אנליזות בהתנדבות בגני תקשורת

שנת הלמודים הנוכחית (2014-2015) היתה השנה הראשונה להתנסות של המכון בקשר של עבודה עם הגנים התקשורתיים לילדים על הספקטרום האוטיסטי ברמת-חן.

ביזמתה של **ארנונה זהבי**, חברת המכון ומנהלת המערך הטיפולי בגני התקשורת הללו מטעם העמותה לילדים בסיכון, נוצר קשר עם המכון. בתמיכת ועדת הכשרה החל הפילוט הראשון **וחני גרינברג,** (המתמחה במסלול ההכשרה לאנליזה לילדים) מעבירה אנליזה בהתנדבות לילד בגן זה תמורת הדרכה. העלות של ההדרכה משולמת על ידי העמותה לילדים בסיכון, שמפעילה את המערך הטיפולי בגנים.

האנליזה מתקיימת בגן של הילד (הגנים פזורים בדרום תל אביב, בעיקר על גבול רמת גן אבל גם במערב), והיא יכולה להיות 3 או 4 פעמים בשבוע, על פי העדפת המטפל. האנליזה מתחילה בתחילת שנת הלימודים (רצוי כבר מספטמבר), והמטפל מתחייב לאנליזה של שנה (באופן שמותאם לדרישות ההכשרה במכון לגבי אורך מינימלי של אנליזה של ילד), כאשר רצוי מאד שהאנליזה תמשיך לפחות לעוד שנה. הטיפולים בגנים מתקיימים לכל אורך השנה, פרט לימי חג, שכן גני התקשורת עובדים גם בחופשות של משרד החינוך שאינם חגים.

מהתבוננות בתהליך השנה נראה שחני גרינברג תורמת לא רק להתפתחות המרגשת של הילד עצמו, אלא גם להתפתחות של הצוות כולו, כך שהתרומה של עריכת פסיכואנליזה בתוך הגנים מתבטאת גם במעגלים רחבים שנוגעים לעומק בעבודה המערכתית והאישית של צוות רחב.

להלן מאמר של אן אלוורז המרחיב את נושא האנליזה בילדים עם קשיי תקשורת:

Levels of Analytic Work and Levels of Pathology: The Work of Calibration

Anne Alvarez

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This paper identifies three points on a continuum of levels of analytic work and levels of meaning. The thinking arose out of many years of work with autistic and borderline children, who were not able, for reasons of profound ego impairment, to respond to the more traditional explanatoryinterpretation as a method of ascribing meaning. Their capacity for introjection was limited. The author suggests that a prior level — lending meaning via description or amplification — is more effective in helping them to think. The paper argues that this second method, where appropriate to the patient's developmental and psychopathological level, need not be seen as inferior to or less complete than the former type. A third, more intensified level of work — an urgent insistence on meaning — is illustrated with a patient where the deficit was not only in the ego, but in the selfand the internal object. The suggestion is that the issue at this third level — with emptied out patients -concerns, not thinking about feeling, nor even identifying feeling, but gaining access to feeling itself. The paper involves an attempt both to elaborate certain of the author's earlier ideas ontechnique and to consolidate these into a wider schema of priorities.

Introduction

There has been much discussion in recent decades about the relative importance, with borderline or very damaged patients, of two different levels of work, that is, of insight versus other more primary levels of understanding. In the present paper, I am suggesting 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 or despairing apathy.

Discussions of the first two levels have been couched in a variety of terms: some concern 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**; **Feldman, 2004**; **Joseph, 1978**; **Steiner, 1994**). Other versions

discuss insight versus mentalization **(Fonagy and Target, 1998)** and 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' (**Sander, 2002**; **Stern *et al.*, 1998**). Schore emphasized the need for a "conversation between limbic systems" in patient and therapist in the more severe levels of pathology (Schore, **2003**, p. 147). Botella and Botella describe the need for the analyst to carry out the "work of figurability" with patients whose memory traces are not representational but more like "amnesic traces" (**2005**, p. xix). More recently, **Tuch (2007)** has discussed how to facilitate the reflective function with pre-interpretive work. Child psychotherapists **Lanyado and Horne (2006)** have explored a variety of ways of working in the transitional area with extremely damaged and acting-out child and adolescent patients, and **Blake (2008)** has illustrated the importance of humour in relieving impasses with aggressive deprived adolescents.

