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Immersion in the surface[1]

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In order to treat patients with a narcissistic structure showing a rigid shell of defence together with a lack of inner differentiation – insufficient subject/object constitution – one has to deal with a split kind of transference. Their compelling need for distance corresponds to their fragile self-esteem. They feel threatened by the analysis and the analytic relationship. Because the seeming normality of these patients' thinking and language is deceptive, a variation of psychoanalytic technique to facilitate the work with them is described and explained in detail. To transform their two-dimensional 'inner' world, which functions in a PS modus, it is helpful to show them, with changing viewpoints step by step, their own manoeuvres, misconceptions and manipulative use of language within the analytic relationship. The gratifying extension of their self-awareness leads to the introjection of the analyst's alpha-function. This makes possible a more distinct separation of subject and object representations and a transformation to a three-dimensional, oedipally structured world with a strengthened capacity to symbolize. This method of working is grounded in Bion's theory of thinking. A case vignette illustrates a development of this kind.

Keywords: deceptive use of language, distinction of self and object, lack of ego-boundaries, narcissistic structure, technical variations (abstinence of interpretation), two-dimensional 'inner' world

Introduction

Since Karl Abraham's *Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische Methode* [A special form of the neurotic resistance to the psychoanalytic method] (Abraham, 1919), there has been wide-ranging discussion of variations of psychoanalytic technique with narcissistically disturbed patients. Abraham was the first to describe the transference situation and the resulting difficulties of ''overcoming the narcissistic reserve of the patient'' (p. 261). The mental state of such patients does not correspond with that portrayed in Freud's topical models, which belongs to a symbolized, three-dimensionally structured mental universe. The mental structure of narcissistic personalities resembles, rather, Freud's ''bird's egg inside an eggshell'' (Freud, 1911, p. 232), where concepts, whether conscious, preconscious or unconscious, give no helpful orientation. The breakdown of the distinction between conscious and unconscious can be confusing for the analyst. And when the use of language is distorted by a regressive dynamic, the reliability of language as an instrument of communication becomes severely limited.

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I have therefore, amplifying Freud's structural theory, taken as the bases for my observations Bion's theory of the development of thinking and the building of mental structures through the effect of the alpha-function and Maurice Bouvet's concept of distance put forward in his IPA panel paper *Technical variation and the concept of distance* (Bouvet, 1958). I shall present a threefold pathological structure featuring a hard outer defensive shell lacking in internal differentiation and with deficient subject/object constitution and accompanying deformation of the transference, and put forward a variation of classical treatment technique. This, coming from 'outside', can lead to a strengthening of the alpha-function and so to a more distinct separation between conscious and unconscious (Bion, 1962), or, in terms of structural theory, via a resolution of splits to a strengthening of the ego through standardization and neutralization. In this way patients can become more active, and act with more initiative, in their dealings with themselves and with others.

The background of my work that is the subject of the present paper consists of recurrent experiences in my own and supervised treatment of patients showing a schizoid structure, borderline patients, and those with narcissistic forms of defence. Treatments were only partly in the classical setting – four hours a week and lying down, but sometimes two or three hours a week and sometimes sitting.

Special features of the analytic relationship, the transference and the counter-transference

These patients display certain distinctive features from the first meeting. They speak in a matter-of-fact, emotionless way about themselves and their lives and 'analyse' themselves in detail, as if they already know all there is to know on the subject. Contact feels sterile because the analyst is treated purely as a spectator of their self-portrayal. What they communicate, indirectly but decisively, is lack of trust. This difficulty in the transference corresponds to that described by Melanie Klein in schizoid patients. She established the existence of a certain distanced hostility running through the entire relationship with the analyst and noted the particularly difficult form of resistance arising from this (Klein, 1946).

These patients' presentation of their own problems is accompanied by self-condemnation and an uncomprehending self-disparagement, because they do not know how to help themselves unaided, combined with the complaint of a lack of relationship with themselves. They describe their powerlessness to exert control over themselves, being rather witnesses 'standing outside themselves'. ''I am the reporter on myself'', said Jakob, as I shall call him, and later: ''I am a surface presented to view''. The aim of all this is to make a certain impression but it is not authentic communication. My title uses a phrase of the painter Max Beckmann characterizing his art as 'immersion in the surface'.

Even when patients broke down in tears as they spoke of their helplessness and deep feelings of guilt, I was uninvolved. This transformation into a purely observing and judging authority was unpleasant though ultimately informative. Zwettler-Otte (2005), like Abraham before her, has described

the deceptive linguistic skill of narcissistic patients, who put some of their aggressiveness into verbal sharpness and precision while 'their soul is silent' as they speak. This 'silence' behind a blank façade appeared to indicate helplessness, fear and shame in high degree. These patients' thinking was clearly pervaded by fantasies and correspondingly adversely affected. It was sound in the abstract, but not in the human–emotional sphere. Their language did not serve the purpose of communicating as precisely as possible but had, rather, a magical, evocative character: *Things are as I say and see*; it was ''speech in which nothing can be taken for granted'', as Bion (1965, p. 99) phrased it. This 'magical' relationship with language, linked with a feeling of the omnipotence of thought, can make the expression of fantasies problematic as patients have the feeling that expressing fantasies makes them real. O'Shaughnessy's (1983) dictum 'Words break omnipotence' is not the view of these patients.

