other words, magic and unreality have to give way to reality and facing life head on.

But if the pain of life remains too great, if the "good" external parental figures are inadequate to the task, then the need for magic remains excessive. As a patient once said, while starting to cry, "Please don't say there isn't a heaven, because it means I will never see my brother again." (who had died tragically that previous year).

Definitions:
Omnipotence: A state of mind, whipped up in relation to a task at hand, which has the emotional meaning of "I can do this". Its use is in proportion to the degree of unconscious baby level anxiety that the task at hand may not be successfully dealt with adequately.
Note that it does not have the significance of I am all powerful and can do anything, only that I can deal with the task at hand this moment.

Omniscience: A state of mind that is meant to counteract the infant's feeling of helplessness attendant to not knowing or understanding what is happening around them and why. Omniscience arrives at an explanation, no matter how incorrect or unsophisticated, and says now I understand. In parallel to omnipotence, it does not claim to know everything there is to know, but rather that it knows "all that it needs to know"

Relationship to Mental Pain:
The average person in life does not go around daily acting like a know-it-all, grandiose I can do anything type person. Where one sees someone excessively claiming to know everything or be able to do anything, that is invariably a left over remnant of tragically painful childhood that left the person feeling horrible vulnerable and inadequate and they seem to be desperately trying to compensate.

What one does see, in situations of crisis and pain, people resorting to maneuvers that are often unhelpful but are an expression of their baby level anxiety and the need for magical reinforcements. Alcohol and drugs are perhaps the most common magical substances in large emotional situations, with cigarettes perhaps the most common is smaller situations.

I remember a young woman in college who described twice in her life going on weeklong drunken binges, both after breaking up with a boyfriend. I remember thinking it was scarily close to being an alcoholic and a pretty risky way to cope with life.

When one thinks of the pains of guilt at a society level for ruining our environment, our personal health, etc. it is scary to think that as a society we could resort to omnipotent or omniscient magical solutions when we really do not understand what is happening and don't want to face the helplessness or guilt in relationship to the issue.

Conclusion:
In mental health work, we are constantly trying to diminish the grandiose overestimation the patient is making in their problematic approaches to life's pains. That is why we are called "head shrinkers". When we see a patient who excessively relies on whatever maneuvers, we need to remind ourselves that these maneuvers were once all the person had available, and that it will take time for them realize that they are out of time and no longer the only options.