Roth (2001) identified four levels of transference interpretation ranging from comments about the meaning of relationships in the external world to enactments in the here-and-now of the analytic relationships. She suggests that, while the latter level is at the epicentre of the analysis, the analyst has to be willing to follow the patient over quite a broad landscape of her experience in order to give a richer, more complete picture of her world. Roth does, however, comment on her patient's capacity to own some guilt at a point when she is making a particularly strong interpretation — which suggests that, at least at this point, she considers that the choice of level depends on the patient's capacity to hear something — but the main thrust of her argument is the usefulness and enrichment provided by working at all levels — all of which Roth seems to suggest can provide insight. Most of the previous authors' primary concern, however, seems to be to identify the conditions under which insight-giving interpretations are inappropriate and something else is required first.

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 have not yet built the house, you cannot 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. Both A.M. Sandler (**1996**, p. 281) and Hurry (**1998**, p. 34) have gone further than Anna Freud, by maintaining that the distinction between developmental therapy and psychoanalytic work is anyway a false one. Here I will be stressing that the analytic work needs to be both developmentally and psychopathologically informed and therefore needs to take account of the patient's capacity for introjection.

Rocha Barros (2002) introduced the notion of a continuum when he pointed out that *steps toward* thinkability may be provided by affective pictograms indreams. He claimed that, at the earlier stages of their appearance, such visual and dramatized images are not yet thought processes, but may contain powerful expressive and evocative elements which lie under

neath unconscious phantasies (p. 1087). He does not say whether the analyst should respond to such early steps with a different sort of interpretation: he does, say, however, that they may thus lead towards the transmutation and working through which then leads further on to symbolic function and verbal understanding. **Moore (2004)** has demonstrated the tendency, in traumatized children, to create drawings which take the form of, not representations, but re-presentations which are not genuinely symbolic. With psychotherapy, the children's drawings tended to become freer and more genuinely representational. She has likened this change to Hartmann's observations on the development, in traumatized adults, from night terrors in stage 4 sleep toward the REM dreams which signal that some degree of processing and digestion of the trauma has taken — and is taking — place **(Hartmann, 1984)**.

Like Rocha-Barros and Moore, I also offer the idea of a continuum, but one which considers how to find the level of intervention appropriate to the level of disturbance and/or of ego development (and object development) in the patient. This will imply attention to his capacity for introjection. Rocha Barros offers the medium of dreams as a model for a particular step with his adult patients, whereas here I am considering how to make contact with the different levels of mental/emotional development in the child or adolescent patient during play or in the conversation between patient and therapist in ways that make sense to — and reach — the patient. How the therapist verbalizes and expresses his understanding, and processes his possibly very disturbing countertransference feelings, may facilitate or hinder moves towards symbolization. In the case of the patients described below, it is sometimes a question of steps towards 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 towards' or add another, such as 'taking in' rather than working through.

Questions of introjection, internalization and identification are at issue. Klein wrote:

> There is no doubt that if the infant was actually exposed to very unfavourable conditions, the retrospective establishment of a good object cannot undo bad early experiences. However, the introjection of the analyst as a good object, if not based on idealization, has, to some extent, the effect of providing an internal good object where it has been largely lacking.

(Klein, **1957** p. 90)

We now understand from Bion, the developmentalists and the neuroscientists that the capacity to think, and therefore to take in interpretations, involves both cognitive and emotional functions, or, as Urwin puts it, cognitive/emotional functions (**Bion, 1962**; **Panksepp, 1998**; **Schore, 1994**; **Trevarthen, 2001**; **Urwin, 1987**). It depends in part on the level of ego, self and object development already achieved, but also on the level of emotional disturbance at any particular moment: when the disturbance is high, it can interfere with an already developed ego and symbolic function.

