LEVELS OF ANALYTIC WORK AND LEVELS OF PATHOLOGY: THE WORK OF CALIBRATION

INTRODUCTION

What we need more of is slow art: art that holds time as a vase holds water.

Robert Hughes.

I love psychoanalysis, not least because it works. I think I can say that most of the children I have treated over the last 50 years have been helped by it. Nevertheless, two of my illest patients in my early years of work, a paranoid borderline psychotic boy and a boy with severe autism, challenged my methods in ways that baffled me. I found my interpretations to the paranoid boy often made him more ill, more persecuted, desperate and dangerously violent. My interpretations to the autistic boy, Robbie, often hardly reached him at all. In a previous book, I traced the origins of my accidental finding of a way through to him and my attempts to conceptualize this as a kind of reclamation. With both children I learned what not to do, and to have some idea of a different method, but only much later have I begun to consider how these different – and differing- methods might fit into a wider schema of psychoanalytic interventions and priorities. This paper is an attempt to describe this.

The following experiences with Robbie when he was much more alive to feeling set me wondering.

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Robbie in his late teens- less autistic, full of feeling and very agitated.

I had seen Robbie, who was severely autistic, and, I thought, cut-off, on a non-intensive and quite interrupted basis from aged seven on. I eventually came to learn that, unlike some other children with autism, he was not hiding, he was lost. In any case, it was only at age thirteen that he came into 5-times weekly treatment. Some years later, when he was in his late teens, he had become more clear-headed, finally had a sense of time

(a very anxious sense, however) and could orient himself spatially and geographically, so that he was able to travel by underground from his house to mine by himself. Furthermore, he now had, at times, an all-too-ready access to feeling. If there were delays on the underground, or if he himself had left late, and he was therefore even one or two minutes late for his session, he would ring the bell in a state of frenzied agitation and fury. I would open the door to a fellow now six foot tall charging toward me with his arm outstretched , his clenched fist aimed straight at my chest. He was having boxing lessons and the sight was quite frightening.

Primo Levi, in The Search for Roots, his personal anthology of books that were vital to him throughout his life, explains why he includes some advice by Ludwig Gatterman on the prevention of accidents in laboratory work in Organic Chemistry. (Levi, 2001 p 75) Gatterman advises:

"Work with explosive substances should never be done without wearing goggles. …… If a fire occurs, everything which may ignite must immediately be removed. The fire should then be extinguished with moist towels or by pouring on carbon tetrachloride, but not water".

For months, whenever Robbie charged up the path, I think I was probably using water, and I was clearly not removing ignitable substances! I certainly tried to interpret quickly. I would say something like, `You are very upset and angry because you (or the trains) were late, you feel as though it must be my fault, and you don't want to know what really happened, or what really caused your lateness'. This was a rather wordy explanatory `why-because' and `who – you' interpretation. He kept coming, still inflamed. Later I shortened it: I simply said, sympathetically, `You are very upset to-day'. This comment on the whatness of his experience helped a little, slowed him down a little, but not much. Note, however, that I was still attempting to locate the experience in him by saying "you". Another few months later, I happened

to say, not looking at him but into a space somewhere between us but off to one side, `It is very upsetting when trains don't run on time', or, simply ` It's so upsetting to be late.' This did help him to pause and think. Steinberg, who had worked with Bryce Boyers (1989)said the staff on an in-patient unit had learned never to say the word `You' to a person in a paranoid psychotic state. (1999) I think this is because the simple word 'You' can sometimes flood or seem to accuse an already overwhelmed person, whereas the 'it' can permit a modicum of perspective. The patient then can take as much or as little into himself as he can bear. In either case, <u>what</u> is being felt may, at certain moments, have to take precedence over <u>why</u> it is being felt, or even on occasion, <u>who</u> is feeling it.

The act of reclamation, however, calling Robbie forth from his earlier far-gone and empty state, was certainly very different. It involved not a `why', not even a `what', but a kind of 'Hey! `. This paper therefore identifies three points on a continuum of levels of analytic work and levels of meaning: in Level 1, an explanatory level which offers alternative meanings (why-because); in Level 2, a descriptive level which enlarges meanings, (whatness and isness) ; in Level 3, a more intensified, vitalizing level which insists on meaning (hey!) .

