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# Trying to Enter the Long Black Branches: Some Technical Extensions of the Work of Frances Tustin for the Analysis of Autistic States in Adults

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The author suggests a number of technical extensions/clinical applications of Frances Tustin's work with autistic children, which are applicable to the psychoanalysis of neurotic, borderline and psychotic adults. These are especially relevant to those individuals in whom early uncontained happenings (Bion) have been silently encapsulated through the use of secretive autosensual maneuvers related to autistic objects and shapes. Although such encapsulations may constitute obstacles to emotional and intellectual development, are consequential in both the relational and vocational spheres for many analysands and present unending challenges for their analysts, the author demonstrates ways in which it may be possible to detect and to modify these in a transference-centered analysis. A detailed process of differential diagnosis between autistic states and neurotic/narcissistic (object-related) states in adults is outlined, along with several clinical demonstrations of the handling of a variety of elemental terrors, including the 'dread of dissolution.' The idiosyncratic and perverse use of the analytic setting and of the analyst and issues of the analysand's motivations are considered and illustrated. A new model related to 'objects in the periphery is introduced as an alternative to the more classical Kleinian models regarding certain responses and/or non-responses to transference interpretation. Issues a propos the countertransference are also taken up throughout.

Never to enter the sea and notice how the water divides
With perfect courtesy, to let you in!
Never to lie down on the grass, as though you were the grass
Never to leap in the air as you open your wings over
The dark acorn of your heart!
No wonder we hear, in your mournful voice, the complaint
That something is missing from your life!

(Mary Oliver, 1997, p. 61)

The title of this clinical communication borrows from the title of a poem by Mary Oliver (1997). The stanza from that same poem, quoted above, seems apposite to many patients who find their way to the analytic couch. These

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patients leave the impression that they are in search of something missing in their lives: perhaps the emotional contact with an elemental quality of self, a certain kind of lived-experience akin to entering a courteous sea, being one with the grass, leaping in air and even opening to the dark acorn of the heart.

These missing elements of experience, linked to various unlived and heretofore unheard aspects of self and their 'uncontained' (in Bion's sense of the term[1]) perceptions of encounters with the agony and ecstasy of being, often come to inhabit a hidden capsule[2] within many ordinary neurotic, borderline or psychotic adults (Bion, 1957; Klein S, 1980; Mitrani, 1992; Rosenfeld, 1985; Steiner, 1993; Tustin, 1986). This capsule may be shrouded in somatic symptoms, encased in extremes of acting-out, ensconced in therapeutic enactment or overlaid with a verbal message that is, by and large, deceptive in its expression. Nonetheless, as disturbing, misleading and distracting as these protective decoys may at times be for the analyst hard at work trying to enter "the long black branches of other people's lives" (Oliver, 1997, p. 61) — we frequently discover that their effect upon us (if we can bear to suffer it) is imbued with meaningful-if-encrypted communications, perhaps signaling a point at which that 'something missing' might have the opportunity to emerge and to develop.

The implications of the findings of Frances Tustin and this author's technical extensions and applications of those findings to the analytic work within these obscure areas of the lives of 'ordinary adults' is the subject of this paper. Throughout, I will demonstrate some of the ways in which Tustin's innovations have and are continuing to open up new possibilities for deepening the analyst's comprehension of those persons in whom unmentalized happenings (Mitrani, 1994) have been silently encapsulated through the use of autosensual maneuvers (Mitrani, 1992). I hope to be able to convey that, although these encapsulations constitute daunting obstacles to

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[1] When the object is unable or unwilling to receive, to make sense of and to reflect the baby's own internal state, or when the object projects her own internal state onto the infant, intentional states will not be *symbolically bound* and the developmental basis of the self-structure will be absent (Fonagy and Target, 1996). The weakness of such a self-image leaves the child with affective and perceptual happenings that remain nameless, confusing and frightening, what Bion considered to be unmetabolized or uncontained (Bion, 1962) and what this author has termed 'unmentalized' (Mitrani, 1994).

[2] Sidney Klein (1980) first described patients who, despite the appearance of progress in the analysis, remain untouched in some essential way due to

encapsulating forces that cut them off from the analyst as well as from the rest of the personality. Klein posited that walled off in these cystic areas are intense and unbearable fears of “pain, and of death, disintegration or breakdown” (p. 400) related to unmentalized experiences of separateness of early infancy. He suggested that such phenomena “are strikingly similar to those observed in so-called autistic children” (p. 400). Compellingly, novelist Patrick Süskind (1986) writes of this encapsulation phenomenon in the extreme. He describes his protagonist Grenouille, born of an overly preoccupied, deprived and unsupported mother. His means of survival is compared to that of a tick: “For which life has nothing better to offer than perpetual hibernation … which by rolling its blue-grey body up into a ball offers the least possible surface to the world; which by making its skin smooth [and] dense, emits nothing … makes itself extra small and inconspicuous [so] that no one will see it and step on it. The lonely tick, which, wrapped up in itself, huddles in its tree, blind deaf and dumb and simply sniffs … for the blood of some passing animal that it could never reach on its own power … the tick, stubborn, sullen and loathsome, huddles there and lives and waits … for that most improbable of chances … and only then does it abandon caution and drop and scratch and bore and bite into that alien flesh … The young Grenouille was such a tick … encapsulated in himself [he] waited for better times” (p. 25).