I was pushed to think about technical issues when treating Robbie, a boy with severe autism, who was extremely difficult to reach in the early years of his treatment. (For a fuller discussion of the uses of psychoanalytic psychotherapy in autism, see Alvarez and Reid's **(1999)** description of an approach which aims to make contact with, and to develop, the non-autistic, but usually developmentally delayed, part of the personality.) I had seen Robbie on a non-intensive and quite interrupted basis from age 7 on, but it was only at age 13 that he came into five-times weekly treatment. By 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, 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 feet tall charging toward me with his arm

stretched out toward me, 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*. ... Care must invariably be taken with *ether* and other *volatile, readily inflammable liquids* that *no flame is burning in the neighbourhood*. 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.
>
> (Levi, **2001**, p. 75)

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 and aptly. 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, and what really caused your lateness' (a rather wordy explanatory 'why?-because' and 'who?-you' interpretation). He stayed inflamed and kept coming. A few months later I shortened it — I simply said, sympathetically: 'You are very upset today'. 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 seem to help him to pause and think. **Steinberg (1999)**, who had worked with Bryce **Boyers (1989)**, said that the staff on an in-patient unit had learned never to say the word 'You' to a person in a paranoid psychotic state! The simple word 'You' can sometimes flood or seem to accuse an already overwhelmed person, whereas the 'it' can permit necessary perspective.

The patient then can take as much or as little into himself as he can bear. In either case, *what* is being felt may have to, at certain moments, have to take precedence over *why* it is being felt.

I would suggest 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)**. In Kleinian language, we might want to consider the difference between an attempt at 'overcoming' such a deficit, and one attempting to defend against it **(Klein, 1937)**.

Here, however, I want to add another dimension to the deficit issue by stressing the existence, in some patients, of a deficit in the internal object. This concerns objects experienced as uninteresting, unvalued (not devalued), useless and possibly mindless. Some years ago I suggested that an intensified level of intervention — termed 'reclamation' — responding to a countertransference sense of desperate urgency — might be needed with patients such as Robbie in imminent danger of something like psychic death (Alvarez, **1980**, **1992**, **1999**). As described above, the later and very different, experience — with a very much alive and almost psychotically frenzied Robbie — led me to wonder about the conditions under which he — and others like him in these differing states — could hear my attempts to reach them.

I suggest, therefore, that historical and chronological developments in theory and technique from Freud and Klein through to Bion, and then on to autismspecialists, 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. Schafer pointed out that the use of a hermeneutic model need carry no implication of "mindless relativism" (Schafer, **1999**, p. 347). And there is certainly no implication that the analysts or therapists quoted herein advocated only one level of work. I am citing particular papers of theirs which have opened the way to extending technique. Furthermore, there is no implication that analytic work can be neatly divided into these three levels. There are many points on the continuum between each of the three, but nevertheless, they might be considered to involve recognizable steps from the foundation up, as it were, on the way to higher symbolic functioning. First, that is, 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.

I shall now introduce the three points on the continuum from the top down.

1. Explanatory Level: Offering Alternative Meanings

Freud (1893-95) 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 paralysed is due to your unconscious guilt about your hostility to your dying father when you were nursing him.) This is a 'why?-because' interpretation. **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. **Bion (1962)** made the link between projective identification andcountertransference: 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 (Bion, **1962**, **1965**).

2. Descriptive Level: Ascribing or Amplifying Meaning

Bion (1962) 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. **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 identifiedprocesses 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 for' 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-tracked thinking without pushing more demanding and possibly incomprehensible two-tracked ideas

upon him. I am suggesting that such a level of work is better defined in terms of what it is, rather than what it is not.

