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The Analyst, Symbolization and Absence in the Analytic Setting (On Changes in Analytic Practice and Analytic Experience)—*In Memory of D. W. Winnicott*

André Green

Tyger! Tyger! burning bright

In the forests of the night

What immortal hand or eye

Dare frame thy fearful symmetry?

W. BLAKE, The Tyger

…… but something

Drives me to this ancient and vague adventure,

Unreasonable, and still I keep on looking

Throughout the afternoon for the other tiger,

The other tiger which is not in this poem.

J. L. BORGES, The Other Tiger

Every analyst knows that an essential condition in a patient's decision to undergo analysis is the unpleasure, the increasing discomfort and ultimately the suffering he experiences. What is true of the individual patient in this connection is equally true of the psychoanalytic group. Despite its appearance of flourishing, psychoanalysis is going through a crisis. It is suffering, so to speak, from a deep malaise. The causes of this malaise are both internal and external. For a long time we have defended ourselves against the internal causes by minimizing their importance. The discomfort to which the external causes subjects us has now forced us to the point where we must attempt to analyse them. It is hoped that, as a psychoanalytic group, we carry within us what we look for in our patients: a desire for change.

Any analysis of the present situation within psychoanalysis must operate on three levels: (1) an analysis of the contradictions between psychoanalysis and the social environment; (2) an analysis of the contradictions at the heart of psychoanalytic institutions (those intermediaries between social reality on the one hand, and psychoanalytic theory and practice on the other; and (3) an analysis of the contradictions at the very heart of psychoanalysis (theory and practice) itself.

We face a difficulty in regard to the interconnectedness of these three levels. To mix them leads to confusion; to separate them leads to splitting. If we were fully satisfied with the current state on the third level alone, we would be inclined to ignore the other two. That this does not always happen is undoubtedly linked with factors operating in the first two levels. However, I shall have to leave for the time being the ambitious aim of articulating the three levels. At present we have enough on our hands to try to examine certain contradictions in psychoanalytic theory and practice which give rise to the malaise previously mentioned. Anna Freud **(1969)**, in her lucid and courageous analysis of 'Difficulties in the Path of psychoanalysis' from various sources, has reminded us that psychoanalysis found the way into the knowledge of Man through the negative experience of neurosis. Nowadays we have the opportunity to learn about ourselves through our own negative experience. Out of our present malaise may emerge both an elaboration and a transformation.

In this paper, devoted to recent changes brought about by psychoanalytic practice and experience, I should like to examine the following three topics:

(1) the role of the analyst, in a wider conception

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(Translated by Kim Lewison and Dr Dinora Pines)

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The accompanying paper by Leo Rangell could only, be included as the last article in this issue, owing to its late arrival.

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of countertransference, including his own imaginative elaboration, (2) the function of the analytic setting and its relation to mental functioning, as shown by the process of symbolization, and (3) the role of narcissism, which opposes and complements that of object relations, as much in theory as in practice.

I. CHANGES IN THE FIELD OF PSYCHOANALYSIS

The appreciation of change: an objective and a subjective view

Since I have chosen to confine myself to recent changes I must regretfully refrain from showing how psychoanalysis has always changed and developed from its very beginnings. This is true of Freud's work itself **(one has only to re-read in chronological order Freud 1904)**, **(1905)**, **(1910b)**, **(1910a)**, **(1912a)**, **(1912b)**, **(1913)**, **(1914)**, **(1915)**, **(1919)**, **(1937a), the sequence of articles from 'Freud's Psychoanalytic Procedure'**, **(1904, to 'Analysis Terminable and Interminable'**, **(1937a)** and of the work of his earliest colleagues. Among the latter Ferenczi (for whom we should certainly reserve a special place) had, in pathetic, contradictory and often clumsy efforts, adumbrated future trends in his later work **(1928)**, **(1929)**, **(1930)**, **(1931)**, **(1933)**. But if insightful change is continuous the perception of it, just as in an analysis, is discontinuous. Frequently (and this is certainly the case today) a conception of change which had been formulated by isolated writers twenty years earlier may become a daily reality for every analyst. Thus a reading of psychoanalytic literature will show that as early as 1949 Balint entitled one of his papers 'Changing Therapeutic Aims and Techniques in Psychoanalysis' **(Balint, 1950)** and that in 1954 Winnicott in 'Metapsychological and Clinical Aspects of Regression in the Psychoanalytic Set-up' formulated the bases of our current understanding of the problem **(Winnicott, 1955)**.

As a first approach, this problem has been looked at from an 'objective' point of view because it makes us study the patient 'in himself' ('*en soi*'), in most cases without taking the analyst into consideration. Khan **(1962)** has drawn up an impressive list of instances which impose new demands on the analytical situation. He includes terms which are now familiar to every analyst and refers to borderline states, schizoid personalities **(Fairbairn, 1940)**, 'as if' personalities **(H. Deutsch, 1942)**, disorders of identity **(Erikson, 1959)**, ego specific defects **(Gitelson, 1958)**, the false personality **(Winnicott, 1956)** and the basic fault **(Balint, 1960)**. The list grows if we also include some French contributions: pregenital structures **(Bouvet, 1956)**, the operative thought of psychosomatic patients **(Marty & de M'Uzan, 1963)** and the anti-analysand **(McDougall, 1972)**. Now the narcissistic personality **(Kernberg, 1970)**, **(1974)**; **(Kohut, 1971)** occupies our attention. The fact that most of the descriptions rediscovered by recent diagnostic enquiries **(Lazar, 1973)** are of such long-standing leads one to wonder whether the present change is due to no more than an increase in the frequency of such cases.

The change formulated twenty years ago has now become established. It is now our task to try to uncover the change which is being foreshadowed today. Rather than to continue with the objective approach I would, at this point, prefer to turn towards the subjective approach. I shall take as a working hypothesis the proposition that the perception of the change which is beginning today is that of *a change within the analyst*. I do not intend to deal with the way in which the analyst may be affected by Society's attitude towards him, nor with the influence exerted upon him by our methods of selection, training or communication. Although all these factors play a part, I will confine myself to the theory and practice which emerges from the analytic situation; i.e. to the view of psychic reality as seen in the analytic situation, to the way that the patient enacts it and makes the analyst experience it. For, all things considered, there is change only to the extent that the analyst is able to understand such change and to report it. This does not necessarily mean that we must deny changes in the patient, but they are subordinated to changes of sensitivity and perception in the analyst himself. Just as the patient's view of external reality is dependent on his vision of his psychic reality, so our picture of *his* psychic reality is controlled by *our* view of our own psychic reality.

It seems to me that analysts are becoming more and more aware of the part they play, as much in their assessment of the patient in the first consultations as in the setting-up of the

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analytic situation and in the development of the analysis. The patient's material is not external to the analyst, as even through the reality of the transference experience the analyst becomes an integral part of the patient's material. The analyst even influences the communication of the patient's material **(Balint, 1962)**; **(Viderman, 1970)**; **(Klauber, 1972)**; **(Giovacchini, 1973)**. Balint **(1962)** said at a congress in 1961: 'Because we analysts belong to different analytical tongues, patients speak differently to us and that is why our languages here are different.' A dialectical relationship is set up between patient and analyst. Inasmuch as the analyst strives to communicate with a patient in his language, the patient in return, if he wishes to be understood, can only reply in the language of the analyst. And the analyst cannot do anything in his effort to communicate, other than to show what he understands, through his own subjective experience, of the effect on him of what the patient tells him. He cannot claim an absolute objectivity in his listening. A Winnicott **(see Winnicott, 1949)** could show us how, confronted by a difficult patient, he has to go through a more or less critical personal experience, homologous or complementary to that of his patient, in order to reach material that had previously been hidden. More and more frequently we see analysts questioning their own reactions to what their patients communicate, using these in their interpretations along with (or in preference to) the analysis of the content of what is communicated, because the patient's aim is directed to the effect of his communication rather than to the transmission of its content. I think that one of the main contradictions which the analyst faces today is the necessity (and the difficulty) of making a body of interpretations (which derive from the work of Freud and of classical analysis) co-exist and harmonize with the clinical experience and the theory of the last twenty years. This problem is aggravated by the fact that the latter do not form a homogenous body of thought. A fundamental change in contemporary analysis comes from what the analyst hears—and perhaps cannot help but hear—which has until now been inaudible. Not that I mean that analysts nowadays have a more highly trained ear than they used to—unfortunately one often finds the reverse—but rather that they hear different things which used not to cross the threshold of audibility.