In their merciless self-analysis they produce a kind of two-dimensional, emotion-free puzzle-picture which, as E. Jacobson (1959) showed in her work on depersonalization, corresponds, as it were, to an external view. Their apparent rationality is armour-like, a protection against feared attacks from outside, for example in apportioning guilt, whereas just such attacks are constantly taking place inside them. Such patients realized their lack of self-determination, of independence of thought and feeling, and were aware of their high degree of dependence on recognition and approval from significant objects. Such 'insights' are actually none at all, they merely appear to be; they belong to as-if phenomena, they have no consequences. ''I have accepted my parents' prescriptions'', one of them said, thereby expressing his lack of a definite, independent identity. Accordingly, they had a pronounced fear of being influenced and becoming dependent in the analytic situation, having no idea how to defend themselves.

The analyst should at first accept the two-sided situation of identificatory inseparability and paranoid distance in the transference, a situation containing something akin to a resistance to close approach for fear of being overcome by alien determination through the analyst, fear of falling under the control of the object (Klein, 1946).

Genesis and structural considerations

What Wolfgang Loch called a characteristic of our existence as subject, that is to say the capacity to say 'I can', which rests on the precondition of a narcissistic balance, was not given to these patients in a central realm. I learned to understand their evident difficulty with the analytic situation as a manifestation of a primal fear that they could take harm in this realm of their capability as subject (Loch, 1975), to understand their precarious internal equilibrium as a special kind of split personality in which 'two opposed representations of the self' (Jacobson, 1959) are linked in a sado-masochistic relationship. Unsparing self-condemnation stood opposite grand fantasies about themselves. A patient can stick to his own perception of reality only if he feels in agreement with the person opposite him. Patients with the kind of split personality under consideration choose submission

and passive satisfaction of drives in order to be free from conflict and turn the hate arising from this behaviour against themselves in the form of self-denigration and self-condemnation. The analytic situation brings up not only primal fear but also the fantasy of release. Patients feel they may attain 'a state of grace' thanks to the analyst, without their own involvement, or, in denial of their own destructive activities, be freed from all problems by injection or enema.

Along with their *self*-accusations, these patients believed that their *parents* were to blame for their misery and that they had been in some way ill-treated or abused by their parents. All the mothers were inconsistent personalities, extremely contradictory in behaviour, obsessive, depressive or highly extraverted. They burdened their children with their own anxieties and problems or monopolized them and made use of them for their own needs, moralizing, punishing and unsympathetic in some situations, seductive in others. They seemed unaware of their children as individual, developing personalities. One patient said that she 'couldn't see herself' and at the same time felt transparent.

If a young child's primary object does not grasp the true nature of a situation and does not read and identify the child's mental reality, but instead continually confronts the child with his or her (the object's) own special interpretations rooted in the object's own fantasies and desires, the introjection of the alpha-function and at the same time the formation of the boundaries of the ego and the growth of the child's sense of identity are severely disturbed. The development of the faculty of recognizing mental processes within oneself presupposes, according to all that we know, a relationship to an object that functions as a container for unendurably powerful or frightening primal emotions and by making these beta-emotions endurable and transforming them (J. P. Haas, 1997) facilitates their recognition. If the primary object fails in this function of simultaneous recognition and transformation, the child can discount the existing divergence so as not to lose the object. If the divergence is replaced by self-condemnation, this will lead to the formation of a persecutory superego. Freud describes narcissistic identification as a relief measure against loss of an object: if the relationship with the object is determined by hate and strongly contradictory elements, narcissistic identification becomes ''a substitute for love-possession, which has the consequence that the love relationship, despite the conflict with the loved person, must not be given up'' (1917, p. 346). A pathological structure results in which omnipotence and powerlessness, a good, idealized and a bad, depreciated union of self and object exist side by side, with no mature superego standing against the split ego.

External sets of circumstances most probably contributed to such a regressive development of the oedipal conflict in my patients. The fathers were weak and dependent on the mother, fear-inspiring tyrants, or both. They were despised and banished to insignificance by their children, who bonded completely with their mothers. Because of the lack of support from the third object, the necessary steps of separation *vis-à-vis* the primary, two-fold partial object and its standardization had never been taken. The conflicts required for internalized aggressiveness to be transformed into a separation

process in which the boundaries of the ego could have been laid down, so that the ego could have been built up in mourning (E. Haas, 2006, p. 357), had never taken place.

Technical procedure

In a situation of ambiguous transference in which not understanding but rather non-understanding is expected, the prerequisites for interpretation in the strict sense are absent. The ''agreement on definitions and judgements'' of which W. Loch writes with reference to Wittgenstein (1991, p. 12) is missing in extensive areas with paranoid–schizoid patients since the capacity to perceive internal and external reality truly is hidden through the mechanisms of denial, splitting and projection (Segal and Bell, 1991). Careful examination of the non-agreements offers a way out here that will be accepted by the patient. The aim in this approach is to make clear to the patient not primarily the content of his or her mental functioning and thinking but the ways in which they work, and to link these with the patient's conscious self-awareness. In this way the analyst does not intrude upon the patient's mental space but, instead, by distinguishing his or her own perceptions and way of thinking, sets up a distance which the patient will try to remove by projective identification, which can find expression in the transference, for example, in the urge to *do something* with words. In my experience it is a common temptation to respond to self-accusatory patients with the desire to protect them from their own attacks on themselves and thus prove oneself a 'good object'.

Patients' liberal use of the instrument of looking away, of not-knowing and denial, takes on especially clear and concrete terms in their silence over the transference relationship. They simply do not mention this so that the analyst has to draw attention to the phenomenon. ''I never think about my relationship with you'', said one patient. ''I can be very obstinate in looking away'', another admitted at the end of his analysis, who for years had considered it sensible not to enter into fantasies about his female analyst and to attach no importance to separations. References to the transference are disturbing to these patients in a literal sense because they then no longer stand at the centre of attention and they experience the analyst as a rival. It is often a long time before the effect of the splitting processes has worn off sufficiently for the analyst's absence at weekends or over holidays to be accorded significance, for holiday periods to be coordinated with the analyst's and the time free of analysis not simply to be thought of as undisturbed time at the patient's disposal. Where narcissistic modes of experience are predominant, feelings of deprivation, sadness or even anger are rejected because they are seen as humiliating or as signs of weakness. ''Your holidays have nothing to do with me,'' said one student. ''It would be childish to have feelings about that. Perhaps that's why I don't.''