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emotional and intellectual development, are consequential in both the relational and vocational spheres for many analysands, and present unending challenges for analysts, it is possible to detect and to modify them.[3]

## Going Forward

Oliver asks:

> Who can open the door who does not reach for the latch? Who can travel the miles, who does not put one foot in front of the other, all attentive to what presents itself continually? Who will behold the inner chamber who has not observed with admiration, even with rapture, the outer stone?

(1997, p. 61)

When the analyst can behold the ‘inner chamber’ without sentimentality, but with an appreciation of both the nature and function of the ‘outer stone’, her own as well as her patient's, she may be able to navigate through a certain range of therapeutic impasses and to tolerate what may at times seem like interminable frustrations when encountering patients' ubiquitous, deeply ingrained and stony autosensual protections. To paraphrase Graham Greene (1929), the category of patient addressed in this paper (not unlike poets and writers) has a splinter of ice in their hearts. Perhaps the analyst's perseverance and her artful and timely delivery of hard-earned and mindful awareness may constitute a warm, therapeutic bath that can enable her to penetrate, to reach and to melt this icy obstruction to development.

By detecting and exploring this dimension of psychesoma, the analyst may be better equipped to refine her insights, to find new ways in which to articulately decipher the plight of the infant in the adult patient, and *to define her current role in the revival of this predicament in the transference*. A familiarity with the concepts of *autistic objects* (Tustin, 1980) and *autistic shapes* (Tustin, 1984) is helpful in this effort,[4] as is our sensitivity to the existential terrors inherent in both the *premature awareness of two-ness* and the *ecstasy of at-one-ment* (Tustin, 1981). Tustin's emphasis on the role of sensation — as both an integral aspect of primordial terrors and as material for the construction of the protective barrier against the awareness of such terrors —draws attention to the dimension of autosensuality and its centrality to the

[3] All clinical material concerns patients who, after the initial evaluation sitting up in a chair, were engaged in four or five times per week analysis reclining on a couch utilized for that purpose only.

[4] Tustin distinguishes *autistic objects* from ordinary objects (inanimate or animate) in that the former are *not related to as objects*, but rather *used for the tactile sensations which they engender* upon the surface of the skin of the subject. Autistic objects differ from ‘transitional objects’ (Winnicott, 1953), which are a combination of ‘me’ and ‘not me’ that constitute a bridge that links the two together during physical absence, while autistic objects are barriers to the awareness of ‘not me’ and as such are impediments to growth and development. *Autistic shapes* are differentiated from objective shapes (such as a square or a circle), in that they are idiosyncratic, endogenous swirls of sensation produced upon the surface of the skin or internally with the aid of bodily substances or objects. These distinctions, first based upon observations with autistic children, are now widely extended to include numerous other behaviors observable in adults and children with an enclave of autism, which may be conceived of as sensationdominated delusions. The key word here is ‘sensation’. Such sensations either serve to distract one's attention away from insufferable happenings, providing an illusion of safety, strength and impermeability, or they may have a numbing or tranquilizing effect upon the individual, which blocks out some terrifying awareness.

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work within primitive mental states. With these enlightening tools in hand, the analyst may be able to avoid becoming hopelessly lost in this dimension where shadow and light are occluded from perception and emotional experience. Additionally, the analyst may become more capable of shepherding her analysand out of a mindless island of sameness and into a shared world where opposites intermingle and attenuate one another, and the ‘rhythm of safety’ (Tustin, 1986) of the analytic frame, process and relationship eventually take the place of the virtual ‘rocking’ and ‘head-banging’ of compulsive repetitions, which are sometimes at the root of interminable analyses.

## Detecting Autistic States in Adults

In these individuals, areas of normal development exist, circumventing those *traumatic happenings* of infancy that could not be

experienced, but were instead walled-off from both conscious and unconscious awareness (Klein S, 1980; Tustin, 1986). Unlike the case of split-off and projected aspects of objects and/or self, or repressed memories of events, it is difficult to locate these encapsulated resources merely by listening for their verbal derivatives, expressed as aspects of self, objects and perceptions residing in other people in the day-to-day life of the patient or as they might be revealed in dreams. This may be so because, while in an autistic state, projective identification is unavailable as a means of communication (Bion, 1962) and, as with autistic children who cannot play (Tustin, 1988), these patients rarely dream since, in this domain of the psyche, symbol formation is as yet undeveloped (Klein M, 1930.)

Because encapsulated 'happenings' are so well hidden — not just from the analyst but also from the patient himself — we are left to intuit the existence of these 'buried treasures' in order to begin to image them, and eventually to be able to explicitly recognize and acknowledge them for and to the patient. This is no mean trick as it requires the analyst's capacity *to be aware of and to bear the awareness of what is missing*, and to be able to digest that awareness such that it becomes food for thought to be shared with the patient.

Along with our consideration of that which we intuit, a continual and rigorous process of 'differential diagnosis' — performed throughout the analytic hour, and derived from a careful and sustained observation and examination of the signs carried on the currents of the immediate transference and countertransference derivatives — is vital in order to insure that the analyst's interventions are usefully geared toward the patient *in that moment*. Accordingly, I will briefly outline some criteria to keep in mind while discriminating autistic states from those more truly object-related states.