This hypothesis covers a much vaster field than those views which propose an extension of the notion of countertransference **(P. Heimann, 1950)**; **(Racker, 1968)** in its traditional sense. I agree with Neyraut **(1974)** that countertransference is not limited to the positive or negative affects produced by transference, but includes the whole mental functioning of the analyst as it is influenced, not only by the patient's material, but also by his reading or his discussions with his colleagues. One can even speak of a swing from the transference to the countertransference without which no elaboration of what is transmitted by the patient could take place. This being so, I do not think that I have overstepped the limits which Winnicott **(1960b)** assigns to the countertransference in restricting it to the professional attitude. Furthermore, this enlarged view of the countertransference does not imply an enlarged view of the transference.

This way of seeing things seems to me to be justified by the fact that those difficult cases to which I alluded earlier are precisely those which, at the same time, test the analyst and invoke his countertransference in the strict sense, while also demanding a greater personal contribution from him. I also feel happier in adopting this point of view in that I can claim to speak only for myself. No single analyst can claim to present a complete picture of contemporary analysis as a whole. I hope not to exemplify Balint's remark **(1950)** that the confusion of tongues comes from the side of the analyst, each keeping to his own analytic language. In the multiplicity of dialects born out of the basic language of analysis **(see Laplanche & Pontalis, 1973)** we try to be polyglot, but our efforts are limited.

The debate on indications for psychoanalysis and the hazards of analysability

For over twenty years we have seen the vicissitudes of an endless written and spoken debate between those analysts who want to restrict the scope of classical psychoanalytic technique **(Eissler, 1953)**; **(Fenichel, 1941)**; **(A. Freud, 1954)**; **(Greenson, 1967)**; **(Lampl-de Groot, 1967)**; **(Loewenstein, 1958)**; **(Neyraut, 1974)**; **(Sandler et al, 1973)**;

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[1] No specific references are given for these authors since in each case all their works given in the references are devoted to this problem

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(Zetzel, 1956) and those who support its extension (Balint, Bion, Fairbairn, Giovacchini, Kernberg, Khan, M. Klein, Little, Milner, Modell, Rosenfeld, Searles, Segal, Stone, Winnicott).[1] The former oppose the introduction of distorting parameters, and go so far as to dispute the validity of using the term 'transference' to include all therapeutic reactions, such as in those patients mentioned in the last section **(see the discussion of the problem in Sandler et al., 1973)**; or, if they accept the extended nomenclature of 'transference', call it 'intractable' **(Greenson, 1967)**. The second group of analysts claims to preserve the basic methodology of psychoanalysis (refusal of active manipulation, maintenance of neutrality although of a more benevolent kind, major emphasis on transference, variously interpreted) while adapting to the needs of the patient and opening new avenues of research.

This split is more illusory than it seems. One can no longer validly regard as opposites those cases which are firmly rooted in classical analysis and those where the analyst wades through uncharted swamps. For today many surprises are possible in charted areas: the appearance of a disguised psychotic kernel, unexpected regressions, a difficulty in mobilizing certain deep layers, and the rigidity of character defences. All these features frequently lead to more or less interminable analyses. A recent paper by Limentani **(1972)** touches a sore point: namely, that our prognoses are shaky, as much with regard to our patients as with regard to our candidates. Fairly frequently, clinical material in a paper relies as much on the analysis of candidates as on that of patients. 'Suitable for analysis is not synonymous with analysable.' This reinforces the scepticism of those who think that an evaluation before the setting-up of the analytic situation is illusory. Even the best of us fall into the trap. The definition of objective criteria, the suitability for analysis **(Nacht & Lebovici, 1955)** and the prognosis in borderline cases, for example **(see Kernberg, 1971)**, are interesting but of limited value. Limentani observes that if a second opinion on analysability is taken, the final decision is significantly influenced by the theoretical conceptions, the affinities and the interaction of the second analyst with the patient. It seems difficult to lay down objective and general limits to analysability which do not take into account the degree of experience of the analyst, or his specific gifts, or his theoretical orientation. Any limit will be over-stepped by the interest formed in a patient, perhaps in collusion, but with the wish to embark on a new adventure. Furthermore, one often sees case material in the work of a supporter of the restriction of the field of psychoanalysis, which contradicts the very principles he propounds. Rather than be told what we should or should not do, it would be more profitable to be clear about what we are in fact doing. Because it may well be that, as Winnicott **(1955)** put it, we no longer have any choice. I personally do not think that all patients are analysable, but I prefer to think that the patient about whom I have doubts is not analysable by me. I am aware that our results do not measure up to our ambitions, and that failures are more common than we might hope. However, we cannot, as in medicine or psychiatry, be satisfied with an objective attitude to failure, when it can be reapproached and modified by the patience of the analyst, or by further analysis. We must also ask ourselves about its subjective significance for the patient. Winnicott showed us the need to repeat failures experienced in the external world, and we know the resultant omnipotent triumph felt by the patient, whether or not he gets better after termination or continues unchanged. Perhaps the only failure for which we are responsible is our inability to put the patient in contact with his psychic reality. The limits of analysability can only be those of the analyst, the patient's alter ego. In conclusion I would say that the real problem in the indications for analysis is the evaluation by the analyst of the gap between his capacity for understanding and the material provided by a given patient, as well as gauging the possible effect, across this gap, of what he in return can communicate to the patient (which will be capable of mobilizing the latter's mental functioning in the sense of the

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elaboration within the analytical situation). It is no less serious for the analyst to be mistaken about his own capabilities than about the patient's. In this way, there could be a place for everyone in the analytic family, whether he devotes himself to classical analysis or to extending its scope; or indeed (which is more generally the case) to both.

Revision of the model of neurosis and the implicit model of borderline states

Is the heart of classical analysis, neurosis, therefore untouched? One may well ask. I am not going to deal with the causes of the growing infrequency of neurosis, which has been commented on many times but which would demand a lengthy study. Neurosis, which used to be seen as the domain of the irrational, is now seen rather as a consistent triad of infantile neurosis, adult neurosis and transference neurosis. In neurosis the analysis of the transference dominates. Through the analysis of resistances, its knots disentangle themselves

almost on their own. The analysis of the countertransference may be limited to the acknowledgement of those elements of conflict within the analyst which are unfavourable to the development of the transference. In the extreme the role of the analyst as object is anonymous; another analyst could take his place. Just as the object of the drive is, of all its elements, that which is most easily substitutable, so in practice, as well as in theory, its role remains obscure. The resultant metapsychology reflects an individual with a capacity for unaided development, undoubtedly with the limited help of the object on which he relies, but without losing himself in it or losing the object itself.

Freud's implied model of neurosis is based on perversion (neurosis as negative of perversion). Today one may doubt whether psychoanalysts still hold that view. The implied model of neurosis *and* of perversion is nowadays based on psychosis. This evolution is present in outline even in the last part of Freud's work. As a result, today analysts are more attuned to psychosis rather than perversion, as lying behind neurosis. This is not to say that all neurosis is etched into an underlying psychosis, but that we are less interested in perverse fantasies of neurotics than in psychotic defence mechanisms, which we find here in a discreet form. In fact, we are asked to listen to a double code. That is what led me to say earlier that we hear different things nowadays, things which used to be inaudible. And this is also why some analysts **(Bouvet, 1960)** write that an analysis of a neurosis is not complete until the psychotic layer is reached, even in a superficial way. Nowadays the analyst is less deterred by the presence of a psychotic kernel within a neurosis, provided it appears accessible, than by fixed and rigid defences. That is what makes us question the authenticity of these patients even when strictly neurotic and even in the presence of apparent fluidity. When at last we reach the psychotic core we find what we may well call the patient's private madness, and this may be one reason why interest is now shifting towards borderline states.