I am not suggesting at this point that we need not use words to convey our understanding, only that when we stay in touch with the deepest feelings the patient has evoked in us, we may manage to get the words and the tone and the tact right. Al Alvarez has written about the way in which John Donne could make his readers sit up and attend. Alvarez writes, ` In a poem called "The Blossom", Donne spoke of "my naked, thinking heart", and that seems to describe exactly what he expresses in his best poems: you can hear his heart beat *and* you can hear him think,

as though they were one and the same process". (Alvarez, 2005,p.55)

As, I said, there has been much discussion recently of two different levels of work, that is, of insight versus other more primary levels of understanding. I also suggest the need for a third level which is prior to both. I am also offering the idea that all three may be linked as points on a continuum of levels of meaning. At the third level (of psychopathology and therefore of technique) the question arises of whether feelings and meanings matter at all to patients in affectless states of autism, dissociation, despairing apathy, or deviant states of excitement..

Discussions of the first two levels have been couched in a variety of terms: the balance between the need for the patient to take responsibility for some feeling versus the need for its containment by the analyst (Bion,1962,Joseph 1978, Steiner,1994, Feldman,2004) Others discuss insight versus mentalization (Fonagy and Target, 1998) interpretation versus play (Blake, 2008). Still others stress the significance of something more than interpretation in terms of a `procedural' mode of information processing during a 'moment of recognition'(Stern et al, 1998) (Sander, 2002) Schore emphasized the need for a `conversation between limbic systems' in patient and therapist in the more severe levels of pathology(Schore2003, p. 147) Klein herself , the great scholar of the infantile levels of the personality, pointed out that when pre-verbal emotions and phantasies are revived in the transference situation, they appear as `memories in feeling' to which we must lend words. ((1957 p.180) Child Psychotherapists Lanyado and Horne have explored a variety of ways of working in the transitional area with extremely damaged and acting-out child and adolescent patients , and Blake has

illustrated the importance of humour in relieving impasses with aggressive deprived adolescents.(Lanyado and Horne, 2006) (Blake, 2008) I shall try and demonstrate in levels 2 and 3 that in order to reach - and communicate with- memories in feeling, or worse, severe loss of feeling, we may have to go beyond words and consider the use of our emotional and even emotive counter-transference responses in ways which determine whether we choose the right words and especially the right tone.

Anna Freud put the issue vividly, but in traditional one-person psychology terms – when, returning to a discussion of the concept of defence with her colleagues at the Hampstead Clinic, she referred to the need for prior structuralization of the personality: she said that if you haven't yet built the house, you can't throw somebody out of it (make use of projective mechanisms). Joseph Sandler added, `nor throw him into the basement'(make use of repression)(Sandler with Freud, 1985,p.238) A Kleinian object relations theorist treating very deprived children might agree, but want to add that basically it is sometimes a question of building two houses, one for the self and the other for the internal object.

Rocha Barros (2002) introduced the notion of a continuum when he pointed out that steps toward thinkability may be provided by affective pictograms in dreams. In the case of the patients described below, it is sometimes a question of steps toward working through, as Rocha Barros suggested; in other cases, however, where the question is not only of processing pain and anxiety, but of introjecting possibly quite new experiences of relief, pleasure, or of the interestingness as well as the receptivity of one's objects , we might want to emphasize his other term, 'working toward ' or add another, such as 'taking in' rather than working through. Questions of introjection, internalization and identification are at issue.

I described earlier the steps toward my finally finding a way of helping Robbie with his frenzied panics whenever he was late, and how I eventually came to avoid the word `you' when I tried to describe his feelings. I started pointing out with feeling that ` It is upsetting when...,' and this seemed to permit necessary perspective. It seemed that then, he could take as much or as little into himself as he could bear. In either case, what is being felt may have to, at certain moments, have to take precedence over why it is being felt (and as I said, even over who is feeling it.)

I would suggest, therefore, that if we are engaged in building Anna Freud's house, or rather Melanie Klein's two houses, (for the self and the internal object)we may have to start with the foundation of each house. Others have described the problem of deficit in the self, and the difference between defensive strategies designed to make up for a developmental arrest and true defences against conflicting desires. (Stolorow and Lachman,1980) Here,, however, I want to add another dimension to the deficit issue by stressing the existence, in some patients, of a deficit or impairment in the internal object. This concerns objects experienced as uninteresting, unvalued (not devalued), useless, and possibly mindless. It may also concern objects with a perverse , sometimes sado-masochistic excitability.