3. Intensified Level: Insistence on Meaning

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 housemetaphor, 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 adefence against the abrupt loss of the mother's love due to her own bereavement or loss (Green, **1997**, pp. 150-1). 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 countertransference 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 (Alvarez, **1980**, **1992**). I later clarified that this technique seemed to be relevant only in cases of a particular sub-type of autism or deprivation where there is severe deficit in the sense of self*and of object* **(Alvarez, 1999)**. Such work may involve waking the patient to mindfulness and meaning — or, in Bion's terms, at the very least, offering realizations to barely

experienced preconceptions **(Bion, 1962)**. Where realizations have failed, preconceptions may have faded or even atrophied. (I am writing here of work with children and adolescents, but **Pierazzoli (2002)**, **McLean (2003)** and **Director (2009)** have suggested that the activity of reclamation may also be relevant to work with certain chronically schizoid cut-off adults. Child psychotherapists have also made use of the concept (Hamilton, **2001**, p. xv; Edwards, **2001**, p. 156; Music,**2009**, p. 149). And **Nesic (2005)** has suggested that work with Asperger's patients involves a process of constant mini-reclamations. **Reid (1988)** 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. She would only use this method with certain autistic patients similar to Robbie and only at certain moments.

It would, by the way, be essential to distinguish a despairing passive patient with a dead internal object from the sort of patient described by **Joseph (1975)** who projects interest and concern into the object who is then pressured to carry liveliness and a capacity for activity that the patient appears to lack. (See an example of a situation where both situations applied with a schizoid borderline patient [Alvarez, **1992**, p. 88]). It would also be essential to disentangle elements of the near atrophy found in something like a psychic desert from those involved in the ‘psychic retreat’ described by **Steiner (1993)**. A psychic desert in infancy may gather defensive or addictive motives during the development to adulthood, and these motives would certainly need analytic attention. However, so also would the accompanying or underlying deficit where the object, rather than being avoided, is hardly found, due to its remoteness or weakness. In such states of mind, the patient is not hiding, he is lost. A retreat offers, at the very least, a place to go; a desert offers nothing.

Elaboration of the Conditions for Work at the Three Levels

1. Explanatory Interpretations: A Necessary Precondition

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 preconditions are clear: some capacity to tolerate anxiety and pain and to bearthinking — 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. (Early on, at the first stage, they shut their eyes while sucking; at the second stage, they begin to be able to alternate sucking with looking; at the third, they ‘soft-pedal’ the sucking, by engaging in non-nutritive sucking while they look at something. [One imagines, though he does not say this, that this something is likely to be the mother's face.]) Bruner (**1968**, pp. 18-24, 52) calls this third stage “placeholding”

(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'. **Bion (1950)** described the psychotic patient's difficulty with binocular vision, and**Segal (1957)** suggested the importance of depressive position development in the achievement of symbolic functioning — a kind of thinking and feeling in parentheses on a deep emotional level, where love and hate are no longer separated but integrated, yet not blurred or confused. 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, in danger ofsymbolic equations and massive splitting and projection. We may risk producing premature integrations when we try to leap-frog their urgent, imperative, single-minded states.

Bruner does not discuss the conditions under which the sense of a reserve may be facilitated or hindered, but psychoanalysts have suggested that the emotionality involved in the move from two-person to three-person (oedipal) relationships may

also play a major part in the development of this type of deep numeracy (**Britton, 1989**; Klein, **1932**, pp. 183-4). Beverley **Mack (1997)** has suggested the following example of a baby learning to think in parentheses. In one observation, this (1 year and 1 week old) baby, Alice, was eagerly watching her brother play in the sitting-room. At one point Alice reached for her cup of milk behind her, and, without looking back, found the exact spot where she had left it some minutes before. On another occasion, the mother helped Alice find a lost toy exactly at a moment when the mother appeared to be — and continued to be — wholly engaged in a lively conversation with her husband. We saw many instances of this, and speculated whether the mother's capacity to keep her baby in the back of her mind, even when not in the foreground, was helping Alice to do the same with her own valued objects; both could manage a type of thinking in parentheses. It seems likely that this capacity to register two different versions of the object — sometimes both positive — i.e. she can be near but also further away while yet present, or she is suckable but also seeable, or she is talking to him but also noticing me, or she waits for me in the background while I talk to him — plays a part in the development of symbol formation and may be an important precursor of the depressive positioncapacity to hold together two far more different and opposed thoughts/feelings (love and hate or love and loss) together.

Yet many children are too ill or too learning disabled due to autism 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. Many learning disabled patients can be found to have something like an underlying ‘wondering disability'.