## Differential Diagnosis of Autistic States: Moment to Moment

Firstly, while in an object-related state, the patient experiences the analyst either as a part of the mother's body associated with some maternal function, or as an animated, lively whole person who is able to move about at will. In contrast, *the patient in an autistic state does not experience the analyst*

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*as a real, animate, lively entity existing in a space of her own, but rather as an inanimate 'thing' that is made up, absorbed, exploited, manipulated or avoided in order to secure a sensation of existence, comfort, safety and impermeability*.

Secondly, in an object-related state, some degree of awareness of separateness from the analyst is tolerated to a greater or lesser extent by the patient. In contrast, *in an autistic state, normal 'flickering states of awareness of otherness' are unable to be endured*. Consequently, analyst and patient remain largely undifferentiated (from the patient's point of reference) and the resulting contact with the analyst is mainly felt on a sensuous level. In this state, the analyst is not related to, *per se*, but is 'utilized' for the sensations that she engenders upon the surface of the skin, eyes, ears and/or the mucous membranes of the patient. These sensations serve either to distract the patient's attention away from potentially anxiety producing happenings —providing an illusion of safety, strength, and impermeability — or they may have a numbing or tranquilizing effect which serves to block out some insufferable awareness.

Thirdly, when the object-related state prevails, anxieties defended against (in unconscious fantasy) are either paranoid-schizoid or depressive in nature — anxieties and defenses well defined by Melanie Klein (1946). In contrast, *those anxieties evaded through auto-sensual or adhesive maneuvers (Bick 1968) in the autistic state are more accurately conceptualized as raw and unmitigated panic equated with the elemental sensations of falling out of control, of discontinuity of being, of nothingness, dissolution, and evaporation, of being a no-body-nowhere*, all terrors delineated in Tustin's work and in the work of Winnicott (1949).

Additionally, while in an object-related state, the individual engages in complex unconscious fantasies (for example, of splitting, projective identification, and manic denial) to defend against the pain, despair and rage of envy and the awareness of helpless dependence upon the analyst. However, *in the autistic state, the patient employs adhesive equation to block out the painful and life threatening awareness of two-ness and the overwhelming ecstasy of at-one-ment*.

Fourthly, in an object-related state, the patient's ego oscillates either between a state of increasing integration and a state of non-defensive regression to unintegration on the one hand, or between a state of integration and a state of defensive disintegration on the other. By comparison, *in an autistic state, ego or self exists and operates predominantly in an unmitigated state of passive primary unintegration* (Meltzer, 1975.)

Fifthly, the nature of 'thinking' in the object-related state is either abstract or concrete and may be either realistic or omnipotent in nature. In contrast, *in autistic states there is little actual mentation (Mitrani, 1994). What appears to the observer as 'thinking' remains on the level of a reflexo-physiological reaction* and 'innate forms'[5] (Tustin, 1986) prevail in the absence of symbolization,

[5] Tustin (1986) defines these as "flexible, sensuous moulds into which, at an elemental level of psychic development, experience is cast, and which are modified by the experience so cast. When an innate form seems to coincide with a correspondence in the outside world, the child has the illusion that everything is synonymous and continuous with his own body stuff" (p. 85).

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unconscious fantasy and imagination since transitional space (Winnicott, 1951) is non-existent.

Sixthly, the truly object-related individual reacts to separations and losses with either expressions of anxiety, neediness and emotional pain, or with a tight-fisted control of the aforementioned through the use of tyranny and seduction. In contrast, *the individual in an autistic state reacts to the awareness of separateness with either total obliviousness or complete collapse*. Consciousness of dependency in the

object-related individual is either experienced as the need for and the act of reliance upon an analyst who is separate from the analysand, or it is defended against through forms of manic denial. *In autistic states, dependency in the analysand assumes the form of a thin and tenacious clinging to the surface of an as-yet-undifferentiated analyst, felt to be part of and contiguous with the analysand.*

Lastly, when defenses against the awareness of *separateness* and loss break down in the object-related state, there is an experience of threat to the patient's sense of omnipotence, culminating in feelings of rejection. In contrast, *when omnipotence fails in the autistic state, this failure is felt as a corporeal collapse, as a dreadful sensation of being ripped-off and thrown away, a bodily feeling of total and irreversible dejection*. It is not an experience of the loss of the analyst or even the presence of the absence **(O'Shaughnessy, 1964)**, as it is in object related states. One autistic child, John, called this the "black hole with the nasty prick" (**Tustin, 1974**, p. 30). This 'black hole' is felt as an awesome force of powerlessness, of defect, of nothingness and of 'zero-ness' expressed, not just as a static emptiness, but as an agonizingly implosive centripetal pull into a void.[6]

## Those Who Have 'Lingered in the Chambers of the Sea'

It might be accurate to say that the patients addressed in this paper have 'lingered in the chambers of the sea' (T. S. **Eliot, 1998**) for much of their lives. They are unwittingly addicted to their sensation-dominated ways of surviving at the expense of experiences of ordinary human relationship. The frequency with which liquid states are evoked in the clinical material of these patients has been noteworthy **(Tustin, 1986)**. For example, one adult patient, Jean, said that she felt like a "waterfall, falling out of control into nothingness" (**Tustin, 1986**, p. 217) when she was aware of slipping out of the mindful attention of her analyst on holiday breaks.