The separation work not done becomes the task of the analyst. The projections that make the analyst unknowable as an independent object demand constant, very deliberate work in the countertransference (Brenman Pick, 1988; Ferro, 2003; Money-Kyrle, 1956). In order to meet the omnipotent

mechanisms and soothe the fear behind the aggressively charged splits and projections, the analyst requires the capacity constantly to carry out transformations in detail. Such mini-transformations make it possible to find one's way out of the power–helplessness polarization of a paranoid–schizoid world in which the structures of time and space are not yet present, and through them the lack of boundaries suffered by these patients can be counteracted (Anzieu, 1989). A third, unusual position is possible, a condition for true self-reflection. Out of the pregenital partial object-relationship can emerge an oedipal object-relationship in which the patient will ultimately be able to see subject and object separately (Bouvet, 1958). As the focus of my method lies in work on the surface, definitions, opening up the patient's awareness and memory, and matters of judgement (e.g. in playing down), there is of course a danger of missing situations in which integration and so symbolized interpretation might be possible. The necessary distance can be lost, identification with the patient's experience can be so predominant that the nature and effect of the splitting in the countertransference can escape notice. Time and again one is exposed to the danger of being taken over by a portrayal or memory of reality distorted by projection (J.P. Haas, 1995; Hinz, 2003; Müller, 2003). ''My mother had a monopoly of assessments and explanations of reality,'' said one female patient, ''and I lose the feeling that there's something else there.'' Just this experience can be manifest in the countertransference.

In an 'inner' world dominated by ideas of power there is only right and wrong; only one of two ways of seeing things can be correct. In a mode of experience characterized by splitting polarizations and omnipotent thinking, the amplification of one perspective by another is impossible (Gutwinski-Jeggle, 1995; Hinz, 2004). The sexual, sadomasochistic dimension of the dynamic of power–powerlessness, through aggressive satisfaction of drives, destroys the scope for shared reflection. If anyone in the analytic situation was permitted to 'interpret', then it was these patients! The analyst's every act, every statement is minutely recorded and, often silently, interpreted, which however means *projectively* 'interpreted'. This is not easy to tolerate. One characteristic of the receiver function is that the receiver can alter emotions (Bion, 1962). For the analyst, therefore, if all goes well, out of feelings of rejection, disappointment and at times boredom, a desire to know can arise, a *K*-relationship, which can open access to an otherwise remote person.

To be perceived in an interested and non-judgemental way and thereby to absorb entirely new points of view about oneself is an unaccustomed experience for patients, one connected with narcissistic and libidinous gratification. It gives rise to new thoughts. I found from my 'tracking' system (Ginzburg, 1983), based on observations of concrete, apparently incidental phenomena that I noted as indications of complex realities in an actual situation, that patients' interest was aroused by this experience, even if they had objections over detail or felt attacked in confrontations. In the proposal to consider the analyst's observations, the invitation to separation is implicit only in the sense of greater differentiation of the patient's subjective world, whereas the interpretation of a transference in the usual sense would by its

negation have the effect, if it were successful, of an unendurable loss of object for the patient (Loch, 1991).

When I discovered how each patient went about abolishing the subject–object boundaries and arousing specific countertransference reactions, my own fantasies took shape. The exact observance of a patient's utterances and behaviour patterns within the analytic relationship is like walking around an area that at first seems featureless but in which in the course of time, as individual aspects become recognizable and are named and classified, a transformation into symbolized partial objects takes place, that is to say, into phenomena that contain significance. As in Hans Andersen's tale of the Snow Queen, the pieces of ice begin to dance and in due course arrange themselves into letters to form a word (Andersen, 1996). Phenomena that used to be fragmented and separate from each other gain connection and therefore shape to such an extent that they can be verbalized and interpreted by both analyst and patient, and thus raised from the concrete to the third dimension. This kind of communication within a commonsense reality shared by patient and analyst (Bion, 1962) takes account of the former's fear of being overwhelmed by suggestion and imputation. Statements about supposed unconscious processes, on the other hand, would leave this consequence of their structurelessness out of account. Only when the constant presence of an intrusive and seductive object can be *thought* can it be distanced from the ego. Only when the omnipotent position of unity with the maternal divinity, as I call the primal mother, can be given up, can individual boundaries, and along with them individual sexuality in the genital sense, be recognized. It is in this, then, that the help given by the analyst–receiver and the analytical function – in which the relationship to the father is always present – consists.

Schlesinger (1994) described a literal, unsophisticated listening session in which attention was given to signs and marks that could be noted in the formal structure of the patient's speech – what Hinz (1989) calls *examination of microprocesses* and elsewhere as construction of the details of an actual situation (Hinz, 2004), and Mario Rossi Monti (2005) *research on a patient's conscious experience*. W. Loch stresses that through the countertransference we are in a position to recognize ''a use of language that is the complete opposite of its 'normal' use'' (1981, p. 991). Since language is the instrument with which patients attempt to give reality to their world, special importance has come to be attached to the use of language.