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. Glover long ago pointed out that: “A transference interpretation of phantasy is incomplete”, and that “as a general rule our next transference- interpretation will be concerned withtransference-indications of defence” (**1928a**, p. **18**). But he also advocated careful regulation and dosage of interpretation with borderline patients and warned against the dangers of premature interpretations with them (Glover, **1928b**, p. **213**).

2. Descriptive Level: Simple Lending or Amplification of Meaning

Bion described two stages in the development of the capacity to think: firstly, a preconception had to meet with a realization for a conception to be born, and secondly, a conception had to meet with frustration for a thought to be born. Interestingly, he neglected to say much at all about the first stage. He seemed much more interested in the second: he thought that real learning depended on the choice between techniques for evasion and techniques for modification of frustration (Bion,**1962**, p. 29) and 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**, pp. 150-1), 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 beingunderstood may *feel right*, without implying a simple adaptation or gratification model; indeed, such experiences 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 ideas concerning the containing of projective identifications over time and the avoidance of premature return of the projected **(Joseph, 1978)**, of **Steiner (1994)** on the importance of analyst-centred interpretations, 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.

Two of Schore's recommendations on technique with borderline patients are relevant here:

> the recognition and identification of unconscious affects that were never developmentally interactively regulated nor internally represented; and an approach that not only identifies discrete, automatic, facially and prosodically expressed affects, but one that also attends to the intensity, and especially the duration and lability of emotional states.
>
> (Schore, **2003** p. 280)

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, **1985**, pp. **53-60**). 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. It is a question whether we should think of descriptive or amplifying interpretations as partial, incomplete (Glover, **1928a**, p. **18**) and simply preparatory for the real thing, or whether we should think of a more complete experience as taking place at such moments. Is it necessarily a partial experience when something feels right?

A most helpful tool for working in this area is Bion's **(1962)** concept of 'alpha function' — the function of the mind that makes thoughts thinkable and lends meaning to experience. 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. Then the patient can choose whether to let it be his experience, owned by himself, or not. Naming and describing experience, I believe, has to have priority over locating it. **Hopkins (1996)** outlines Winnicott's views on the importance of simple naming via play: he supervised her work with a 3 yearold child with no speech or attachment, or capacity to play. This level of work is important for psychotic patients emerging from states of severe dissociation and needing simply to identify and verify an emotional state well before they are able to acknowledge it as their own; it is also important with some traumatized or deprived patients who have little structuring of their emotional brain/ mind. **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. I am speaking mostly here of patients such as borderline or autistic or psychotic, but in fact some verbally precocious people may also need much slowing down to attend to their actual experience. One adolescent, seemingly very keen to understand her difficulties, could say: 'I was very irritated with Matthew, and I know it is because I was jealous when he talked too long to that attractive girl last night.' I had to learn, however, not to be misled by the apparent insight, and sometimes simply to ask what she meant by 'jealous'. She needed help to slow down and examine her own experience, rather than to rush to swallow my interpretations whole and then feed me her rather undigested understanding.

Descriptive Lending of Meaning Continued:

(b) An example of containment of projective identification Bion's concept of projective identification as a communication described situations

where the mother contains and transforms the projections of the infant in ways which make the unbearable bearable (Bion, **1962**, **1965**). He compared this to thecontaining function of the analyst, and there are many instances of this in clinical work where the patient is able to explore an unbearable experience via someone else. **Joseph (1978)** has drawn attention to the need for analysts to contain such often very powerful experiences within themselves, sometimes for long periods, without returning the projection to the patient; and **Steiner (1994)** has distinguished between analyst-centred and patient-centred interpretations.
In child work such containment may occur through the therapist's willingness to enact (for a time), via the play, the part of the child's unwanted self. **Freud (1911)** and **Bion (1962)** have stressed the importance of frustration in the learning process, but in certain cases it seems to be the freedom *from* frustration which promotes thinking -the opportunity to explore the experience in someone else who can feel it deeply and also think about it. **Kleitman (1963)** has shown that wakefulness from choice, states of lively curiosity, occur in newborn infants after a feed and a defecation, when the baby is comfortable, and not, as previously thought, when the baby is driven by hunger and discomfort.