I suggest , therefore, that historical and chronological developments in theory and technique from Freud and Klein through to Bion ,and then on to autism specialists, from the top down, as it were, may need to be reversed when we take clinical, psychopathological, and developmental considerations into account. I shall work my way down from the top level of the house described by Anna Freud through the ground floor to the basement and its foundations by looking at three different ways in

which an interpretation may ascribe meaning to experience or fantasy. When I arrive at the foundation level, I shall try and show that initially,, certain patients need to be helped to be able to feel and to find meaning, sometimes via an experience that something matters imperatively to someone else; then, feelings can begin to be identified and explored ; eventually, explanations which bring in additional alternate meanings may be heard and taken in.

To introduce the three points on the continuum from the top down:

1. **Explanatory Level: Offering Alternative Meanings**.

   Freud (1895) discovered the power of explanatory interpretations about the link between repressed, displaced parts of the personality and defences against them.(Your belief that your leg is paralyzed is due to your unconscious guilt about your hostility to your dying father when you were nursing him.) This is a 'why-because' interpretation. B) Klein (1946), elaborated and amplified Freud's work on projection by emphasizing that whole parts of the personality could be projected into others. This may lead to another type of explanatory interpretation, i.e. locating or relocating split off or projected parts of the personality. (You are trying to make me feel inferior in order to get rid of your own feeling of inferiority) This is a 'Who?- You'. or 'Where?-There'. interpretation. Both types of interpretation tend to replace one meaning with another, the conscious with the unconscious, or the disowned with the re-owned. But Bion (1962) made the link between projective identification and counter transference: he pointed out that projective identifications emanating from the patient could be felt powerfully in the mind of the analyst and require both containment and transformation there before being returned to the patient.(1962) (1965) This led to other implications….

2. **Descriptive Level: Ascribing or Amplifying Meaning**.

Bion made a further point, however: he suggested that some projective identifications took place not simply for defensive or destructive motives, but for purposes of needed communication. (1962) Joseph (1978) and Steiner (1993) went on to draw attention to this element of need, that is, the necessity, with certain patients, for the analyst to contain projections at certain moments without returning them to the patient. The analyst would explore the nature of the missing part of the patient as it resided in the analyst until the patient was able to own or re-own it. This more receptive attitude to the patient's need to project is not dissimilar to Winnicott's ideas on allowing the transitional object to carry meaning in its own (paradoxical) right, without being explained away too prematurely.(Winnicott ,1953) Coming from the perspective of normal development, the researchers' study of parent-infant communication - and the consequences for infant mental health - has identified processes occurring in shared mental or emotional states which seem to imply that certain more simple empathic or amplifying comments may, by not overloading the patient with ideas, reach both the feeling and thinking parts of the mind at the same moment.(Stern, 1985, Trevarthen,2001) . The Kleinians cited above are describing a phenomenon of `feeling in behalf of ' and the developmentalists are describing a `feeling with'. Both seem to be central to the work of communicating understanding at very basic levels. Either method of lending meaning, when it is an interpretation, concerns the whatness, the is-ness of experience, and, I suggest, raises issues concerning both the degree and nature of introjective processes and the level of the patient's capacity for symbol formation. It respects the patient's need for assistance at the level of one

thought at a time, that is, one-tracked thinking, without pushing more demanding and possibly incomprehensible two-tracked ideas upon him. Perhaps such a level of work is better defined in terms of what it is, rather than what it is not.

3. **An even more prior level of work.: Intensified Vitalizing Level: Insistence on Meaning**.

   Here, as I said, , I want to add another dimension to the deficit issue by stressing the existence in some patients of a deficit or impairment in the internal object. This concerns objects experienced as uninteresting, unvalued (not devalued), useless, mindless, or perversely excitable. The level of work required may need to precede both the explanatory and the descriptive level. At the most severe level of psychopathology -and therefore most extreme level of technique- the question arises of whether feelings and meanings matter at all to patients in affectless states of autism, dissociation or apathy following chronic despair. (The question also arises where dissociation and hardness has gathered perverse motivations to it). Some years ago I suggested that an intensified level of intervention – I called it `reclamation' - responding to a counter-transference sense of desperate urgency - might be needed with patients such as Robbie in the early stages of treatment, in imminent danger of something like psychic death. (1980, 1992, 1999)There the deficit was even more severe: the object was so remote and faint it hardly existed.