Description, the importance of which Wolfgang Loch has emphasized in *Deutungs-Kunst* [The Art of Interpretation] (Loch, 2006 [1993]), accounts for a large part of my repertoire of means of intervention. When I describe things, what I notice, hear and think I understand, it seems rather like telling tiny stories in which implicit connections are made explicit. A variety of viewpoints, available to the analyst from his familiarity with infantile modes of functioning and relating, are evoked by patients' utterances and mutually complement each other. Gradually these lead to the removal of polarizations, to recognition of common ground and the increasing complexity of the self and its object-representations, and so to the development of 'three-dimensional' self- and object-representations which may ultimately facilitate

interpretations in the transference. Patients can say intelligent things about themselves which have the impact of writing in the sand. It is only in following their concrete thoughts, as Selow (2006) has described, that we get to know the surprising paths of their individual experiences and ways of thinking.

I clear up obscurities and draw attention to incorrect connections, violations and inconsistencies, and gaps or breaks in a line of thought, if I see them as consequences of an unconscious dynamic which does not lead to anything being said about the significance of phenomena to which I have attached significance. Meanings can be disputed; there is no evidence for them as long as there are no common premises. If something remains unintelligible to me or I would like to emphasize something, I pose questions – in full awareness of courting the danger of breaching the neutrality I have offered.

I try to make the emotional content of statements visible and show moralizing judgements for what they are, for example, when personal interests camouflage condemnation or selfishness. Where patients immediately change the subject when an awareness becomes painful, I point out that they are not allowing their feelings free reign and are turning away from them; when feelings are being thrust aside, I always draw attention to the fact. Feelings are connective joints to the self and must be recognized as such if that connective function is to be fulfilled. This often stands in opposition to the high value patients place upon their capacity to adopt a neutral, objective attitude, and they should be made aware of this so that they can see what they are doing. In all of the foregoing, I make it clear that I am not entering a private purview but seeking to find out how patients see themselves, how they are defending themselves, and how they are eschewing commonsense reality.

When patients speak of 'one' instead of 'I' or seek to take refuge in other generalizations, I draw their attention to this. I make them wary of talking in absolutes – saying that something is *always* so! It is important to define time dimensions, for treating them as absolute is one of the ways in which real life can be destroyed (Gutwinski-Jeggle, 1995). Expressive figurative elaboration can be both seductive and closing off for the analyst. This kind of aptitude seeks to get something acknowledged and established before the content of the figurative language or the function of 'apposite' formulations have been examined. I show the patient that rhetorical questions put in order to produce an anticipated answer, or apodictic assertions that leave no room for another point of view, have the function of building up a self-enclosed world. Patients can believe, with astonishing certainty, that they know what another person, especially an analyst, is thinking or feeling. The analyst's assessment, with such patients, of displacement of their own thoughts and feelings, that they are putting themselves in another's place, meets with bland acceptance or unexpressed disbelief, until indisputable evidence for it turns up. Responsibility for ensuring that even when confrontational attempts are allowed to surface a sense of trust is communicated, so that confrontations will not be destructive or divisive but seen as an inevitable part of the process of the patient's development, lies with the analyst.

When false connections brought up in 'explanations' ignore reality and I feel I am being made complicit in a subjective version of the world, I carefully make this clear, for example, when physical symptoms which have arisen in clear temporal connection with emotionally pressurizing situations, and are so described, are nevertheless 'explained' as consequences of *physical* pressure. Sometimes in an intervention I question what I regard as a claim to omniscience, or possibly even covert attempts, in the sense of reversible perspective (Bion, 1962), to deny legitimacy to my attempts to discover mental connections. It is as necessary here as it generally is in analytical work to give consideration to distinctive physical phenomena. Rapid speech can be an indicator of excitement without the content of the speaker's utterance being given due attention. It can then be productive to stop the patient and discuss what is being said. It is often the case that biographical constructions are in play that the patient might take to be solid fact, but which – through omissions, distortions and resorts to the absolute – help to build up the puzzle-picture. Memories that do not occur spontaneously and unexpectedly, but are simply lifeless building stones of a patient's established version of him- or herself, are not active material and so do not contribute to progress.

Dramatizing utterances in which affective experience is asserted but is not traceable and does not seem authentic have a manipulative character, and, if I believe I understand what the manipulation is serving, I tell the patient. If the patient's helplessness *vis-à-vis* him- or herself is given verbal expression, I formulate the inner discordance and unsolved conflict. Observation of broken connections can help to restore them and bring blocked-off emotions back to life. The passing over of the analyst's interventions as simply disturbances, appropriations of perceptions as if it is the patient who has made them and suchlike are effective means of arousing the analyst's vexation and impatience. Only if the patient can be brought to realize that he or she is *actively* doing something, and that it is destructive, i.e. if the denial is dropped, does it become possible to discuss *why* the patient is doing it.

Dreams are frequently experienced by these patients either as if they were real life, or as something not belonging to them personally, as, say, a film sequence. They often describe nightmares featuring death, murder, corpses and terror, which graphically convey that their inner world is a problematic place. That dreams can have a meaning is a new idea to these patients. Since affects are here bound up with *images*, they readily approach interpretations in the spirit of academic aesthetic interpretations, but not as means of any kind of illumination of their inner situation. It can be a long time before dreams are felt to be creations of patients themselves and have a meaning.

From minor interventions patients can learn how the analyst thinks and observes. They can agree, amplify or even contradict. They can express an opinion. The phenomena under discussion concern them closely enough for them to speak about them, and they have the last word. Clarification and exploration of particular phenomena and a focus on defined connections encourage them to carry out their own investigation of themselves. Greater understanding of their own contradictions makes them feel more coherent

and therefore stronger. Minor confrontations, therefore, generally have a supportive character. All this springs out of the unified world that the patient seeks to establish. If, on the other hand, the analyst speaks of phenomena that are outside the patient's awareness, if the patient is not met on recognizable ground, then what the analyst says will be of no interest for its content but will be heard primarily as confirmation or rebuttal, as something to be absorbed or spat out, to borrow from Freud's description of the pleasure principle.