From now on I will use the convention of referring to borderline states, not to denote certain clinical phenomena in contrast to others (e.g. false self, problems of identity or the basic fault) but as a generic clinical concept capable of division into a multiplicity of aspects. It might be better to consider them as 'borderline states of analysability'. It may be that borderline states play the same role in modern clinical practice as the 'actual neurosis' played in Freudian theory, with the difference that borderline states are durable organizations capable of evolving in different ways. We know that what characterizes these clinical pictures is the lack of structure and organization—not only when compared with neuroses but also in comparison with psychoses. Here, unlike in neurosis, we can observe the absence of infantile neurosis, the polymorphous character of the so-called adult 'neurosis' in such cases and the haziness of the transference neurosis.

The contemporary scope of analysis oscillates between two extremes. At one end lies social 'normality', of which McDougall **(1972)** has given a striking clinical description, referring to the 'anti-analysand'. She describes the failure to start the analytic process, albeit in an accepted analytic situation. The transference is stillborn, despite the analyst's efforts to help or even to provoke its appearance. The analyst feels caught in the patient's network of mummified objects, paralysed in his activity and unable to stimulate any curiosity in the patient about

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himself. The analyst is in a situation of 'object exclusion'. His attempts at interpretation are treated by the patient as his madness, which soon leads the analyst to decathect his patient and to a state of inertia characterized by an echo response. At the other end are those states which have in common a tendency towards fusional regression and object dependence. There are numerous varieties of this regression, from beatitude to terror and from omnipotence to total impotence. Their intensity varies from overt expression to subtle indications of their presence. We see it, e.g. in an extreme associative release, a haziness of thought, an ill-timed somatic display on the couch, as if the patient were trying to communicate through body language, or even more simply, when the analytic atmosphere becomes heavy and oppressive. Here the presence **(Nacht, 1963)** and the help of the object are essential. What is demanded of the analyst is more than his affective capacity and empathy. It is his mental functions which are demanded, for the patient's structures of meaning have been put out of action. It is here that the countertransference receives its most extensive meaning. The technique of the analysis of neuroses is deductive, that of analysing borderline states inductive; hence its hazardous nature. Whatever the descriptive varieties, the causes invoked and the different techniques advocated, three facts emerge from the works of most of the writers who have described these states: (1) The experiences of primary fusion bear witness to a confusion between subject and object, with a blurring of the limits of the self. (2) The particular mode of symbolization is derived from a dual organization of patient and analyst. (3) There is present the need for structural integration through the object.

Between these two extremes (normality' and fusional regression) there is a multiplicity of defence mechanisms against this regression. I shall regroup these into four fundamental categories. The first two constitute mechanisms of psychic short-circuiting while the last two are basic psychic mechanisms.

1. *Somatic exclusion.* Somatic defence is the polar opposite of conversion. Regression dissociates the conflict from the psychic sphere by restricting it to the soma (and not to the libidinal body) by a separation of the psyche and the soma. This results in an asymbolic formation through a transformation of libidinal into neutralized energy (I use the term in a different sense from Hartmann) which is purely somatic, and sometimes capable of putting the patient's life in danger. I refer here to the work of Marty, de M'Uzan & David **(1963)** and of M.Fain **(1966)**. The ego defends against possible disintegration in a fantasied confrontation which might destroy both the ego itself and the object, by an exclusion which resembles acting out, but is now directed towards the non-libidinal body ego.
2. *Expulsion via action.* Acting out is the external counterpart to psychosomatic acting in. It has the same value in expelling psychic reality. Both the function of transforming reality, and the function of communication contained in action, are overshadowed by its expulsive aim. Significantly, the act takes place in the anticipation of a type of relationship in which object and ego are alternatively consumed.

These two mechanisms have the remarkable effect of creating a psychic blindness. The patient blinds himself to his psychic reality, either to the somatic sources of his drive or to its point of entry into external reality, avoiding the intermediate

processes of elaboration. In both these cases the analyst has the impression of being out of touch with his patient's psychic reality. He must make an imaginative construction of this, either from the depths of the soma or from a nexus of social actions which are over cathected to such a degree that they eclipse the internal world.

3. *Splitting.* The mechanism of (so-called) splitting remains in the psychic sphere. All the other defences described by Kleinian authors (the most accepted being projective and introjective identification, denial, idealization, omnipotence, manic defence, etc.) are secondary to it. The effects of splitting are numerous. They go from a protection of a secret zone of non-contact where the patient is completely alone **(Fairbairn, 1940)**; **(Balint, 1968)** and where his real self is protected **(Winnicott, 1960a)**, **(1963a)** or again which hides part of his bisexuality **(Winnicott, 1971)**, to attacks on linking in his thought processes **(Bion, 1957)**, **(1959)**, **(1970)**; **(Donnet & Green, 1973)** and the projection of the bad part of the self and of the object

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(M. Klein, 1946) with a marked denial of reality. When these mechanisms are used the analyst is in touch with psychic reality, but either he feels cut off from an inaccessible part of it or he sees his interventions crumble, being perceived as a persecutor and intruder.

4. *Decathexis.* I shall deal here with a primary depression, almost in the physical sense of the word, constituted by a radical decathexis on the part of the patient who seeks to attain a state of emptiness and aspires to non-being and nothingness. It is a question of a mechanism which is for me at the same level as splitting, but different from secondary depression with, according to Kleinian authors, its aim of reparation. The analyst feels himself identified here with a space devoid of objects, or finds himself outside it.

These two mechanisms suggest that the patient's fundamental dilemma, over and above all defensive manoeuvres, can be summed up in the alternative: *delusion or death*.

The implicit model of neurosis in the past led us back to castration anxiety. The implicit model of these borderline states leads us back to the contradiction formed by the duality of separation anxiety/intrusion anxiety. Hence the importance of the notion of distance **(Bouvet, 1956)**, **(1958)**. The effect of this double anxiety, which sometimes takes on torturing forms, seems to me to relate essentially not to the problem of the wish (as in neurosis) but to the formation of thought **(Bion, 1957)**. Donnet and I have described **(Donnet & Green, 1973)** what we have called *blank psychosis (psychose blanche)*, i.e. what we consider to be the fundamental psychotic kernel. This is characterized by blocking of thought processes, the inhibition of the functions of representation, and by 'bi-triangulation' where the difference of the sexes which separates two objects disguises the splitting of a single object, whether good or bad. The patient then suffers from the combined effects of a persecutory intrusive object and of depression consequent on loss of the object.

The presence of basic mechanisms belonging to the psychotic lineage and its derivatives is not enough to characterize borderline states. In fact, analysis shows us the superimposition of such mechanisms and their derivatives on the defence mechanisms described by Anna Freud **(1936)**. Many writers point out in different terms the coexistence of the psychotic and neurotic parts of the personality **(Bion, 1957)**; **(Gressot, 1960)**; **(Bergeret, 1970)**; **(Kernberg, 1972)**; **(Little & Flarsheim, 1972)**. This coexistence may be the result of a situation of sterile stalemate between the reality principle and sexual libido on the one hand, and the pleasure principle and aggressive libido, on the other. All pleasurable activity and all response to reality of the self are infiltrated by aggressive components. But, conversely, since all destruction is followed by a form of object recathexis, which is libidinal in the most primitive form, the two aspects of libido (sexuality and aggression) are not well separated. These patients show a great sensitivity to loss but also a possibility of object recovery through a fragile and dangerous substitute object **(Green, 1973)**. This attitude is found in mental functioning through the alteration of linking and unlinking activity. Its consequence for the analyst is the permanent overvaluation or undervaluation both of his function as object and of the degree of development of the analytic process.