   This final level of work – at the foundations of mental and relational life - addresses the problem of being heard by patients who cannot listen or who cannot feel, perhaps due to autism , dissociation of a chronic nature due to trauma, or chronic apathy as a result of despair or neglect. This is

not a question of one or two tracks, this is a question, first, of helping the patient to get on track , or back on track, in situations where he has been profoundly lost. (not hiding.) Or, to return to the house metaphor, to help our patients get onto `solid ground', as a recovering autistic adolescent put it. (Edwards, 1994) What is at stake is not simply a weak ego, or even major defects in the sense of self: it is a matter of defects both in self and internal object, where BOTH are experienced as dead and empty or useless. There is often a chronic apathy about relating which goes beyond despair. Nothing is expected. Green describes something similar in the case of patients who in infancy have experienced sudden depression in their mother . He describes the `decathexis of the maternal object and the unconscious identification with the dead mother' as a defence against the abrupt loss of the mother's love due to her own bereavement or loss.(1997,pp 150-151). Here, however, I am thinking of cases where it is seems likely that the mother's withdrawal was more chronic or the patient's withdrawal more like `undrawal', sometimes for constitutional reasons. Bob Dylan describes something similar but more aggressively, "I ain't looking for nothing in anyone's eyes.' (Dylan, 1987) Dylan, however, knows what he isn't looking for. Some children do not. These clinical problems may arise in very different ways with a particular `undrawn' sub-type of autism and also with some very deprived or abused and perverse children. I have suggested that the act of reclamation or claiming by a therapist responding to a powerful counter-transference sense of urgency may be an extreme form of the mother's normal activity of awakening and alerting the normal, mildly depressed, or slightly distracted, infant. (1980)(1992

Reid has described a similar more intensified intervention: whereas reclamation refers to instances of the therapist calling the child into

contact with the therapist, Reid wrote of how the therapist may try to fan a little interest in a toy or some other object in the room. She termed this the `generation' or `demonstration' of interestingness or meaning. (Reid, 1988) She would only use this method with certain autistic patients similar to Robbie and only at certain moments.

Elaboration of the State of Mind of the Patient Relevant for Work at the Three Levels.

1 Explanatory Interpretations: A Necessary Pre-Condition .

The higher levels of interpretation involve a two-part interpretation, and therefore, I suggest, assume a capacity for two-tracked thinking, that is, a capacity to think two thoughts fairly fully at the same time.(Bruner, 1968). The emotional pre-conditions are clear: some capacity to tolerate anxiety and pain and to bear thinking – in other words, a state not too far from the depressive position. Yet there is an element of cognitive functioning involved too –that is, of already achieved ego development and symbol formation. Taken together, this may involve a neurotic or mildly borderline state of mind. It is worth noting that even a here–and-now transference interpretation, - concerning a moment where a boy, say, is complaining about how a female teacher at school treats another boy, - involves considering four thoughts in mind at once - that is, she, he , you and me.

Bruner (1968) has described a cognitive development which he has called the capacity to `think in parentheses' or to hold something in reserve. Bruner's study observed babies developing from a newborn

state of what he called one-tracked attention, where they can either only suck or only look, to a coordinated capacity for two-trackedness at four months, where they can do both more or less at once. Bruner (1968: 18-24,52) calls this final stage `place-holding', (like putting your finger on a line in a book, while you listen to someone for a moment).

Others have described something similar to Bruner's `two-tracked thinking' - binocular vision (Bion, 1950), depressive position development in the achievement of symbolic functioning .(Segal, 1957) Bion, (1955, p 237)also described how thoughts can behave like people, that is, get on top of each other, and, we might add, chase us, haunt us, chase each other –and, in poetry and the other arts, occasionally conjugate in harmony. The normal child can hold a thought in reserve, consider the thought within the thought, and the thought beyond the thought. On the other hand, borderline patients (in their psychotic moments), are concrete, one-tracked, overwhelmed by the singularity of their state of mind, We may risk producing premature integrations when we try to leap-frog their urgent, imperative, single-minded states.

2. Descriptive level : Simple Lending or Amplification of Meaning with Patients with Ego Deficits.

Many of our patients nowadays are too ill or too learning disabled due to autism or trauma or neglect to be able to think two thoughts together, or even in close sequence. For them, the simple exploration of the qualities that surround an aspect of the object (its brightness, say) or of the self (my voice can be louder!) may be enough to be going on with if their mind is to grow.. I should say that although I have implied that different levels of pathology correspond to the three levels , patients themselves refuse to stay put in neat diagnostic categories, so the levels refer only to

different states of mind, which of course can occur in the same patient at different moments in the same session.