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 sellotape 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* theidentity 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, countertransference 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 (1982)**described the way in which justice and even revenge phantasies could lead to the 'rectification' of a lifelong feeling of bitterness. 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 precedeempathy 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 projectiveidentification: 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 retraumatized 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 as described by **Freud (1917)** — involving only a piecemeal step at a time. Robert Hughes (**2004**, p. 10), 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." 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 an even more primary level 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. With an older patient, something like a 'how horrible' might offer some needed alpha function, assuming that the therapist had truly been able to imagine himself into the situation.

One obvious caveat: it is clear that the therapist needs to sense when the patient is able to take in higher levels of interpretation — that is, when he is sufficiently emotionally calm or intellectually able really to want to understand why and who questions. (We see such curiosity increasing in leaps and bounds in Little Hans and it is helpful to consider Pine's injunction about "striking when the iron is cold" with borderline patients (**Freud, 1909**; Pine, **1985**, p. 153). **Steiner (1994)** has pointed out that the same patient at a better moment may be able to own the feeling and many fragmented child patients gradually begin to alternate between fragmented and more integrated states.

Steiner (**1994**, p. 421) points out that, in any case, it is not a simple question of an either/or dichotomy between containing the projection versus returning it. Clearly, tone of voice and grammar can convey different levels of receptivity on a continuum of levels of receptivity to projective identification. (And, of course, the tone of voice accompanies the grammar; this is not a mere question of words.) A 'You want me to feel …' is very different from a 'You feel I should feel …'; both

are different from ‘I think I should feel …’, and all three are different from Searles's open confession of his jealousy about his borderline and schizophrenic patients' relationship with idealized figures, parts of themselves, or even with their hallucinations (Searles, **1961**, p. 438)! Such calibration of degrees of receptivity may be closely correlated with the degree to which the patient has experienced himself as previously projected into and the consequent need to make use of projectiveidentification, not as a defence, but as a necessary communication **(Bion, 1962)**. Moving to the other end of this particular spectrum, how long, we must ascertain, should we go on playing the part of the victim that the abused child once was and for a while needs us to be, and when should we start showing the resistance he was unable to muster?

3. Intensified Levels of Work: Reclamation and Getting the Right Band of Intensity

(a) 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 whom Tustin (**1981**, pp. 23-30) described as of the “shell-type” and Wing termed ‘aloof’ **(Wing and Attwood, 1987)**. Robbie seemed more undrawn than withdrawn, more lost than hiding. I gradually came to the conclusion that his passivity was not the result of a defensive retreat: he had given up rather than turned away. Nor was it the result of a massive projection of parts of his ego into the object: his internal object seemed as emptied out as he was.

He eventually termed it ‘a net with a hole in it’ — not a very human, containing, nor, for that matter, attractive or interesting object. Receptive containment of a toopassive nature seemed not to be helping him, and in any case I believe his capacity for projection was very weak. 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 countertransference 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 longlost 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 break-out 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 with great excitement but quite 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. **Edwards (2006)** has pointed out that, for Robbie, not only his self, but his internal objects too, were coming to life at this moment.

The implication seemed to be of some sort of lifeline, and the *length* 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. (It is possible that an autistic constitutional weakness was accompanied by a dissociation triggered by his sudden separation from his parents under frightening conditions.) I originally thought of his near psychic 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 (1989) has pointed out 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. We talked a lot about the difference between his misuse of help and his genuine need for help in the early days. This intensified technique would of course not be necessary with a patient who had sufficient ego, sense of self and interest in life to struggle with his habit of withdrawal. It is interesting that my emergency rescue operation did not need to be repeated after that rather dramatic day, his subsequent breakdown, and the change to intensive treatment. What I learned from it, however, was that I had 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. An almost hypervigilant attention is required with some autistic patients if contact is to be maintained — until, that is, they discover their own motivation for relationship. In fact, infant observation and research suggests that certain babies do require a firmer pull on the lifeline of contact than others (Brazelton and Nugent, **1995**, pp. 65, 66, 73). Certainly, it was also important to take note of, and to interpret, the consequences when I slackened. Robbie later, when he had more language, described an image of two boats slowly drifting further and further apart. One day he also told me that, long ago, his uncle had helped him out of a deep freeze, where he had been stuck and 'left to be dead forever and ever with no eyes, no ears, no mouth, and no penis'. He demonstrated what it had been like to struggle out of the ice, with his legs moving terribly slowly at first. It seemed to me a vivid illustration of the difficulties of overcoming chronicity, and is a reminder of the *practice* it takes, once the patient is more alive, to stay alive. Robbie became much better at catching himself drifting off or, for that matter, sinking.