Thomas Müller (2003) describes how he worked with a psychotic female patient to try to identify the characteristic features, without being concerned with the content, of her thinking, as well as external reality. He gave priority to analysis of the processes of the splitting of the ego. The result, however, was not improved integration but a deepened splitting between the psychotic and the non-psychotic sides of the patient's personality. In my own experience with less ill patients, on the other hand, increased self-observation and improved understanding of how their thinking and speaking functioned were the major prerequisite for improved integration. Such patients, who long for their true nature to be seen and recognized, gain more courage to acknowledge themselves and their unconscious fantasies and impulses when they can show themselves in the analytic relationship without being judged and with all their contradictions.

Case study

My patient Jakob was 37 years old at the start of therapy. Duration of treatment was 307 hours, of which 300 were paid for by health insurance and a further seven, up to the end of his 40th year of age, by him personally. For 17 months sessions were twice a week, and thereafter three times a week; in the 18th month he decided to lie down.

The first session took place before his release from a psychiatric hospital after five months of treatment as an in-patient. I had before me an intelligent and articulate man, thoughtful and rational in utterance, and I instinctively had far more confidence in him than he did in himself.

I heard the story of a deeply troubled life, told in sober and unemotional terms. He had been married for five years and had two children, a daughter and a son. After breaking off his studies he had been earning an unskilled living. Shortly before his breakdown he had accepted his superior's offer of a part-time one-year training course giving a recognized qualification. His wife then left him. He had tried to live with her in a highly idealized relationship, a kind of *folie à deux*, with conscious fantasies of inseparability until death. For several years he had increasingly denied his aggressive impulses and dominant desires and projected them on to his wife. The prospect of a professional qualification on his part clearly upset the balance of this state of affairs. After the departure of his wife, who took the children with her, he became depressed with suicidal tendencies and was hospitalized.

He maintained he had no memories from before his 8th year when he had suffered concussion from an accident. This was later revealed to be part of a narcissistic defence formation, selective amnesia so to speak. At the age of

10 he had acquired a brother, which plunged him into a crisis leading to anorexia. Physically, he was a late developer.

In adolescence he had begun to spend hours at a time ''holding up time''. Looking at his mirror image, which he found completely alien, he would think: ''He must be very old now''. The actual but impossible function of the mirror image was to produce a reflection from the position of an inner third party (Matzner-Eicke, 1993), to observe the perception of passing time too.

After memories gradually began to emerge and he ''could permit himself to have had a childhood'', as he put it, we were able to talk about a conviction of his: ''My mother knows me. She knows what's good for me.'' When, in the period of therapy, she gave him a size M shirt and he told her it was too small, his size was L, she answered that he had always worn size M, and then he suddenly couldn't remember what the right size was. He would be very ashamed when relating things of this kind, but never sought an explanation. Mother and son seemed to have been holding onto an inner image which went back to his younger days, so that the mother's error collided with the son's wish and subordinated his control of reality to a joint wish. Since childhood, so as to maintain his idealization, he had split his own faculty of judgement from the relationship with his mother. One day he spoke of ''numbness of tolerance'' [*Duldungsstarre*] towards his mother's assertions about what was real. Female hares experience ''numbness of tolerance'' during copulation, he explained to me. This comparison had an unequivocal female sexual connotation in an incestuous fantasy. The recognizable problem of sexual identity here through the classification: active = male and passive = female, and lack of a *genital* definition of male and female, seems to me characteristic of such patients.

As a child Jakob had been allowed to do or not do whatever he liked. He had tyrannized his parents and his mother had excused and justified everything he did on the grounds that he was just the same as she was. When the father tried to step in, she stopped him. Jakob had a pillow on his bed which for years he told everything to and wept into, which no one was supposed to know. When his mother threw it away one day because it had become a disgusting object, he mourned for a long time.

As my procedure challenged Jakob's powers of observation and judgement, and as he opened up and thus became unable to maintain his passive submission any longer, the anxious request emerged that the therapy should not be directed against his mother. He himself wanted to rebel against her and free himself from her, and had managed to displace these wishes on to me; he was worried, not entirely without reason, that I might attack his relationship with her. I really had to take note of my indignation at his mother's irresponsible behaviour and handle it carefully.

A differentiation process came about between him and his mother just as it had between him and his wife. The working through of external conflict situations took up much of this period, for example, over my refusal to postpone a session to suit his parents' travel plans. ''I can't decide between conflict and force,'' he said, hoping that I would tell him what he should

think. His hope led to the skirting around and denial of all the differences between us.

In the couple's joint discussions with the therapist during his stay in the psychiatric clinic, it was agreed that on his release Jakob would return home. When his wife suddenly rescinded this decision when he was on one of his preliminary visits home, he hit her on the head. He stated that he had done this from a desire that for once she should experience as much fear as he did. This 'blow for freedom' was a unique event, absolutely out of character for him. His wife now attempted to have him placed under power of attorney, and partly from a bad conscience and partly on account of his identification with her he accepted her arguments and wished to atone for his action. Along with much else, this would have meant that in future he would be allowed to see his children only at long intervals and only in the presence of a social worker. Attempting to clarify the elements of the situation with him, I questioned his idealization of non-aggressiveness. He eventually said that he felt as if he had had a hemiplegia; he needed someone to hold him up. This was a fantasy no longer dependent on the idea that he must give up his own thinking in analysis, as had been his attitude at the beginning of treatment. I understood it, rather, as an image of the damage to the ego caused by the destruction of his identification with the oedipal father whom he had devalued and fought against (Bion, 1967).