Bion thought that real learning depended on the choice between techniques for evasion and techniques for modification of frustration (1962, p.29) and, like Freud, he linked tolerance of frustration with the sense of reality. His concept of the preconception meeting with a realization seems to have some hints of the element of perfect fit implied in the theories of primary narcissism,(Freud,1938-39,pp150-151), symbiosis (Mahler, 1968)and illusion (Winnicott,1953) and which can seem to imply a somewhat sleepy mindless state. Pleasant surprises, however, can be extremely alerting and cognitively stimulating so perhaps Bion's first stage, that of the introjection of moments of contact or 'moments of meeting, or moments of recognition'(Sander 2000) deserves more study. The feeling of being understood may feel right, without implying a simple adaptation or gratification model; indeed, such experiences may not involve meetings or recognitions exactly: because of the element of delighted surprise, they can be vitalizing and thought-provoking.

In any case, this level of work involves something more like simple ascribing or lending of meaning. Here, as I said, I suggest we are in the area of Joseph's (1978)and steiner's(1994)ideas concerning the containing of projective identifications over time and the avoidance of premature return of the projected, of Winnicott's ideas on respecting the paradox in the transitional area – i.e not identifying the transitional object too readily as belonging to the object or to the self.(Winnicott 1953) Concepts of mental state sharing and attunement, offered by developmentalists such as Stern(1985) or the mindful companionship suggested by Trevarthen(2001) are relevant too.

The therapist of such patients may need, in Stern's terms, to be alert to his patient's `vitality affects', i.e. the shaping, intensity, and temporality of his patient's emotions, as much as their content and certainly more than their link with other emotions. (Stern 1983, pp53-60) That is, we might say, not only `you are very upset to-day", but , " You are still terribly upset, aren't you?' Or, to a previously rigidly controlled and controlling child, `You seem really to enjoy bouncing that ball , especially the way that it doesn't always come back in the same place'. To link the experience with other thoughts, for example, to its symbolic connections, may be at best redundant, at worst, an interference with a new development.

A most helpful tool for working in this area is Bion's concept of 'alpha function' – the function of the mind that makes thoughts thinkable and lends meaning to experience. (1962) As with Robbie, sometimes it may be better to avoid the whole question of who is having the experience. If the patient is very persecuted or desperate, or simply confused, it may be better to get an adjective or two attached to the noun, an adverb or two attached to the verb, and let it rest. An `It is upsetting when..' may serve to place the feeling at some distance. Naming and describing experience, I believe, has to have priority over locating it. Hopkins (1996) Winnicott's views). Schore (2003)has suggested that, when we are working with borderline patients, it is not a question of making the unconscious conscious, but of restructuring or even structuring the unconscious.

De**scriptive Lending Of Meaning Continued**:: **An example of containment of projective identification**

Bion's described situations where the mother contains and transforms the projections of the infant in ways which make the unbearable bearable.

(1962, 1965) He compared this to the containing function of the analyst.,) In certa0in cases it seems to be, not frustration, but the freedom from frustration which promotes thinking - the opportunity to explore an unbearable experience in someone else who can feel it deeply and also think about it .

A disabled and deformed girl, Jill, condemned to live life in a wheelchair, became desperate and suicidal when she moved from her primary school to a large secondary school. After a few months in therapy, she began to make her therapist sit in a chair with cellotape wrapped around her legs. She told the therapist that she (the therapist) would never get out, she would have to stay there forever. The game was pretend (the therapist was not really trapped) but the tone was deadly - acidly - serious. Clearly this figure represented Jill, but from the clinical point of view it was important for the therapist to imagine – and to describe - this extremely disturbing experience as belonging to herself and not to return the projection in the early stages. The patient not only wanted, she needed to try on the identity of being the healthy one, while seeing someone else experience despair and bitterness on her behalf. She felt it ought to be somebody else's turn. The sense of urgent and rightful need is very different from a wish – even a passionate wish- that things be otherwise, and the therapist's words , counter-transference responses and dramatizations can reflect that. The game began sadistically, but as the weeks progressed, it became more symbolically dramatized, and eventually -at moments - humorous. Returning the projection prematurely would only have increased the child's already unendurable frustration and despair and prevented the slow exploration of painful truths. She knew perfectly well how disabled she was and how deep was her despair. But somewhere she had a preconception of herself as a healthy able being, and here she found an opportunity for that to be realized, if only in