Greenspan (1997) has discussed technique in managing extremely disordered (very high or low) levels of arousal in certain patients, many of whom, but not all, are autistic. Greenspan's ideas on how to down-regulate over-aroused patients would probably accord with the Bick model of containment (different from Bion's — to do with fostering integration, in the sense of a coherent sense of self and the object world, and even offering soothing to frantically hyperactive agitated children)**(Miller, 1984)**. But Greenspan also suggests that, for under-aroused patients, clinicians can create 'a more compelling personal environment', by up-regulating, that is, by, among other things, energizing their voices to reach them. Greenspan's method, which seems to follow from a one-person psychology, may therefore seem a bit thin to those versed in object-relations thinking, and in the whole rich complexity of the inner world with its ebb and flow of projective and introjective

processes, but I suggest that this area of unawakened or unaroused states of mind, were it to take account of the existence of internal objects which may also be dead, unvalued and uninteresting, might require more study of the methods of introducing meaning and significance to — and making emotional contact with — patients in such depleted states.

Conclusion

Psychoanalysis has spent decades studying processes of projection. Attention is beginning to be paid also to patients' introjective processes (**Feldman, 2004**;**Williams, 1997**). 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* of internal objects perceived as useless and unvalued (not devalued). 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 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 autistic children needs to be not only psychoanalytically, but also developmentally and psychopathologically informed. This is an attempt to calibrate some of these thoughts into a hierarchy of priorities.

Translations of Summary

Ebenen der analytischen Arbeit und Ebenen der Pathologie: Die Kalibrierung. Dieser Beitrag identifiziert drei Punkte auf einem Kontinuum verschiedener Ebenen der analytischen Arbeit und verschiedener Bedeutungsebenen. Die Überlegungen wurden in vieljähriger Arbeit mit autistischen und Borderline-Kindern entwickelt, die wegen gravierender Beeinträchtigungen ihres Ichs nicht in der Lage waren, auf die traditionellere explanatorische Deutung als Methode der Bedeutungszuschreibung zu reagieren. Ihre Introjektionsfähigkeit war eingeschränkt. Die Autorin vertritt die Ansicht, daß eine frühere Ebene — die Bedeutung durch Beschreibung oder Erläuterung verleiht — besser geeignet ist, solchen Patienten das Denken zu erleichtern. Sie

argumentiert, daß diese zweite Methode, sofern sie dem Entwicklungs- und Psychopathologieniveau des Patienten angemessen ist, gegenüber der traditionellen Vorgehensweise weder minderwertig noch unvollständig ist. Eine dritte Ebene der intensivierten Arbeit -ein unnachgiebiges Insistieren auf Bedeutung — wird am Beispiel eines Patienten illustriert, dessen 2Defizite nicht allein sein Ich, sondern auch das Selbst und das innere Objekt betrafen. Die Autorin vertritt die These, daß das Problem auf dieser dritten Ebene — mit ausgeleerten Patienten — nicht das Nachdenken über Gefühle oder auch nur die Identifizierung von Gefühlen betrifft, sondern die Schaffung eines Zugangs zum Fühlen an sich. Der Beitrag beinhaltet auch den Versuch, bestimmte frühere technische Überlegungen der Autorin detaillierter auszuführen und sie in ein erweitertes Prioritätenschema einzuarbeiten.