Despite his long period in the psychiatric clinic, Jakob passed the exam at the end of his one-year training course. Only subsequently did he tell me of serious disturbances to his studies. He had been ashamed to admit to himself and to me how strongly he had resisted making himself say and do something simply because it was necessary.

After some time I realized that by many of his concrete observations he had produced in me the feeling that I might form an opinion about what was happening in reality between him and his mother, or between him and his wife, while he himself was behaving as if he knew nothing of it. He did not seem aware that his wife was suffering from severe mental illness. When I pointed out to him that he wanted to leave it to me to form an opinion about his observations, his fear of admitting their meaning became palpable. He was afraid to do his wife an injustice so as he feared this too in regard to his mother. He had watched her alcohol abuse for years without intervening. When she eventually accused him of sexually abusing their daughter, he took all the necessary steps himself to rebut the accusation, after he and I had quickly clarified that he had been assuming that everyone, including myself, would unhesitatingly believe it.

His relationship with his children was of material help in treatment. He cared for them lovingly and thoughtfully, and took them to stay with him while his wife was receiving hospital treatment for delirium tremens as an in-patient. Contact with his children often meant confrontations with himself, especially in view of his avoidance of conflicts with his mother. ''That would have broken me up,'' he said sadly.

He found a girlfriend who despite her own difficulties was loving and warm-hearted towards him and the children, and he was able to speak with

gratitude of how much she had helped him find his way out of his sealed world.

Towards the end of the analysis it occurred to the patient for the first time that in his interests and his way of seeing, observing and describing things he was much more like his father than his mother. And for the first time he could see himself and the similarities and differences between himself and his parents. The spell under which he had lived for so long – ''I am like my mother'' – was broken.

Case material

Jakob says he has checked the remaining number of hours before the insurance cover ends, which he has long put off doing – four weeks actually now remain. He says he would like to pay for a few more hours himself, up to his 40th birthday, and I agree.

Now he describes a dream he recently had in which *a faceless female patient has died. The doctor has certified the death, but Jakob is shocked to notice signs of life. He brings the woman home to his cellar, where she at once falls to pieces, leaving a pile of tatters and bones. He separates the remains into their component parts and puts them in a bag which he disposes of in a rubbish bin. His fear at once disappears.* [He has previously often expressed surprise that he does not know his mother's face and cannot memorize her features; but he doesn't mention that on this occasion.]

He thinks of ''skeletons in the cupboard'' – years ago a colleague advised him to come to terms with this – and then asks what it will do to me, his analyst, if he removes himself from my competence: ''You won't have access to me any more.'' And he adds: ''I must totally destroy something if I'm going to be able to separate.''

At the beginning of the next hour Jakob expresses the idea of marrying his girlfriend and having a child with her: ''To anyone knowing my prehistory that must sound absurd. Two sick people unite,'' he said. I point out to him that in this thought he is using stereotypes of 'sick' and 'healthy' expecting me nevertheless to accept these terms and so be against his wishes. He replies that he sees no reason for this assumption. I reply: ''You are looking for a reason in the conscious realm. You won't find one there.'' When I later offer the interpretation that he is rejecting the analytical relationship because he sees it as evidence that he is abnormal, he replies that a hair-raising comparison has recently occurred to him. He is in the same case as Hitler, who would rather lead his people to destruction than be parted from his fantasies of grandeur. I then remind him of his dream and his comment on it that he must destroy everything in order to separate. I tell him that he does not like the idea of preserving something from me inside him and keeping it alive in order that he should grow.

The next sessions contained close examination of his fantasies of destruction and self-destruction, until he said in the penultimate hour: ''The vacuum that has arisen with the distancing from my mother has been filled by myself. I would have expected it to be filled by you. But in a certain way it's right. But you're in another place as my mother.''

Conclusions

If we take the circle as a model of the *early* inner–outer relationship of the self to the world, and, by contrast, the sphere for the relationship of the *oedipal* self to the world (Bion, 1995). it will be seen that in the case of the early self there is a boundary between inner and outer worlds on one plane only. Not until a person attains the depressive position and is able to build the oedipal structure, ''which consists in the production of these two identifications which are in some way in mutual concordance'' (Freud, 1923, p. 262), does inner space open up. Only then does concrete thinking change and symbolic equations can be transformed into true symbols which point to something absent. Only then will the transference, through the condensation of many different aspects and the convergence of different perspectives, have the symbolic quality which will make it possible to interpret it and other unconscious connections and fantasies. Only then can attitudes, opinions and ways of thinking and seeing that have hitherto been felt as ego-synthons be examined by the patient with a clear feel for what belongs to him or her individually and what to the personalities of his or her primary objects.