Let us pinpoint our observations on *blank psychosis* more precisely. In that psychotic kernel without apparent psychosis, the object relations which a patient shows us are not diadic but triadic; i.e. both the mother and the father are represented in the oedipal structure. However, the profound difference between these latter two objects is neither the distinction between their sexes nor their functions. The differentiation is effected by way of two criteria: the good and the bad on the one hand, and nothingness (or loss) and the dominating presence on the other. On the one side the good is inaccessible, as if out of reach, or never present in a sufficiently durable form. On the other, the bad is always intruding and never disappears, except for a momentary respite. Thus we are dealing with a triangle based on the relationship between the patient and two symmetrically opposed objects which are in fact one entity. Hence the term bi-triangulation. Generally we describe these relations solely in terms of love-hate relationships. This will not do. What we must add is the implication of these relationships for thought processes. In fact, the intrusive presence arouses a delusional feeling

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of influence and inaccessibility to depression. In both cases this has repercussions on thought. Why? Because in both cases it is impossible to constitute absence. The object which is always intrusively present, permanently occupying the personal psychic space, mobilizes a permanent countercathexis in order to combat this break-in, which exhausts the resources of the ego or forces it to get rid of its burden by expulsive projection. Never being absent, it cannot be thought. Conversely, the inaccessible object can never be brought into the personal space, or at least never in a sufficiently durable way. Thus it cannot be based on the model of an imaginary or metaphorical presence. Even if this would be possible for an instant, the bad object would drive the imaginary presence out. And again, if the bad object gave way, the psychic space which can only momentarily be occupied by the good object would find itself completely objectless. This conflict leads to

divine idealization which conceives of an inaccessible good object (the resentment against this non-disposability being actively denied) and to diabolical persecution by the bad object (the attachment which this situation implies being equally denied). The consequence of this situation in the cases with which we are dealing is not manifest psychosis, where mechanisms of projection operate in a wide area, nor open depression where the work of mourning could take place. The final result is paralysis of thought which is expressed in a negative hypochondriasis, particularly with regard to the head, i.e. a feeling of empty-headedness, of a hole in mental activity, inability to concentrate, to remember, etc. The struggle against these feelings can bring in its wake an artificial thought process: ruminations, a kind of pseudo-obsessional compulsive thought, quasi-delirious wanderings, etc. **(Segal, 1972)**. One is tempted to think that these are only the effects of repression. But this is not so. When a neurotic complains of similar phenomena we have good reason to think, when the context allows it, that he is struggling against representations of wishes which have been censored by the superego. When we are dealing with a psychotic, it is we who infer the existence of underlying fantasies. These are not, in my opinion, situated 'behind' the empty space, as in neurotics, but 'after' it, i.e. they are forms of recathexis. What I mean is that primitive drives, barely elaborated, force themselves forward, once again, into the empty space. The position of the analyst in the face of these phenomena is affected by the structure of the patient. The analyst will respond to the empty space with an intense effort of thought in order to try to think that which the patient cannot think, and which would find expression in an effort to achieve imaginal representation on the analyst's part, so that he will not be overtaken by this psychic death. Conversely, faced with secondary projection of a mad kind, he may feel confused, even amazed. The empty space must be filled and the overflow emptied. The search for a balanced exchange is difficult. If one fills the emptiness prematurely through interpretation, one is repeating the intrusion of the bad object. If, on the other hand, one leaves the emptiness as it is, one is repeating the inaccessibility of the good object. If the analyst feels confused or amazed he is no longer in a position to contain the overflow, which then expands without limit. And finally, if one responds to the overflow with verbal overactivity, then even with the best of intentions, one is doing no more than responding with an interpretative talion. The only solution is to give the patient the image of elaboration, situating what he gives us in a space which is neither the empty one nor one filled to overflowing, but a ventilated space, a space which is neither that of 'this is meaningless' nor that of 'this means that' but one of 'this may mean that'. It is the space of potential and of absence for, as Freud was the first to see, it is in the absence of the object that the representation of it is formed, the source of all thought. And I must add that language imposes limits on us here as, clearly, 'wanting to mean' does not simply signify using words, carrying content, but indicates the patient's search to transmit a communication in the most elementary forms, i.e. a hope directed to the object, where the aim is quite undefined. Perhaps this justifies Bion's recommendation **(1970)** that the analyst should attempt to achieve a state without memory or desire, doubtless in order to allow us to be permeated by the patient's state as fully as possible. The goal to strive for is to work with the patient in a double operation: to give a container to his content and a content to his

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container, always keeping in mind, however, the flexibility of boundaries and the multivalency of meanings, at least in the mind of the analyst.

Because analysis was born of the experience of neurosis it has taken the thought of the wish as its starting point. Today we can state that there are only wishes because there are thoughts, using this term in a wide sense which includes the most primitive forms. It is questionable that the attention devoted to thoughts today comes from intellectualization. For the originality of psychoanalytic theory, from Freud's first writings, is the connecting of thoughts with drives. One may even go further and state that a drive is an inchoate form of thought. Between drive and thought there is a whole series of intermediate and diversified chains which Bion has conceptualized in an original way. But it would not be enough simply to conceive of these as hierarchic relationships. Drives, affects, thing and word representations all communicate with one another and influence one another's structure. The unconscious is formed in the same way. But psychic space is contained within limits. Tensions remain tolerable there, and the most irrational fulfilments are successes of the psychic apparatus. To dream while fulfilling a wish is an accomplishment of the psychic apparatus, not only because the dream fulfils the wish, but because the dream itself is a fulfilment of the wish to dream. An analytic session has often been compared to a dream. However, if this comparison is justified, it is because, just as the dream is contained within certain limits (the abolition of the opposite poles of perception and motor activity), the session is also contained by the conditions of the analytic formalities. It is this containment which helps to maintain the specific functioning of the various elements of psychic reality. But all this is true in the classical analysis of neurosis and is subject to revision in difficult cases.

II. CURRENT PROBLEMS ARISING OUT OF THE PARALLEL DEVELOPMENT OF THEORY AND PRACTICE

Mental functioning and the analytic setting

Three tendencies can be distinguished in the parallel development of psychoanalytic theory and practice. For reasons of space I can only give an outline here which, like all outlines, is only relatively accurate, since reality, being more complex, ignores arbitrary limits, and different currents flow into each other.

1. In the first tendency analytic theory fastened on the historical reality of the patient. It uncovered the conflict, the unconscious, the fixations, etc. It moved towards the study of the ego and the mechanisms of defence **(Anna Freud, 1936)**, extended by psychoanalytic studies of the psychology of the ego **(Hartmann, 1951)**. In practice it shows itself in the studies of the transference **(Lagache, 1952)** and resistances in the application of empirically established psychoanalytic rules, without introducing technical innovations.
2. In the second tendency interest moved towards object relations, understood in very different ways by, e.g. Balint **(1950)**, Melanie Klein **(1940)**, **(1946)**, Fairbairn **(1952)**, Bouvet **(1956)**, Modell **(1969)**, Spitz **(1956)**, **(1958)** and Jacobson **(1964)**.

In a parallel movement the idea of the transference neurosis is gradually substituted by the notion of the psychoanalytic process. This is seen as a form of organization, during the analysis, of the internal development of the patient's psychic processes, or as exchanges between patient and analyst **(Bouvet, 1954)**, **(Meltzer, 1967)**; **(Sauguet, 1969)**; **(Diatkine & Simon, 1972)**; **(Sandler et al., 1973)**.