Niveles de trabajo analîtico y niveles de patologia: El trabajo de la calibración. El presente articulo identifica tres puntos en el continuum de los niveles de trabajo psicoanalitico y de los niveles de

significado. Estas ideas surgen a partir de muchos años de trabajo con niños autistas y fronterizos, que no podian, por una profunda incapacidad del yo, responder a las interpretaciones explicativas mâs tradicionales como método de atribuciön de significados. La capacidad de introyecciön de aquellos niños era limitada. La autora sugiere que un nivel previo es mâs eficaz para ayudarlos a pensar: aquel en que se atribuyen significados a través de la descripciön o amplificaciôn. El articulo sostiene que este segundo método, apropiado para el nivel de desarrollo y de psicopatologia del paciente, no debe ser considerado inferior o menos completo que el primero. Se ilustra un tercer nivel de trabajo mâs intensificado, la insistencia urgente en el significado, con un paciente que no solo tenia un déficit del yo, sino también del self y del objeto interno. Se sugiere que el tema de este tercer nivel — con pacientes ‘vacios’ — no está relacionado con pensar en los sentimientos, ni identificar los sentimientos, sino con lograr acceder a los sentimientos mismos. El articulo es un intento de elaborar algunas de las ideas tempranas de la autora sobre técnica, como consolidarlas en un esquema mâs amplio de prioridades.

Niveaux de travail analytique et niveaux de pathologie: Le travail de calibrage. L'auteur de cet article distingue trois points de repères sur un continuum de niveaux relatifs au travail analytique et au sens. Cette conception est issue d'une longue pratique clinique auprès d'enfants autistes et borderline qui, en raison de failles très profondes dans l'organisation du moi, sont incapables de répondre aux interprétations explicatives classiques correspondant à une méthode d'attribution de sens. Leur capacité d'introjection est limitée. L'auteur suggère que pour aider ces

enfants à penser, il est plus pertinent d'opter pour un niveau préalable, en prêtant sens aux choses via leur description ou leur amplification. Selon l'argumentation développée dans cet article, cette deuxième méthode, lorsqu'il s'avère qu'elle est justifiée par le niveau de développement et de pathologie du patient, ne doit pas être considérée comme inférieure ni moins complète que la première. Un troisième niveau de travail plus intensif — avec une insistance particulière sur le sens — est illustré par le cas d'un patient qui présentait à la fois un défaut du côté de l'organisation du moi et un défaut du côté du soi et de I'objet interne. Ce troisième niveau -dans le cas de patients à la coquilel vide — implique non pas de penser l'éprouvé, ni même d'identifier l'éprouvé, mais d'ouvrir l'accès à l'éprouvé en tant que tel. L'auteur tente d'élaborer ses conceptions antérieures au sujet de la technique tout en les ancrant plus solidement dans un schéma de priorités.

Livelli di lavoro analitico e livelli di patologia: L'attività di calibrazione. Questo saggio identifica tre punti su un *continuum* di livelli di lavoro analitico e livelli di significato. L'idea si è sviluppata dopo diversi anni di lavoro con bambini autistici e borderline non in grado, a causa di una profonda compromissione dell'io, di rispondere a una più tradizionale interpretazione esplicativa come metodo di attribuzione del significato. La loro capacità di introiezione era limitata. L'autrice afferma che un livello antecedente — prestare un significato attraverso una descrizione o un ampliamento — sia più efficace per aiutarli a pensare. Il saggio sostiene che questo secondo metodo, ove adeguato al livello evolutivo e psicopatologico del paziente, non deve essere considerato inferiore o meno completo di quello precedente. Viene descritto un terzo, più intenso, livello di lavoro — una pressante insistenza sul significato — con un paziente con un deficit non solo nell'io, ma anche nel sé e nell'oggetto interno. L'implicazione è che — a questo terzo livello, con pazienti cosi deficitari — il fine non è pensare a sentire, e nemmeno identificare la sensazione, bensi avere accesso alla sensazione stessa. Il saggio richiede un tentativo sia di elaborare alcune precedenti idee sulla tecnica dell'autrice, sia di consolidarle in uno schema più ampio di priorità.

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