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[6] Due to the limitations of scope of this paper, I have not addressed in depth the differential diagnosis between dissociative and autistic states, a topic that deserves a paper of its own. Suffice to say that, although both states are related to trauma, *the dissociative state can be included in the object-related category*. It may be expressed in amnesia (forgetting) or fugue and dissociative/multiple personality disorders (in which the split-off or repressed aspect(s) of self can be given life/expression, at least temporarily). In contrast, the encapsulation common to autistic states constitutes a virtual isolation chamber in which the unmentalized traumatic perception (as well as what Meltzer and Bion described as the associated aspect of the dismantled perceptual apparatus) is hermetically sealed off from future development, expression or memory. Such relatively advanced defenses as splitting and projection, repression, denial and displacement are not relevant in the autistic state. As such, traumatic events can neither be remembered nor forgotten. Additionally, the traumatized aspect of the personality cannot be lived (in the ordinary sense of the word) either tentatively/alternatively.

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The experience of freezing in autistic states is a reaction to this terror of falling out of control when a personal sense of existence is still fluid, and when the personality and body are not yet fully differentiated or solidified **(Tustin, 1986)**. In fact, freezing is the way in which a liquid becomes a solid body. However, when our patients freeze up in order to attain a *sensation of solidity*, their icy barrier often impacts others by leaving them cold. Consequently, the occurrence of healing emotional transactions is impeded.

In her novel, *The Lovely Bones*, author Alice Sebold's opening words express two different views of the frozen capsule of the autistic state:

> Inside the snow globe on my father's desk. There was a penguin wearing a red-and-white-striped scarf. When I was little my father would pull me into his lap and reach for the snow globe. He would turn it over, letting all the snow collect on the top, then quickly invert it. The two of us watched the snow fall gently around the penguin. The penguin was alone in there, I thought, and I worried for him. When I told my father this, he said, "Don't worry, Susie; he has a nice life. He's trapped in a perfect world".

(**Sebold, 2002**, p. 3)

Like Susie, the analyst may be moved to *feel* the isolation within the perfect world of the icy sphere of autism, while the untrained or emotionally distant observer may see this world as idyllic. We know that, without lively human connections, it is not possible for certain vital internal mental and physical structures to develop and, when emotional contact is interrupted, previously developed structures can wither away **(Spitz and Wolf, 1946)**. Without these durable structures, patients can suffer emotional and physical 'meltdowns' in the face of life's stressors. In analysis, just as the firm, reliable, resilient and receptive presence of the analyst is an important factor if these lasting structures are to be established, it is also important that a physical setting with similar qualities be provided.

## The Setting

To facilitate the emergence of the infantile transference in analysis, an environment of relative safety and security needs to be maintained. Our consulting rooms are equated, in the unconscious, with the maternal body **(Klein, 1961)**. Furthermore, just as the modulation of the ups and downs of the mother's emotional and mental state and her physicality are essential to healthy fetal development and the emergence of the baby from the womb, for adult patients the therapeutic setting and the rhythm and consistency of the work affect development, the ability to attach and to separate healthfully.

In analysis, we aim to and often do penetrate our patients' protective capsules, releasing explosive feelings of violence, overwhelming terrors, unutterable rapture and torrential grief. Thus it is essential to provide a setting capable of bearing and containing these emotions. For both analyst and analysand, frequent meetings are indispensable. As one patient expressed it: "I'd be crazy to be open and vulnerable when you're only with me once a week!" Perhaps the same can be said for the analyst who is charged with sustaining and transforming all that she has opened herself up to in a given hour.

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For both members of the analytic couple, prerequisites of continuity of frame, attention, listening and interpretation are a necessary complement to the analyst's alert and constrained attention. Within such an ambience, the patient can more readily experience both a listening and speaking object. However, when changes and alterations in the setting or schedule are unavoidable, the analyst is *alert to and mindful of the consequences of such modifications* and the need to be sensitive when listening for and dealing with the patient's reactions, including those experienced/expressed in the realm of sensation, as might be seen in the following vignettes.

## Lucie

Thirty-five year old Lucie was vulnerable to the slightest variation in the setting and to any change in my person. Over a weekend prior to the week preceding a long holiday break, I had trimmed my hair. When she saw me on Monday, Lucie appeared grief-stricken. Once on the couch her anguish turned to rage and she quickly clammed up. With time and encouragement, she grudgingly spat out a few telling words: “Your hair! How could you? You didn't even save the cuttings for me.”

With this brusque protest, everything came to a screeching halt. Walled off in sullen silence, Lucie turned to face the wall for much of the hour. Absolutely nothing I could say to her served to re-establish contact: it felt that *she had become the wall*. During the silence, I was very aware of *my own dread* of what would become of her during my absence. I envisioned a very rocky reunion, if indeed she returned to the analysis at all. Then I began to feel that all had come to an end and feared that *I was about to be abandoned*.

Barely overcoming a strong inclination to retreat from her rejection and in light of my fantasies of abandonment and loss, which I took as a sign of how unbearable and permanent our separation had felt to her — not a separation but an amputation, a cut — I told Lucie that I thought she might be communicating the sense that my hair-cut was a ‘her-cut.’ Furthermore, I said that I thought she was letting me know that *she could not bear the feeling* of my thoughtlessly cutting her off along with the soft texture of our contact.