3. In the third tendency we can pinpoint a movement which concentrates on the mental functioning of the patient (Bion and the psychosomatic school of Paris), while in regard to clinical practice questions are asked about the function of the analytic setting **(Winnicott, 1955)**; **(Little, 1958)**; **(Milner, 1968)**; **(Khan, 1962)**, **(1969)**; **(Stone, 1961)**; **(Lewin, 1954)**; **(Bleger, 1967)**; **(Donnet, 1973)**; **(and Giovacchini, 1972a)**. These questions relate to whether the analytic setting (frame) is not a precondition for defining the analytic object and the change which is the aim of the specific use of the analytic setting. The problem is both epistemological and practical.

To clarify things we can say that the analytic situation is the totality of the elements making up the analytic relationship, at the heart of which we can, in the course of time, observe a process whose knots are tied by the transference and the countertransference, due to the establishment and the limits of the analytic setting. **(This definition completes that given by Bleger, 1967)**.

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Let us be more concrete. In a classical analysis the patient, after the surprises of the beginning, ends by assimilating all the elements of a situation which allows the analysis to proceed (regular appointments, fixed length of sessions, the respective positions of couch and armchair, limitation of communication to a verbal level, free association, the ending of the session, regular breaks, means of payment, ect.). Absorbed in the strangeness of what is going on inside him, he forgets the setting and soon allows the development of the transference in order to attach this strangeness to an object. The elements of the setting provide material for interpretation only when there are occasional modifications. As Bleger **(1967)** and others have seen, the setting constitutes a silent, mute base, a constant which allows the variables of the process a certain rein. It is a non-self **(Milner, 1952)** which reveals its existence only by its absence. One could compare it to the body, silent in health, if a better comparison had not been suggested by Winnicott, i.e. that of the facilitating environment.

Our experience has been enriched by the analysis of patients who cannot use the setting as a facilitating environment. It is not only that they fail to make use of it, it is as if somewhere inside them they leave it intact in the non-use they make of it **(Donnet, 1973)**. One is therefore led from the analysis of the content to the analysis of the container, to an analysis of the setting itself. Equivalents can be found at other levels. Winnicott's 'holding' refers to the care of the external object, Bion's 'container' to internal psychic reality. It is no longer enough, even if analysis is considered as a 'two-body psychology', to study object relations. One has also to question oneself about the space in which these relations develop, its limits and its breaks as well as the temporal development in which they evolve, with its continuity and discontinuities.

We can establish two situations. The first is that already mentioned, where the silent setting, as though absent, becomes forgotten. It is at this level that the analysis takes place between persons, and allows us to enter their substructures and the intrapsychic conflicts between processes **(Rangell, 1969)** and even permits an analysis of the part object relations which are contained in a functional whole, to the extent to which the atmosphere of the session remains fluid and the processes remain relatively clear. Interpretation can afford the luxury of subtlety. The interaction of persons pushes the relation with the setting into the background.

The second situation is that in which the setting makes its presence felt. The feeling is that something is happenning which acts against the setting. It is a feeling which can be found in the patient, but is above all present in the analyst. The latter feels the effect of a tension which acts like an internal pressure, which makes him aware of having to act through and within the analytic setting, as if to protect it from a threat. This tension forces him to enter a world which he can only glimpse and which requires efforts of imagination from him. This is the case where the analysis develops not between persons but between objects. It is as if persons have lost their reality and have given way to an ill-defined field of objects. The vivacity of certain representations can suddenly take on a shape emerging from a haze, but at the limits of imagination. It often happens that the analyst has even more ill-defined impressions which take on the shape neither of images nor of memories of earlier phases of the analysis. These impressions seem to reproduce certain drive-trajectories, through the expression of internal movement in the analyst, giving rise to feelings of envelopment and development. Intensive work takes place on these movements, which eventually succeeds in conveying them to the consciousness of the analyst before he can transform them, by an internal mutation, into sequences of words which will be used at the right moment to communicate with the patient by means of verbalization. When the analyst arrives at a sort of internal order, often before the verbalization, the affective disturbance changes to a feeling of satisfaction at having reached a coherent explanation, which plays the part of a theoretical construction (in the sense that Freud used the expression in his description of infantile sexual theories). For the moment it hardly matters whether this theory is true or false—there will always be time to correct it later in the light of further experience. What counts is the fact of having succeeded in binding the inchoate, and in containing it within a form. Everything

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takes place as if it were the analyst who has been able to reach a state analogous to an hallucinatory representation of the wish, as in a child or a neurotic. One frequently talks of a feeling of omnipotence which follows the realization of an hallucinatory wish. But omnipotence begins before that. It is associated with the success which consists in the transformation, through binding of the inchoate into a meaningful form, which can be used as a model for deciphering a situation still to come. However, if it is for the analyst to devote himself to the task of elaboration, it is certainly because the patient himself is only able to achieve a minimal degree of structure, insufficiently bound to make sense, but just enough to mobilize all the analyst's patterns of thought, from the most elementary to the most complex, and to

give effect, albeit provisionally, to symbolization which is always begun and never finished.

The description I have just given can be applied either to certain critical moments in a classical analysis—when the deepest levels are reached—or to a wider comparison with the general a mosphere of the analysis of difficult cases, in contrast to those of classical analysis. But it must be remembered that such work is only possible through the function of the analytic setting and the guarantees given by its constancy, which relays the importance of the presence of the analyst as a person. This is necessary in order to maintain the isolation of the analytic situation, the impossibility of discharge, the closeness of contact which is restricted to the sphere of the psyche, and the certainty that the mad thoughts will not go beyond the four walls of the consulting room. It ensures that the language used as a vehicle for the thoughts will remain metaphorical; that the session will come to an end; that it will be followed by another session and that its weighty truth, truer than reality, will be dissipated once the door shuts behind the patient. Thus, rather than saying that the establishment of the setting reproduces an object relation, I find it more appropriate to say that it is this which allows the birth and development of an object relation. I have centred this description on mental functioning rather than on the expression of the drives and defences which lie at its root, because much has already been said about them, whereas mental functioning is still a vast uncharted area within the analytic setting.

When the theory of object relations was at the beginning of its development we were at first led to describe the interaction of the self and the object in terms of internal processes. Not enough attention was paid to the fact that in the phrase 'object relation' the word 'relation' was the more important. This is to say that our interest should have been directed at what lies between these terms, which are united by actions, or between the effects of the different actions. In other words, the study of relations is that of links rather than that of the terms united by them. It is the nature of the link which confers on the material its truly psychic character which is responsible for intellectual development. This work was postponed until Bion examined the links between internal processes and Winnicott studied the interaction between the internal and the external.

Let us take the latter case first. We only know what goes on inside the patient through what he tells us, while we lack knowledge of the source of the communication and of what is unfolding within these two limits. But we can overcome our ignorance of that internal space by observing the effect which the communication has on us, and what is produced between our affective (indeed bodily) impressions and our mental functioning. Of course we cannot claim that this is what is taking place inside the patient, but only that what happens to us provides an analogue or a homologue. And we displace the knowledge of what is happenning in our own internal space into the space between him and us. The patient's communication—different from what he lives and feels—is situated in the transitional space between him and us, in the same way as our interpretation is carried by communication. Thanks to Winnicott we know the function of the transitional space, of the potential space which unites and separates mother and child, creator of a new category of objects. Language, in my view, is the heir to the first transitional objects.