fantasy. I am stressing here that the usefulness of such containment by the therapist need not only be seen as a step along the way to subsequent re-introjection of the sense of disablement, but rather also as a necessary step in the growth of hope and agency (and the desire for a decent, partially able life) in the self that has been left behind while carrying out the needed projection. Kundera described the way in which justice and even revenge phantasies could lead to the `rectification' of a lifelong feeling of bitterness. (Kundera 1982) Careful containment of projective identification seemed to enable Jill to recover from her despair and to begin to see herself as more able. Careful monitoring should warn us of the danger of going on too long and too passively with such receptivity, and of therefore denying reality, or worse, feeding narcissism or sado-masochism.

Descriptive Lending Of Meaning Continued:

C) An example of alpha function providing something like self-resonance.

A little boy, David had been born prematurely, and had breathing crises and hospitalizations throughout the first year of his life. He had also been emotionally abused and was severely delayed in his development. At first he did not know how to play or talk, but eventually he began to scold and shout at a teddy bear. Then he added a new game: he started asking the therapist to join him in dramatizing someone coughing and choking. He and the therapist coughed, retched, and choked together, David insisting on exact renderings of each detail. When his therapist, remembering the early history, at one point said, "Poor baby!" David rejected this with desperate impatience. The therapist seemed to have to BE David before David was ready for him to feel WITH him, and certainly before he was ready for him to feel FOR him. Perhaps

companionship in identification of the experience has to precede empathy and empathy has to precede sympathy. Sympathy, after all, comes from an other. Perhaps David first needed to find and identify his traumatic experience , and to make the unthinkable thinkable. The exactness of the replay was clearly important to him. (It is worth noting that this is not an example of projective identification: both the child and the therapist had to enact the part. It was a duet, not a solo, and the duet seemed to provide the necessary alpha function and resonance. When a child sees that someone other than himself gets it, as it were, I think we do witness the 'dyadically expanded states of consciousness' which Tronick describes.(Tronick et al, 1998))I have seen traumatized patients be re-traumatized and shocked by interpretations trying to link a current small phobia, say, to larger, more horrific events in the past: instead, they needed the therapist to treat recovery from trauma exactly like the mourning process (Freud1917) –involving only a piecemeal step at a time. Robert Hughes, the art critic said, `What we need more of is slow art: art that holds time as a vase holds water.' He also said, ` A string of brush marks on a lace collar in a Velazquez can be as radical as the shark that an Australian caught… some years ago and is now murkily disintegrating in its tank on the other side of the Thames. More radical, actually.'(2004) Patients deep in the paranoid –schizoid position may need much help in getting alpha function around various miniscule elements within each side of the split, either the good or the bad, long before they are ready to integrate the two. The tiniest of brush strokes from us may suffice.

David's therapist lent meaning by taking part in a duet of actual coughing, but there are many verbal equivalents. My `You are very upset' to Robbie, offered some kind of sympathy, but the `It is upsetting when' had more to do with empathic identification. But, I suspect, David was

at a level even more primary than the need for empathy: he needed to explore what it felt like nearly to choke to death, to get a handle on it, as it were.

3. Intensified and Vitalizing Levels Of Work: Reclamation and getting the right band of intensity with patients with deficits in ego, self and internal object..

What is at stake here is a matter of defects both in self and internal object, where *both* are experienced as dead and empty, useless or capable of deviant excitements. There is often a chronic apathy about relating which goes beyond despair. Nothing is expected. In more severe cases, the child, for reasons of autism or severe neglect, may never have become attached. (see Strathearn (2010) and Perry (2001) on the effect of neglect on the brain.)

An example of reclamation.

I now want to return to the autistic patient, Robbie, at an earlier phase of his treatment. He was a child who differed considerably from other children with autism I had seen- those who Tustin (1981, pp23-30)described as of the ' shell- type' and Wing termed 'aloof '.(1987)Robbie seemed more undrawn than withdrawn, more lost than hiding. I despaired for years about how I was to become dense enough, substantial enough, condensed enough to attract his attention and concentrate his extremely flaccid mind.