Lucie turned her head slightly in my direction. I thought that this might be a sign that she could now dare to separate from the wall that protected her from the catastrophic awareness of our separateness during the break. Thus I was encouraged to say: “Perhaps you are also conveying how insufferable is the palpable dread that you and I might never grow back together again, especially when it feels that I cut off those soft and delicate wisps of cooperation that grew in our work together over the term and that I've carelessly thrown it all away.”

Lucie opened just a bit and said: “Yes, that's true. And what if there's a crash?” As Lucie's response seemed to let me in on an additional feature of her dilemma, I added: “When I hurt and enrage you so carelessly by cutting you off like that, a terrible collision occurs, with both of us crashing and falling out of control, exploding to bits. So horrifying is this sense of

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us in pieces, you must turn away from me, gluing yourself to the wall for protection.” This last intervention addressed an additional significance in Lucie's turn toward the wall for durable comfort. It seemed to me that when her crashing emotions (provoked by my holiday leave) were felt as potentially threatening (“And what if there's a crash?”) to the wholesomeness of our contact, I too was momentarily experienced as ‘cut’ and broken, unreliable and even dangerous, not only when I was absent but when present in that moment as well. Perhaps moments like these, when the analyst can continue to function mindfully and non-defensively in the face of explosive emotions (the patient's as well as her own), the fear of coming apart, falling apart out of control, can be attenuated and faith in relationship can be restored.

This moment with Lucie also demonstrates how something that may seem like an image to the analyst from the descriptions the patient articulates is instead *felt* as “a repertoire of relatively uncoordinated *sensations*, which are sensed rather than imaged” (**Tustin, 1986**, p. 216). In like manner, what might appear to be fantasies or dreams are more like tactile hallucinations, and the analyst must try to make her own images explicit and present them in a language that may touch the patient in such a state of mind. Another patient, Brad, also suffered from these tactile hallucinations.

## Brad

Early in our work together I discovered that Brad felt physically crumpled up and thrown out at the end of the session, equating himself with the paper towel that lay on the pillow of my couch where he rested his head during the hour. He often felt that I peeled him off my body-couch or breast-pillow and that I carelessly threw him away, and he begged me to fold and to save him from time to time **(Mitrani, 1992)**. Otherwise Brad said that he felt he was always ‘starting from scratch.’

I eventually came to realize that the ‘scratch’ my patient referred to was the sensation he experienced on his tender skin. His way of mastering this happening, and thus making it bearable, was to scratch the skin on his arms, legs and face after each session, sometimes until he bled, in order to achieve a renewed sensation of re-birth and ‘there-ness’, to evade an experience of helplessness and vulnerability, and to toughen up against what he felt to be my careless treatment of him.

## Audrey

Audrey physically felt the impact of any shifts on my bookshelves as though my books were parts of me that must be kept in order, always the same. She had memorized their placement, which gave her a sensation of control over me. She could put me in my place and I would stay put. However, each new addition to or subtraction from my library provoked a reaction, much like the stranger anxiety observed in babies in the latter half of the first year of life. With time we could appreciate her indelible sense of mother's manic-depressive mood swings, which were felt like a mother in pieces, out of control, in fragments and out of sorts: a monster-mother who was

unable

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to hold herself or the baby-Audrey together. This feeling pre-empted the establishment of a sense of comforting familiarity and obstructed the development of a consistent basis for trust in the other, tolerance for change and the evolution of Audrey's self-confidence.

### Connie

A similar reaction to variations in light in my room, mainly connected to the varied times I would see her throughout the week, was a source of distress for Connie. She would often brace herself physically by holding onto the doorframe with both hands before entering my room. I learned that this change in the intensity of the light was experienced by my patient as a ‘dizzying’ and ‘disorienting shock’ that, on a sensation level, was felt as a ‘slap in the face’ or as an ‘earthquake,’ a harbinger of my ‘change in mood’ or shift in my feeling for her. Connie was able to tell me that these changes were like a ‘Tsunami’ that threatened to sweep her away.

Such changes in the therapeutic setting may be grist for the analytic mill, and as such can be made meaningful through interpretation. However, the development of “a rhythm of safety” (**Tustin, 1986**, p. 26) is, in part, established through an experience of constancy in the environment of the consulting room, as well as in the consistent functioning of the analyst as a receptacle for projections and as a reliable source of verbal understanding for the ‘grist’ brought into the therapeutic relationship *by the analysand*. This point brings me to the problem of patients' idiosyncratic use (while in an autistic state) of the reliable setting provided.

## The Idiosyncratic Use of Objects

Even though the analyst strives to provide a stable environment within which those in their care may come to feel safe, patients often turn the analyst and the analytic environment upside-down, in one way or another. Tustin (**1980**, **1984**) discovered that autistic children use ordinary objects not in the course of child's play as a mode of communication, but for the sensations that these objects engender on the surface of their skin. Auto-sensuous maneuvers may also become apparent in the way that certain adult analysands use the consulting room, the objects in it — including the couch itself — and the qualities of the analyst. When the analysis is used in these idiosyncratic ways, opportunities for gaining insight into and having experiences from which to learn can be lost. I will present some examples of what I am suggesting from my work with Karen, an outwardly successful professional in her mid-30s.