I alluded earlier to the work of symbolization, and I would now like to explain why the analyst's internal processes have as their goal the construction of symbolization. The notion

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of symbol which I am using here goes beyond the limited meaning which it has in psychoanalysis, but follows its original definition very closely. The symbol is 'an object cut in two, constituting a sign of recognition when those who carry it can assemble the two pieces' (*Dictionnaire Robert*). Is that not what happens in the analytic setting? Nothing in this definition suggests that the two parts of a symbol are equal. Thus even when the work of analysis compels the analyst to make great efforts, which lead him to form a picture in his mind of the patient's mental functioning, he supplies what is missing in the patient. I have said that he replaced the part which is missing in order to understand the relationship between the sources of the communication and its formation, through observing homologous processes in himself. But in the end the real analytic object is neither on the patient's side nor on the analyst's, but in the meeting of these two communications in the potential space which lies between them, limited by the setting which is broken at each separation and reconstituted at each new meeting. If we consider that each party present, the patient and the analyst, is composed of the union of two parts (what they live and what they communicate), one of which is the double of the other (I use the word double in the sense of a wide homologous connection while admitting the existence of differences), one can see that the analytic object is formed of two doubles, one belonging to the patient and the other to the analyst. One has only to listen to patients to realize that they continually refer to it. For, in order to have a formation of an analytic object, an essential condition is the establishment of homologous and complementary relations between the patient and the analyst. What determines our formulation of interpretations is not our appreciation of what we understand or feel. Whether formulated or withheld, it is always based on the measure of the distance between what the analyst is prepared to communicate, and how much of it the patient can receive in order to form the analytic object (what I call useful distance and efficacious difference). From this point of view the analyst does not only unveil a hidden meaning. He constructs a meaning which has never been created before the analytic relationship began **(Viderman, 1970)**. I would say that the analyst forms an absent meaning **(Green, 1974)**. Hope in analysis is founded on the notion of a potential meaning **(Khan, 1974b)** which will allow the present meaning and the absent meaning to meet in the analytic object. But this construction is never free. If it cannot claim objectivity, it can claim a homologous connection with what escapes our understanding either in the present or in the past. It is its own double.

This conception, which evokes the notion of doubles **(Green, 1970)**, **(1974)**, helps us to extricate ourselves from the deaf dialogue between those who believe that regression in treatment is, in its extreme forms, the reproduction of the initial infantile state, and that interpretation is the quasi-objective reproduction of the past (whether it aims at events or internal processes), and those who are sceptical about the possibility of reaching such states or of the objectivity of reconstructions. In fact, regression in treatment is always metaphorical. It is a miniature and modified model of the infantile state, but it is one which still has a homologous relationship to that state, just like interpretation which elucidates its meaning, but which would have no effect if the relationship of correspondence did not exist. It seems to me that the essential function of all these much-decried variants of classical analysis only aim, in varying the elasticity of the analytic setting, at searching for and preserving the minimum conditions for symbolization. Every paper on symbolization in psychotic or

prepsychotic structures says the same thing couched in different terms. The patient equates but does not form symbols (the symbolic equation of H. Segal, 1967). He conceives of the other on the model of himself **(the projective reduplication of Marty et al., 1963)**. This also recalls Kohut's description **(1971)** of mirror transferences. For the patient the analyst does not represent the mother, he *is* himself the mother **(Winnicott, 1955)**. The notion of 'as if' is missing **(Little, 1958)**. We could also invoke the notion of 'direct acting out' **(de M'Uzan, 1968)**. One can conclude from this that it is a question of the inherent shape of the dual relationship. On the other hand we must not forget the stress which has been placed on the lack of differentiation

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between self and object, on the blurring of boundaries to the extent of narcissistic fusion. The paradox is that this situation only rarely leads to a completely chaotic and unformed state, and that figures of duality emerge very quickly from the undifferentiated whole. One can add, to the dual relationships which characterize the interchanges with the object, what I shall call the dual relationship within the self itself, and which one finds in the importance of the mechanisms of double reversal (turning against himself, and reversal to the opposite) which Freud said were present before repression **(Green, 1967b)**. Thus, to the idea of a mirror in the exchanges with the representative of the external object one can couple the idea of an internal mirroring of the self to oneself. All this seems to show that the capacity for reflection is a fundamental 'given' of the human. By this means one can explain the need for the object as an image of the 'similar' **(see Winnicott's article on 'the mirroring role of the mother', 1967)**. For the most part symbolic structures are probably innate. However, we now know, as much through the study of animal communication as through psychological or psychoanalytic research, that they require the intervention of the object in order to move from potential to realization at a given point in time.

Without disputing the truth of clinical descriptions, we must now assess that duality in its context. Verbalization, however disorganized, introduces a distance between the self and the object. But we may already suppose that from the creation of what Winnicott calls the subjective object a very primitive triangulation between the self and the object is sketched out. If we now turn to the object which is the mother, we must admit that a third person is also present. While Winnicott tells us that 'there is no such thing as a baby', alluding to the couple that the baby forms together with maternal care, I am tempted to add that there is no such couple formed by mother and baby, without the father. For the child is the figure of the union between mother and father. The whole problem stems from the fact that, through a concern with reality, even in the boldest imaginative constructions, we seek to understand what goes on in the mind of the patient alone (i.e. with his mother) without thinking of what goes on between them. For between them we find the father who is always somewhere in the mother's unconscious **(Lacan, 1966)**, whether he be hated or banished. It is true that the father is absent from this relationship. But to say that he is absent means that he is neither present nor non-existent but that he has a potential presence. Absence is an intermediary situation between presence (as far as intrusion) and loss (as far as annihilation). Analysts tend more and more to think that when they verbalize experience through communication they are not simply elucidating the latter, but are reintroducing the father's potential presence, not through any explicit reference to him, but through the mere introduction of a third element into the communicative duality.

When we employ the metaphor of the mirror, which Freud was the first to use, and which I admit can be a deforming mirror, we always forget that the formation of the couple of the image and the object depends on the presence of the third object, i.e. the mirror itself. Similarly when we speak of the dual relationship in analysis, we forget that third element represented by the setting, which is its homologue. It is said that the setting represents holding and maternal care. But the 'work of the mirror' itself, so obvious in the analysis of difficult cases, is neglected. One could say that the psychic counterpart of the physical activity of maternal care is alone able, metaphorically, to replace physical activity, which is reduced to silence by the setting. It is only thus that the situation can evolve towards symbolization. The psychic functioning of the analyst has been compared to the fantasy activity of the mother's reverie **(Bion, 1962)** which is undeniably an integral part of holding and maternal care. Faced with the diffuse discharge of the patient which spreads and invades the space, the analyst responds using his capacity for empathy, with a mechanism of elaboration which presupposes the inhibition of the aim of the drive in itself. The effect of lessening the inhibition of aim in the patient prevents that retention of experience which is necessary for the formation of mnemic traces, on which the activity of remembering depends. This is all the more so because the discharge is permeated with destructive

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elements which oppose the construction of links, and whose attacks are directed at the thought processes. Everything happens as if it were the analyst who was moving towards the registration of experience which could not have taken place. From this follows the idea that these patients find themselves more closely caught in current conflicts **(Giovacchini, 1972c)**, **(1973)**. The response by way of countertransference is that which should have taken place on the part of the object.

Drives seek satisfaction by means of the object, but where this is impossible, due to inhibition of aim imposed by the setting, there remains the avenue of elaboration and verbalization. What is it that causes the lack of elaboration in the patient, so that it has to be supplied by the analyst? In normal psychic functioning each of the components used by the psychic apparatus has a specific function and a direction (from drive to verbalization) which allow the formation of correspondent relationships between differing functions (e.g. between the identity of perception and the identity of thought). All psychic functioning is based on a series of connections which relate one element to another. The simplest example is the relationship between a dream and a daydream. More complicated connections can lead one to compare primary and secondary processes. These relationships are not only ones of opposition, but also of collaboration, since if it were otherwise we would never be able to move from one system to another and to translate e.g. manifest content into latent content. But we know that this is only possible through intensive work. The dream work reflects the work of the analysis of the dream. All this implies that these connections can be established on the basis of a functional distinction: that the dream be considered as a dream, that the thought be

considered as a thought, etc. But at the same time a dream is something other than a simple dream, a thought something other than a simple thought, etc. We find again the dual nature of the connection–reunion and/or separation. This is what we call the internal connections of symbolization. They bind the different elements of the same formation (in dreams, fantasies, thoughts, etc.) and of the formations, simultaneously ensuring the continuity and discontinuity of psychic life. In the analytic work, this implies, on the part of the patient, that he take the analyst for what he is, and at the same time for what he is not, as himself and not himself, but being able at the same time to maintain the distinction. It also implies that, conversely, the analyst can have the same attitude towards the patient.