Translations of summary

Die Vertiefung in die Oberfläche. Um Patienten mit einer narzisstischen Struktur, einer harten Schale von Abwehr bei Mangel an Binnendifferenzierung – einer ungenügenden Subjekt/Objektausbildung - zu behandeln, muss man sich mit einer gespaltenen Übertragung auseinandersetzen. Ihr dringendes Bedürfnis nach Distanz entspricht ihrem brüchigen Selbstwertgefühl. Sie fühlen sich durch die Analyse und die analytische Beziehung bedroht. Da die scheinbare Normalität des Denkens und der Sprache dieser Patienten trügerisch ist, wird eine Variation der psychoanalytischen Technik im Einzelnen beschrieben und begründet, die die Arbeit mit ihnen erleichtern kann. Um ihre zweidimensionale ''innere'' Welt zu transformieren, die in einem PS-Modus funktioniert, ist es hilfreich, ihnen unter wechselnden Gesichtspunkten Schritt für Schritt ihre Manöver, ihre Fehlkonzeptionen und ihren manipulativen Sprachgebrauch in der analytischen Beziehung aufzuzeigen. Die für sie mit Befriedigung verbundene erweiterte Selbstwahrnehmung führt zur Introjektion der Alphafunktion des Analytikers. Dies ermöglicht eine klarerer Trennung der Subjekt- und Objektrepräsentationen und die Transformation in eine dreidimensionale, ödipal strukturierte Welt mit einer gestärkten Fähigkeit zu symbolisieren. Diese Arbeitsweise wurzelt in Bions Denktheorie. – Eine Fallvignette illustriert eine derartige Entwicklung.

Inmersión en la superficie. Para tratar pacientes con una estructura narcisista caracterizada por un rígido escudo de defensa y una falta de diferenciación interna (constitución sujeto/objeto insuficiente), es necesario encarar una transferencia dividida. La irresistible necesidad de distanciarse propia de estos pacientes se corresponde con su frágil autoestima: se sienten amenazados por el análisis y por la relación analítica. Debido a que la aparente normalidad de su pensamiento y su lenguaje es engañosa, se describe y explica una variación de la técnica psicoanalítica que facilita la tarea del analista. Para transformar su mundo 'interno' bidimensional, que funciona según una modalidad PS, es útil mostrarles, con puntos de vista que cambian gradualmente, sus propias maniobras, sus concepciones erradas y su uso manipulador del lenguaje dentro de la relación analítica. La expansión gratificante de su conocimiento de sí mismos lleva a su introyección de la función alfa del analista. Esto posibilita la separación más clara entre representaciones de sujeto y de objeto, y el pasaje a un mundo tridimensional y estructurado edípicamente, con mayor capacidad de simbolización. Este método de trabajo está basado en la teoría del pensamiento de Bion. Una viñeta clínica ilustra una evolución de este tipo.

Immersion en surface. Pour traiter des patients de structure narcissique présentant une carapace défensive rigide ainsi qu'un manque de différenciation interne – avec constitution insuffisante de la limite sujet/objet – on doit se confronter à un type clivé de transfert. Leur besoin contraignant d'une mise à distance correspond à leur fragile estime de soi. Ils se sentent menacés par l'analyse et par la relation analytique. Comme le langage et la pensée d'apparence normale de ces patients sont trompeurs, une

modification de la technique analytique, destinée à faciliter le travail auprès d'eux, est décrite et explicitée en détail. Pour pouvoir transformer leur monde interne bidimensionnel, qui fonctionne de façon schizoparanoïde, il est utile de leur montrer, avec des points de vue changeants et pas à pas quelles sont leurs propres manoeuvres, méconceptions et leur usage manipulatoire du langage au sein de la relation analytique. L'expansion gratifiante de leur conscience d'eux-mêmes conduit à l'introjection de la fonction alpha de l'analyste. Ceci rend possible une séparation plus différenciée des représentations du sujet et de l'objet et une transformation allant vers un monde tridimensionnel structuré par l'Oedipe et doté d'une capacité renforcée à symboliser. Cette méthode de travail est basée sur la théorie bionnienne de la pensée. Une vignette clinique illustre une telle évolution.

Immersione in superfice. Per poter curare pazienti narcisisti che presentano una struttura di difese rigida accompagnata da una carenza di differenziazione interiore – insufficiente distinzione fra soggetto e oggetto – si deve far fronte a un tipo di transfert scisso. L' urgente bisogno di distanza corrisponde in questi pazienti a un' autostima fragile : l'analisi e il rapporto analitico costituiscono per loro una minaccia. Siccome la normalità delle loro facoltà verbali e intellettive potrebbe essere d'inganno, si rende necessaria, per facilitare il lavoro, una modifica della tecnica psicoanalitica, che descrivo e spiego nei dettagli. Per trasformare la dimensione bi-dimensionale del mondo interiore di questi pazienti, che funziona secondo modalitá schizoparanoidea, è utile proporre loro prospettive diverse in maniera graduale, per dimostrare le loro manovre, i falsi ragionamenti e un uso manipolativo del linguaggio all'interno del rapporto analitico. La crescente gratificazione del loro grado di auto-consapevolezza che ne risulta conduce il paziente a introiettare funzione alfa dell'analista. Tutto ciò rende possibile una differenziazione maggiore della rappresentazione soggetto/oggetto e la graduale costruzione di un mondo interiore tri-dimensionale a struttura edipica che rinforzi la capacità di simbolizzazione. Questo metodo di lavoro si fonda sulla teoria del pensiero di Bion. L'esempio di un caso clinico illustra il processo che conduce a questi risultati in terapia.

References

Abraham K (1919). Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische Methode [A special form of the neurotic resistance to the psychoanalytic method]. In: *Psychoanalytische Studien II*, 254–61. Frankfurt: Fischer, 1971.

Andersen HC (1996). *Die Schneekönigin. Sämtliche Märchen* [The snow queen: Collected tales], vol. I, 313–50. Munich: Artemis & Winkler.

Anzieu D (1989). *The skin-ego*, Turner C, translator. New Haven, CT: Yale UP. [(1985). *Le moi-peau*. Paris: Dunod.] [(1992). *Das Haut-Ich*. Frankfurt: Suhrkamp.]

Bion WR (1962). *Learning from experience*. London: Heinemann.

Bion WR (1965). *Transformations*. London: Heinemann.