### Karen

Throughout the first year of her analysis, no matter if the room were warm or cool, before lying down, Karen would take up the blanket that lay at the foot of the couch. While holding a corner of it in the palm of one hand, the thumb on that same hand was inserted into, sucked, and slid rhythmically in and out of Karen's mouth. The remainder of the blanket was spread out

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and covered all but Karen's toes, which she wiggled continuously whenever I spoke to her.

So secretive and smooth were Karen's undercover movements that it took many months of careful observation and listening, as well as much attention to my own imagination, before I could make explicit the use that my patient was making of the blanket — to hide a myriad of sensation-producing activities. Under cover, Karen constantly caressed her breasts with her free hand or masturbated with her hand in her trouser pocket, activities just barely detectable under wraps from my position in the chair behind the couch.

At the same time, I noticed that Karen's negative feelings toward me were almost never expressed verbally. However, when I was aware of being somewhat off in my understanding of her, it became clear that she would begin to pinch her nipples, scratch her arms, or pick at the skin of her cuticles and tear at her fingernails. Over time and little by little, I was able to speak to Karen about these hidden, self-inflicted wounds as well as the soothing sensations that she could reliably create for herself. We also considered how these each might serve to obliterate any awareness of helplessness, dependency and the existence of hurtful otherness as well as any real experience of togetherness.

The ecstasy[7] of at-one-ment **(Tustin, 1981)** can become just as terrifying as the despair evoked by separateness or abandonment. With Karen's unconscious cooperation, I was able to ‘uncover’ the equation of the softness of the blanket with the soft musicality of my voice, further equated with the softness of Karen's own skin and the silent and pleasurable sensations she produced during the hours. My words were rarely taken in for their meaning, but instead were more often felt as harmonious sensations that flowed over Karen's skin and slipped in and out of her ears, not unlike the sensation of her thumb slipping in and out of her mouth in a self-controlled and self-soothing way.

It became apparent that, whenever Karen repeated these gestures in the many hours of absence between the sessions and during weekends, she could obliterate the sharp distinctions between separateness and togetherness. Since we were felt to be inseparable, I was neither experienced as a ‘real person,’ separate from herself, nor did I exist outside the sensations that I inspired, produced or provoked for her.

My voice was also equated with Karen's hand and, as she had managed to find an exact duplicate for my blanket and sleuthed out and found the perfume I usually wore, she was also able to reproduce the comforting visual, tactile and olfactory sensations that she experienced while she was in my physical presence, no matter the place or time of day. Additionally, Karen's thumb — sucked much of the time during the analytic hours and (when no one was watching) between the hours — was *not* a transitional object that functioned to bridge

a gap between us during times of felt

[7] Dr. Theodore Mitrani pointed out that the word 'ecstasy' comes from the Greek term *ex stasis*. So it appears that, in ancient times, the Greeks knew something about the destabilizing effect of experiences of joy, beauty and love, which may become overwhelming to the baby when left unmet and uncontained by the mother **(Mitrani J, 1998b)**.

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separation. Instead, the sessions, my voice and the blanket held in her hand against her face functioned to 'recharge her thumb,' so that its utility — as concrete proof of our indivisibility — could retain the power to smooth out the sensations of the jagged and potentially terrifying agony of the separateness, and the equally unbearable ecstasy of our reunions.

Eventually, Karen began to notice that her clever maneuvers had a 'short half-life.' They clearly failed to sustain her throughout prolonged holiday breaks when we would be 'out of touch' for two or three weeks at a stretch and, with time, these tactics barely sufficed over longer than usual three-day weekends. As we came to appreciate the function of these manipulations and their limited effectiveness, Karen had an important epiphany: "I made you up in my brain! You weren't real. But now I realize that, if you aren't real and I lose you, I have no hope of ever finding you again, of remembering you. And if I'm lost and you're inanimate, not real, you won't be able to find me."

It was becoming clear to us that Karen felt the small bits of understanding she was receiving from me as a sign that there was both an inside and an outside, a Dr. M and a Karen, sometimes linked together by tolerable emotional encounters and a growing experience of an 'other' who might be willing and able to tolerate and to adapt to her needs, while still remaining a separate individual. These events only became relevant as Karen could begin to bear the awareness that we were two very real people, that we were not 'one pretend figment of her brain,' but two people who could touch and effect one another on a heartfelt if sometimes disturbing level.

## A Question of Motivation

I should like to clarify that quite often, although it appears that patients like Karen destructively defy the therapeutic boundaries, it is important to consider that their motives may include, at least in some small part, an attempt to survive. Tustin referred to these wayward[8] patients as suffering from a miscarriage of motivation. Rather than attending to the life-enhancing possibilities that are available to them, both within themselves and in the outside world, their attention has become fixated upon autochthonous sensation-objects and sensation-shapes that insure survival on the most elemental level. Tustin *would ask patients to abstain from their autosensual activities, while at the same time interpreting their intended function alongside the deleterious side-effects of these behaviors as they emerge in the material*.

Certainly, when patients turn the analytic framework upside-down, permanent damage can be avoided if we are able to maintain a mindful attitude while being overthrown. For example, especially in this era of electronic communications (i.e. voicemail, texting, tweeting and email), patients seek and often do manage to provoke contact with us outside agreed upon hours.