In the structures with which we are dealing it is very difficult to establish the internal connections of symbolization, because the different types are used as 'things' **(Bion, 1962)**, **(1963)**. Dreams, far from constituting an object of psychic reality linked to the body **(Pontalis, 1974)**, and delimiting an internal personal space **(Khan, 1972c)**, have an evacuative function. Fantasies can represent a compulsive activity destined to fill a void **(Winnicott, 1971)** or are considered as facts **(Bion, 1963)**. Affects have a representative function **(Green, 1973)** and actions no longer have the power to transform reality. At best they serve to ensure a communicative function, but more often they relieve the psyche of an intolerable quantity of stimuli. In fact the whole of psychic functioning is impregnated by the model of action which is the consequence of the impossibility of reducing the massive quantity of affects, which have not been able to be influenced by the elaboration of thought, or have only been able to arrive at a caricature of it **(Segal, 1972)**. Bion **(1963)** has made great advances in the study of internal mental functioning. The economic point of view is all the more important here, provided one does not restrict it to quantitative connections and includes the role of the object in its capacity for transformation. It is also the function of the setting to tolerate extreme tensions and to reduce them, through the mental apparatus of the analyst, in order to arrive eventually at those objects of thought capable of occupying the potential space.

Narcissism and object relations

We are now confronted by a third topographic model elaborated from the analytic space in terms of self and object. But while the object belongs to the oldest psychoanalytic tradition, the self, of recent origin, remains an imprecise concept used in very different senses **(Hartmann, 1950)**; **(Jacobson, 1964)**; **(Winnicott, 1960a)**; (Lichtenstein,

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1965). The rebirth of interest in narcissism, after its eclipse by the study of object relations, shows how difficult it is to engage in deep study of this kind without feeling the need for a complementary point of view. From this came the concept of the self. However, any serious discussion of the question must tackle the problem of primary narcissism. Its complete refutation by Balint in favour of primary love has not, despite apparently convincing arguments, prevented other writers from defending its autonomy **(Grunberger, 1971)**; **(Kohut, 1971)**; **(Lichenstein, 1964)**. Rosenfeld **(1971b)** linked it to the death instinct, but subordinated it to object relations. The uncertainty of our opinions on the subject probably goes back to Freud who, having introduced narcissism into his theory, rapidly lost interest in it and turned towards the death instinct, which we know has provoked resistance among some analysts. The Kleinian school, which has adopted Freud's point of view, seems to me to have maintained the confusion, absorbing the death instinct into the aggression which was originally projected on to the object. Even when it is an internal object the agression is directed centrifugally.

The return of narcissism is not limited to explicit references to it. An ever-widening tendency exists towards the desexualization of the analytic field, as if we were returning surreptitiously to a restricted conception of sexuality. On the other hand, we have seen the development of ideas which allude to a central non-libidinal ego **(Fairbairn, 1952)** or to a state of being in which all instinctual qualities are denied (Winnicott and his disciples). In my opinion it is only a question here of problems concerning primary narcissism, as Winnicott none the less saw **(1971)**, without being precise on this point. The fact is that primary narcissism is the subject of contradictory definitions in Freud's work. Sometimes he means that which allows the unification of auto-erotic drives, contributing to the feeling of individual unity, and sometimes he means an original cathexis of the undifferentiated ego, with no reference to unity. Writers rely sometimes on one definition, sometimes on the other. I will base myself on the second. Unlike Kohut, I think that it is indeed the orientation of cathexes which points to the primitive narcissistic nature, whereas the quality of the cathexes (the grandiose self, the mirror transference and the idealization of the object), which eventually encompasses the object in the form of 'self-object', is secondary in sequence. These aspects relate to 'unifying' narcissism and not to primary narcissism in its strict sense.

Lewin **(1954)** has reminded us that in the analytic situation the wish to sleep, i.e. to achieve as full a state of narcissistic regression as possible, dominates the scene, just as it is the ultimate wish in dreams. The narcissism of sleep and the narcissism of dreams are distinct. It is significant that the oral triad which Lewin describes consists of a double relationship (e.g. eat–be eaten) and a tendency towards zero (falling asleep). Winnicott, following his description of the false self (which one can equally see as a double since it deals with the formation on the periphery of the self of the creation of a self-image which conforms to what the mother wishes), comes to the conclusion, in a remarkable article, that the real self is silent and isolated in a state of permanent non-communication. Even the title of his paper is revealing: 'Communicating and Non-Communicating Leading to the Study of Certain Opposites' **(1963a)**. Here again it seems that the construction of opposites is related to a state of non-communication. For Winnicott, this lack of communication is in no way pathological, since it strives to protect that which is most essential to the self, which must never be communicated and which the analyst must learn to respect. But it seems that towards the end of his work Winnicott went even further, beyond the protective space which shelters subjective objects **(see his 1971 addendum to the article on transitional objects)**; **(Winnicott, 1974)**, by formulating these problems more radically: in a way which recognizes the role and importance of emptiness. For example, 'Emptiness is a prerequisite to gather in' and 'It can be said that only out of non-existence can existence start' **(Winnicott, 1974)**. All this invites us to reconsider Freud's metapsychological hypothesis of *primary absolute narcissism* as a tendency to come as close as possible to the zero degree of excitation rather than as a reference to unity. Clinical practice too makes us more and more aware of this, and from a technical point of

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view a writer like Bion—who is nevertheless a Kleinian—recommends to the analyst to attain a state without memory or desire, a state of the unknowable but yet a starting point for all knowledge **(1970)**. This concept of narcissism, although held by a minority of analysts, has been the object of fruitful thinking, but has been centred for most of the time on its positive aspect, which takes as its model the state of satiation that follows satisfaction and allows quietude to be re-established. Its negative counterpart has met much resistance as far as theoretical formulations are concerned. However, the majority of writers have recognized that most defensive manoeuvres of patients with borderline states and psychoses attempt to struggle, not only against the primitive persecutory fears and the associated threat of annihilation, but also against the confrontation with emptiness which is probably the most intolerable of states, feared by patients, and whose scars leave a state of eternal dissatisfaction.

In my experience relapses, outbreaks of aggression and periodic collapses after marked progress all point to a need to maintain a relation with a bad internal object at all costs. As soon as the bad object loses its power there seems to be no other solution than to make it reappear, to proceed to resurrect it in the form of another bad object, which resembles the first like a brother and with which the patient identifies. It is less a question of the indestructibility of the bad object or of the wish to be certain of controlling it in this way, than of the fear that its disappearance will leave the patient confronted by the horrors of emptiness, without any possibility of ever being able to provide a replacement in the shape of a good object, even though this latter would be available. The object is bad, but it is good that it exists even though it does not exist as a good object. The cycle of destruction and reappearance recalls the hydra with its multiple heads, and seems to repeat the model of a theory (in the sense in which the term was used earlier) of the construction of the object which Freud said was knowable in hatred. But this compulsive repetition is due to the fact that here emptiness can only be cathected negatively. The abandonment of the object does not lead to the cathexis of a personal space, but to a tantalizing aspiration towards nothingness which drags the patient to a bottomless pit and eventually to negative hallucinations of himself. This tendency towards nothingness is far more than the aggression which is only one of its consequences. It is the real significance of the death instinct. Maternal deficiency aids it, but does it create it? One may wonder why we need so much care to prevent its appearance. Since something has not been provided by the object, there is no choice other than this flight towards nothingness. It is as if it were a question of finding the state of peace and quietude which follows satisfaction by its opposite, the non-existence of all hope of satisfaction. It is there that we find the solution of despair, when the struggle has been abandoned. Even those writers who emphasize to a large degree the domain of aggression have been forced to recognize its existence **(Stone, 1971)**. We find traces of it in the psychotic kernel (blank psychosis) just as in what has recently been called the 'blank self' **(Giovacchini, 1972b)**.