Bion WR (1967). Attacks on linking. In: *Second thoughts*, 93–109. London: Heinemann.

Bouvet M (1958). Technical variation and the concept of distance. *Int J Psychoanal* **39**:211–21.

Brenman Pick I (1988). Working through in the countertransference. In: Spillius EB, editor. *Melanie Klein today*, vol. 2, 34–47. London, New York, NY: Routledge.

Ferro A (2003). Die Person des Analytikers, seine Selbstanalyse und seine Funktionsebenen [The personality of the analyst, his self-analysis and his levels of functioning]. *EPF Bulletin* **57**:153–63.

Freud S (1911). Formulierungen über die zwei Prinzipien des psychischen Geschehens [Formulations on the two principles of mental functioning]. GW **8**, 230–8.

Freud S (1917). Trauer und Melancholie [Mourning and melancholia]. GW **10**, 428–46.

Freud S (1923). Das Ich und das Es [The ego and the id]. GW **13**, 237–89.

Ginzburg C (1983). *Spurensicherungen* [Collections of evidence]. Berlin: Wagenbach.

Gutwinski-Jeggle J (1995). Denken lassen oder selber denken. Denkstörungen als Teil einer narzisstischen Abwehrorganisation im Licht innerer und äußerer Realität [To allow thought or to think. Disruptions to thinking as part of a narcissistic defence organization in the light of inner and outer reality]. In: Haas JP, Jappe G editors. *Deutungs-Optionen*, 189–220.Tübingen: Diskord.

Haas ET (2006). Melancholische Arbeit [Work on melancholia]. *Psyche* **60**:349–69.

Haas JP (1995). Zur Psychodynamik der Unechtheit [The psychodynamics of authenticity]. In: Haas JP, Jappe G, editors. *Deutungs-Optionen*, 151–88. Tübingen: Diskord.

Haas JP (1997). Bions Beitrag zu einer psychoanalytischen Theorie der Emotionen. [Bion's contribution to a psychoanalytic theory of the emotions]. *Jahrb Psychoanal* **38**:137–93.

Hinz H (1989). Projektive Identifizierung und psychoanalytischer Dialog [Projective identification and psychoanalytic dialogue]. *Psyche* **43**:609–31.

Hinz H (2003). Wer nicht verwickelt wird, spielt keine Rolle [Whoever is not implicated is irrelevant]. In: Frank C.Weiß H. editors. *Normale Gegenübertragung und mögliche Abweichungen* [Normal countertransference and possible deviations], 68–96. Tübingen: Diskord.

Hinz H (2004). Neubeginn, schrittweise, diskontinuierlich. Theoretische Umwanderung des Wunders seelischer Veränderung [New beginning, step by step, discontinuously. A theoretical stroll around the miracle of mental change]. *Psyche* **58**:869–97.

Jacobson E (1959). Depersonalisation. *J Am Psychoanal Assoc* **7**:581–610.

Klein M (1946). Notes on some schizoid mechanisms. *Int J Psychoanal* **27**:99–110.

Loch W (1975). Ärztliche Psychotherapie auf psychoanalytischer Grundlag [Medical psychotherapy on psychoanalytic principles]. *Psyche* **29**:383–98.

Loch W (1981). Kommunikation, Sprache, Übersetzung [Communication, language, translation]. *Psyche* **35**:977–98.

Loch W (1991). Therapeutische Monologe – Therapeutik des Dialogs [Therapeutic monologues – Therapeutics of dialogue]. *Luzifer-Amor* **4**:9–23.

Loch W (2006). *The art of interpretation: Deconstruction and new beginning in the psychoanalytic process*. London: IPA. [(1993). *Deutungs-Kunst. Dekonstruktion und Neuanfang im psychoanalytischen Prozeß* [The art of interpretation. Deconstruction and a new beginning in the psychoanalytic process]. Tübingen: Diskord.] [(1999). 2nd edn. Tubingen: Diskord.]

Matzner-Eicke J (1993). Beobachtungen zu Raum und Raumlosigkeit in der analytischen Situation [Observations on space and lack of space in the analytical situation]. In: Gutwinski-Jeggle J, Rotmann J M, editors. '*Die klugen Sinne pflegend* [Taking care of the wise senses]'. *Psychoanalytische und kulturkritische Beiträge* [Psychoanalytical and cultural essays], 136–60.Tübingen: Diskord.

Money-Kyrle R (1956). Normal countertransference and some of its deviations. *Int J Psychoanal* **37**:360–6. [(1978). In: Meltzer D, editor: *The collected papers of Roger Money-Kyrle,* 330–42. Strath Tay: Clunie.]

Müller T (2003). Über psychotische Identifizierungen [On psychotic identifications]. *Psyche* **57**:35–62.

O'Shaughnessy E (1983). Words and working through. *Int J Psychoanal* **64**:281–9.

Rossi Monti M (2005). New interpretative styles: Progress or contamination? *Int J Psychoanal* **86**:1011–32.

Schlesinger HJ (1994). How the analyst listens: The pre-stages of interpretation. *Int J Psychoanal* **75**:31–7.

Segal H, Bell D (1991). The theory of the narcissism in the work of Freud and Klein. In: Sandler J, editor. *Freud's* On narcissism: *An introduction*. New Haven, CT, London: Yale UP.

Selow E (2006). The 'newspaper reader': On the meaning of concrete objects in a psychoanalytic treatment. *Int J Psychoanal* **87**:1629–47.

Zwettler-Otte S (2005). Das vorbewußte dynamische Kräftespiel in der Sprache des Analysanden [The pre-conscious play of forces in the language of the analysand]. *Z psychoanal Theor Prax* **20**:216–23.