[8] In a scholarly paper drawing the work of clinicians from several orientations, American analyst Ruth **Stein (2005)** discussed patients who were seen as engaged in non-sexual perverse relationships with their analysts whom they approach as inanimate things, manipulated in service of creating physical sensations that camouflage hatred and paranoia. She coins the term 'false love' to characterize the nature of relatedness that may appear affectionate, but which circumvents affect.

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In doing so, they challenge the analytic boundaries, perhaps because they have no flexible boundaries of their own. These patients often fall outside the realm of the known and we may need *to be willing and able to fall with them for a time, while maintaining our capacity to right ourselves and them through hard-won and thoughtful interpretative understanding*.

Throughout the process of developing a narrative of shared meaning, enactments of all kinds can be put to good use. Perhaps the experience we gain through free-falling with our patients may stimulate us to stretch our imaginations to the fullest. Learning from experience may help us bear *to 'know' what we do not know that we know*, to access our faith **(Bion, 1970)** in the analytic process, in the unconscious and in human relationship. Perhaps by having such experiences, rather than trying to avoid them at all costs, may enable us to reach, to catch, to bear, to better apprehend and to make known our understanding through our interpretative contributions.

Regarding the treatment of the autistic child, Dick, Melanie Klein wrote:

> In general I do not interpret the material until it has found expression in various representations … however where a capacity to represent … is almost entirely lacking, I have been obliged to make … interpretations on the basis of general knowledge.

(**1930**, p. 246)

It is this author's belief that our 'general knowledge' must include not just our theories, but a first-hand and hands-on experience of what it feels like to be physically helpless, dependent and as yet unintegrated, stemming from our own experiences in the transference as analysands and from our familiarity, as analysts, with this dimension of the countertransference (**Mitrani, 1992**, **1993**, **1998a**, **1999**, **2001**, **2007a**, **2007b**). Perhaps one of the most challenging happenings for the analyst in this sphere is related to a specific feature of autistic states, which warrants explication.

## The Object in the Periphery

Tustin (1986) linked a particular class of auto-generated sensation-shapes to the well-known observation that autistic children frequently do not look directly into the eyes of others, instead taking in a great deal by peripheral vision. On this topic, she wrote:

> This over-developed fringe awareness means that fringe-shapes are formed which can never be clearly focused and which constantly elude the children. Autistic children show that they are constantly tantalized by such elusive, self-generated shapes … In the end, such shapes are not tranquilizing but tantalizing [and] also impede attachment to the mother, which is fostered by looking at her face, especially at her eyes. As a result of the tantrums of panic and rage that she was not a part of their body that they could take for granted, the children have turned away from the mother and became frightened of her eyes. This separateness had been forced upon their attention before they were ready for it. In Winnicott's terms it 'impinged'; they did not find it out in their own time when they were ready for it. This was painful beyond all bearing. They had swerved away from the pain, and from the mother who was the source of it. They stopped looking at her and at other people, attending instead to the fringe shapes they could make by looking out of the corners of

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> their eyes. This brought some sort of order into their bewildering world but, like will-o'-the-wisps, these side-long shapes eventually isolated them in immobilizing bogs, cut off from contact with other human beings.

(Tustin, 1986, p. 154)

This variety of soft, blurry, indistinct autistic shape (Tustin, 1984) initially creates a sensation of at-one-ment with the primary environment. I believe it may be useful to notice that *there exists an analogous phenomenon, commonly encountered in our work with adult patients in analysis*.

For example, many analysts have the experience of speaking to a patient who responds as if the analyst has said nothing. That is, the patient goes right on without reference to the analyst's verbal communication. The sense one gets is that the patient has rolled over, run through or maneuvered around what the analyst has said. Although kept in the periphery of the patient's attention, at times the analyst can detect some faint refraction of her communications, embedded in seemingly unrelated stories that the patient tells about himself in relation to others. Alternatively, the analyst might detect a slight rephrasing of what she has said, presented as though it is the product of the patient's own insight. This situation is quite common and may be the result of a displacement subsequent to some resistance in patients who are neurotically organized and for whom separateness is a narcissistic issue. In the classical Kleinian model, this situation is often taken up as an expression of envy and a sign that the patient is usurping the function the analytic breast, so to speak.

However, the analyst may wish to entertain an additional dimension of significance with regard to this phenomenon: that her intervention has inadvertently forced an *awareness of separateness* upon the patient's attention before he is able to contend with it. As such, the interpretation may constitute an impingement that is painful beyond all bearing. In reaction to this impingement, the patient may swerve away from the pain and from the mother-analyst who is felt to be the source of a *reality that he cannot face head on*. In the countertransference, the analyst can detect this state as it will often engender in her the feeling that *she does not exist*. It is as if she were invisible or unheard, except for the faint echo of her words in her own solitary mind. At other times, the patient's response may resemble the echolalia of the autistic child. When encountering this phenomenon, the question of motivation is essential for the analyst to consider.