Thus we must join together the two effects of primary narcissism, i.e. the positive effect which follows regression after satisfaction and the negative effects which constructs a death-like quietus out of emptiness and nothingness.

I have put forward elsewhere a theory of primary narcissism **(Green, 1967b)** as a structure and not simply as a state which, alongside the whole positive aspect of object relations (in the visible, audible sense), be they good or bad, gives way to the negative aspect (in the invisible, silent sense). This negative aspect is formed by the introjection which takes place at the same time as maternal care forms the object relation. This is the relation to the structural framework of that care through the negative hallucination of the mother during her absence. That is the obverse of that which the hallicunatory realization of the wish is one side. The space which is thus delimited, side by side with that of object relations, is a neutral space capable of being fed in part by the space of object relations but distinct from it. It constitutes the basis of identification when relationships aid the continuity of the feeling of existence (forming the personal secret space). On the other hand, it may empty itself by means of the aspirations

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towards non-existence, through the expression of an ideal, a self-sufficiency which is progressively reduced in the direction of self-annihilation **(Green, 1967b)**, **(1969a)**. One must not formulate things simply in terms of space. Radical decathexis also affects time through a frantic capacity to suspend experience (far beyond repression) and to create 'dead times' where no symbolization can take place **(see the 'foreclosure' of Lacan, 1966)**.

The clinical application of this theory can be seen during the course of analysis, and it is this which stimulates the analyst's imagination most of all, whereas an excess of projections often has shock-like effects. But even in the most classical analysis something of it remains. This leads us to reconsider the question of silence in treatment. It is not enough to say that side by side with his communications the patient preserves within him a silent zone. One must add that the analysis develops as though the patient had delegated this silent function to the silence of the analyst. Thus the analysis evolves between the doubles of communication and the zero of silence. However, silence, as we know, can be experienced in certain borderline situations (*situations limites*) as the silence of death. This confronts us with a difficult technical choice. At one extreme is the technique proposed by Balint, which tries to organize experience as little as possible so as to allow it to develop under the benevolent protection of the analyst and his attentive ear, in order to encourage the 'new beginning'. At the other extreme is the Kleinian technique, whose aim is, on the contrary, to organize the experience as much as possible through interpretative verbalization. But is there not a contradiction in maintaining that object relations in the psychotic part of the personality have undergone a premature formation, and in responding to it with interpretations that are in danger of reproducing this same prematurity? Is there not a danger of overfilling the psychic space, when one should be helping to form the positive cathexis of the empty space? What is it that is structured in this way? The skeleton of experience, or its flesh which the patient needs to live? With these reservations I must acknowledge the difficulty of the cases whose treatment the Kleinians undertake and which compel one's respect. Between the two extremes is Winnicott's technique, which gives the setting its appropriate place, and recommends the acceptance of these unformed states and the non-intrusive attitude. He supplements through verbalization the lack of maternal care in order to encourage the emergence of a

relationship to the ego and to the object, until the moment is reached when the analyst can become a transitional object and the analytic space a potential place of play and field of illusion. If I feel in harmony with Winnicott's technique, and if I aspire to it without being able to master it, it is because, despite the risk of fostering dependence, it seems to me to be the only one which gives the notion of absence its rightful place. The dilemma which places in opposition the intrusive presence—which leads to delusion (*délire*)—and the emptiness of negative narcissism which leads to psychic death, is modified by transforming delusion into play, and death into absence, through the creation of the playground of potential space. This requires one to take into account the notion of distance **(Bouvet, 1958)**. Absence is potential presence, a condition for the possibility not only of transitional objects but also of potential objects which are necessary to the formation of thought **(see Bion's 'non-breast', 1963)**, **(1970)**. These objects are neither present nor tangible objects, but objects of relationships. Perhaps analysis only aims at the patient's capacity to be alone (in the presence of the analyst), but in a solitude peopled by play **(Winnicott, 1958)**. We are too rigid or too idealistic if we think that it is a question of transforming primary processes into secondary ones. It would be more accurate to say that it is a question of initiating play between primary and secondary processes by means of processes which I propose to call tertiary **(Green, 1972)** and which have no existence other than that of processes of relationship.

CONCLUDING REMARKS

To conclude does not mean to close the work, but to open the discussion and to leave the floor to others. The solution to the crisis in which psychoanalysis finds itself does not lie within analysis alone. But analysis holds some cards with which its destiny will be played. Its future will depend on the way it finds in which to preserve

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its Freudian heritage while integrating its later acquisitions. For Freud there was no previous knowledge. Undoubtedly it needed his creative genius to invent psychoanalysis. Freud's work has become the basis of our knowledge. But an analyst cannot practise psychoanalysis and keep it alive by applying knowledge. He must attempt to be creative to the limits of his ability. This is perhaps what has made some among us extend the limits of the analysable. It is remarkable that the attempt to analyse these states has resulted in such a flowering of imaginative theories—too many for some, i.e. too many theories and too much imagination. All these theories strive to construct prehistories where there is not even any evidence of a history. Above all, this shows us that we cannot do without a mythical origin, just as a small child must construct theories, even romances, about his birth and infancy. Undoubtedly our role is not to imagine, but to explain and to transform. However, Freud had the courage to write, 'Without metapsychological speculation and theorizing—I had almost said "phantasying"—we shall not get another step forward' **(1937a, p. 225)**. We cannot accept that our theories are fantasies. The best solution would be to accept that they are not the expression of scientific truth but an approximation to it, its analogue. Then there is no harm in constructing a myth of origins, provided we know that it can only be a myth.

In the last twenty years psychoanalytic theory has seen the considerable development of the genetic point of view **(see the discussion in Lebovici & Soulé, 1970)**. Without embarking on a critique of our psychoanalytic concepts of development, of which many seem to me to adopt a non-psychoanalytic notion of time, it seems to me that the time has come to pay more attention to problems of communication, without limiting it to verbal communication, but taking in its most inchoate forms. That is what has led me to stress the role of symbolization, that of the object, of the analytic setting and also that of non-communication. Perhaps this will also allow us to tackle the problem of communication between analysts. Outsiders are frequently amazed that people whose profession is listening to patients are so bad at listening to one another. My hope is that this paper, which shows that we all have similar problems to face, will contribute towards our listening to one another.

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SUMMARY

This paper has been guided by a personal theme while taking into account the psychoanalytic contributions of others.

1. The emphasis placed on the changes within the analyst was designed to show that, as well as changes within the patient, one must also consider the double created by the changes within the analyst, due to his capacity for constructing, by complementarity, in his mental functioning, a figure homologous to that of the patient.

2. The problems of indications for analysis has been approached from the point of view of the gap between the analyst's understanding and the patient's material, and from that of the evaluation of the mobilizing effect of the analyst's communication on the patient's mental functioning, i.e. on the possibility—which varies with each case and with each analyst—of forming an analytic object (a symbol) by the meeting of the two parties.

3. The description of the implicit model of a borderline state by putting splitting (a condition for the formation of a double) and decathexis (as a striving towards the zero state) in the dominant position shows us that borderline states raise the question of the limits of analysability in the dilemma between delusion and death.

4. The attention given to the analytic setting and to mental functioning attempted to structure the conditions necessary for the formation of the analytic object through symbolization, by taking into account the intervention of the third element, which is the setting, in the dual relationship.

5. The place of primary narcissism gives us a point of view which complements the preceding one. In other words, alongside the doubles of communication of object relations is an encapsulated personal space which is a narcissistic domain, positively cathected in the silent self of being, or negatively cathected in the aspiration towards non-being. The dimension of absence, essential to psychic development, finds its place in the potential space between the self and the object.

This paper does not claim to solve the crisis facing psychoanalysis, but only to raise some of the contradictions inherent in a theoretical pluralism and a heterogeneous practice. We have, above all, attempted to formulate an image of psychoanalysis which reflects personal experience and gives it a conceptual form.

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