At one point, when Robbie was 13, I had to stop his twice weekly therapy for some months due to the birth of my baby. During the same period, his mother also had a new baby, and when Robbie returned to what was only a series of monthly reviews, he seemed to have completely given up. He seemed to have died psychologically. In the last session before the summer break, I felt in my counter-transference a desperate

sense of urgency: I was talking about the coming break, the need to say good-bye, and the possibility of his considering us remembering each other. Nothing reached him and I felt more and more worried that I had lost him for good. I then found myself moving my head into his line of vision and calling his name. He suddenly looked at me in surprise, like someone surfacing from the deep, , and said "Hello-o-o…" wonderingly and sweetly, like someone greeting a long-lost friend.(Note that, unlike a defended patient, he showed no resistance to his emergence, only surprise) The day after, he had a sort of depressive breakdown, or rather a breakout from his autism. He sobbed for several days to his parents about a traumatic separation he had had from them at the age of 2 when his mother had been rushed to hospital. A few months later, after an increase to five-times-weekly sessions, he told me excitedly but coherently that he had been down a deep well and someone had thrown down a long, long, long stocking and pulled him and all his loved ones out. One by one they had all gone 'flying over to the other side of the street' He normally spoke in tiny little wisps of phrases – listless utterances that he seemed to feel had no importance, and that were all too easy to ignore or forget. But here Robbie came verbally, musically, and dramatically to life as his voice rose and fell with the story of the characters' rescue and flight.

The implication seemed to be of some sort of lifeline, and the <u>length</u> of the rope corresponded exactly to my feeling that my emotional reach had had to be long because Robbie was a long way off and he had been there a long time.(he was now 13). I had spoken more loudly, with more emotional urgency and had unconsciously placed my face so that it caught his gaze; all in all, I was demanding his attention in what seemed to me at the time an unusually active manner, and to my surprise, I got it. Later, I had, of course, also increased his sessions from once-monthly to

five times weekly. I believe that Robbie needed to be recalled both to himself and to the human family and that the process did seem to involve a kind of awakening from autism or life-long dissociation – or both. I originally thought of Robbie's psychic near-death as a kind of withdrawal, but I came to think it was closer to a despairing giving up than a defensive cutting-off. In any case, the chronicity of any condition needs to be carefully distinguished from the original defensive use of it, or, for that matter, from the deficit that may have started it off. And analytic technique can take account of this.

Reid has pointed out (1989) that one would not want to advocate such a technique with the shell-type autistic child, with whom we must not be intrusive. For that matter, it would have been counter-productive with Robbie at later stages when he exploited his passivity often simply because it was comfortable to leave the work of feeling and thinking to everyone else. . However, I continued to have to do much work on myself to provide a tauter, tighter, less slack ongoing attention. Work in the casualty department of my mind had to be replaced by work in its intensive care ward – until, that is, Robbie began to discover his own motivation for relationship

There is a second type of intensified use of the counter-transference – which is different from the desperate urgency I felt with Robbie when I felt he had nearly died psychologically. It sometimes arises where there is feeling of empty boredom and meaninglessness in the countertransference.Here one may have to help the patient to get a move on, as it were. Or in another situation of a third type,there may be a feeling of vast impatience, if not outrage, with the perversely repetitive nature of sado-masochistic activity.

Conclusion

Psychoanalysis has spent decades studying processes of projection. Attention is beginning to be paid also to patients' introjective processes. (Williams, 1997) (Feldman 2004) I have tried to identify moments when it was useful for the therapist to slow down the work to a more purely descriptive level, in order to try to offer understanding which manages to `hold time as a vase holds water'.I have also suggested that with certain autistic, despairing/apathetic, or fragmented children, we may have to descend to another, even more prior, level of work which involves the containment and intensified transformation and vitalization of internal objects perceived as useless and unvalued (not devalued), weak, or too easily excited by perversion,. It is not easy to strike a balance between being too intense and therefore intrusive, and being experienced as too remote or too weak. Yet, as I said in the introduction, long before certain patients process their hatred and find their capacity for love, they may have to develop the ability to be interested in an object with some substantiality and life. Something and someone has to matter. This is work at the very foundation of human relatedness. That is, although we must draw attention to their lack of interest, we may sometimes also have to find ways of attracting their attention, and then find out how to keep it. Once this is achieved, the work can move to higher levels, sometimes in the course of a single session. What I am certain of , however, is that our work with very disturbed or developmentally impaired children needs to be not only psychoanalytically, but also developmentally and psychopathologically informed. This paper is an attempt to calibrate some of these thoughts into a hierarchy of priorities.

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