In extreme cases, wherein *the awareness of separateness is an existential issue*, the patient may at first seem relaxed, unperturbed by what the analyst has said, and may simply go on as if untouched. Sometimes there can be varying degrees of weepiness or other bodily signs (for example, coughing, flatulence, fidgeting) indicating that the analyst has punctured the protective capsule and signaling that a process of *dissolution* (which I will elaborate upon further below) has begun. However, powerful efforts to staunch the flow from the wound of two-ness work rapidly to seal up protection once again, and such embryonic signs of having been being touched may lead to a 'dead end' that is frequently marked by the patient's complaint, registered either directly or obliquely, that he does not feel the analyst to be alive or present.

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Ideally, the analyst may be able to convey, both gently and firmly, her sense of the patient's experience. Her understanding needs to address three distinct areas. The first area has to do with acknowledging the pain and dread of separateness 'beyond all bearing', provoked by the analyst's intervention. The second concerns the ways in which the patient deadens the insufferable pain and attenuates this nameless dread. Finally, the third area must recognize the ways in which these self-protective maneuvers culminate in the feeling of 'being neither here nor there' with an analyst who is either a 'nobody' or a tantalizing somebody, out of touch and just out of reach in the periphery of the patient's existence (i.e. the side effect of this protective maneuver). In time and with patience, a process of working-through may lead to an increasing capacity to tolerate separateness and, in place of the dead-end of therapeutic impasse, the analytic couple may be able to move forward on the road toward emotional and mental development.

## The Dread of Dissolution

In some individuals, *autosensual protections against the awareness of unbearable separateness or the turbulence of real emotional closeness* are like the thorny vines surrounding the castle where the Princess Aurora lay protected from the prick of death, or the wall of fire that encircled Brunhilde in Wagner's *Ring*. The analyst needs to be courageous, as well as 'charming' and imaginative, in order to

engage these 'sleeping beauties when faced with the poisonous pricks and the fiery flames of intense emotion.' As Tustin once said:

> These patients will break your heart, just as they had once been heartbroken. The therapist can provide an object lesson in bravery and resilience, while suffering life's heart breaks with the aid of human relationship.

(Tustin, 1989, personal communication, Amersham, Bucks)

Perhaps personal analysis, supervision and peer consultation could be helpful for managing the heartbreak as well as the primitive dreads that must first be borne by the analyst before the patient can be expected to bear them on his own. Among these dreads, the 'dread of dissolution' is predominant.

The term *dissolution* **(Tustin, 1986)** describes the awesome danger associated with the awareness of otherness in earliest infancy, with the events of psychic and physical changes, and with the emotional havoc engendered by such changes. Changes are often felt, on a primordial level, as a transformation from a solid existence to a liquid state. The terrors of spilling out of control into a bottomless abyss, and even evaporating into nothingness **(Mitrani, 1993)**, threaten to prevail when left uncontained.

When the analyst dares to infiltrate the blockade imposed by autosensual protections, she also becomes exposed to these same dangers, especially while 'taking the transference' **(Mitrani, 2001)**. This most difficult aspect of our work is an unconscious act governed by unconscious factors in response to emotional happenings actually experienced and suffered by the analyst,

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to some significant degree. This is essential to what Bion called the maternal function of 'reverie': the attentive, actively receptive, introjective and experiencing aspect of the containing object. Perhaps our capacity to take the transference is never so important as it is with these individuals who have spent much of their lives 'wrapped tight', as one patient explained with deep regret.

The patient's history (most convincingly as it unfolds in the transference-countertransference continuum, where we have the chance to learn from experience) approximates the basic constellation underlying pathological autosensuality. It is common for mother's emotional accessibility to be impaired especially while in a narcissistically vulnerable state, such as is often the case during the pre- and post-partum period. The mothers of autistic patients have often been insufficiently supported and are frequently disheartened, depressed or preoccupied by nature or by circumstance around the time of giving birth **(Tustin, 1981)**. Consequently they temporarily withdraw, recoil, reject or turn away from their babies on an emotional level, especially when the baby is felt to be a source of potential narcissistic injury.[9]

In cases where a baby is exceptionally sensitive and expressive, its cries may reinforce the mother's sense of being a failure as a mother. If such avoidant behavior on the part of the mother extends beyond the baby's own limited innate capacity to sustain itself, normal projective identification **(Bion, 1965)** — at first aimed at communicating unbearable states of excitement, pain or terror in search of reception and transformation — will grow to hyperbolic proportions. Eventually the result is a sealing-off of vital aspects of the infant's nascent self, along with its capacity to perceive emotional happenings. Bion's **(1974)** description of the sequence that follows a failure in maternal containment may depict a common precursor to autistic encapsulation:

> The infant takes back into itself the sense of impending disaster, which has grown more terrifying through the rejection of the mother and through its own rejection of the feeling of dread. This baby will not feel that it gets back something good, but the evacuation with its badness worse than before. It may continue to cry and to rouse powerful anxiety in the mother. In this way a vicious cycle is created in which matters get worse and worse until the infant cannot stand its own screams any longer. In fact, left to deal with them by itself, it becomes silent and closes within itself a frightening and bad thing, something which it fears may burst out again. In the meantime, it becomes a 'good baby', a 'good child'.

(**Bion, 1974**, p. 84)

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[9] In the interest of clarification, although Tustin often stated that Bettelheim's **(1967)** notion of 'the empty fortress' was an apt way of describing the autistic protection, she explicitly disagreed with his characterization of the mothers of autistic children when she wrote: "I have a great deal of sympathy for these mothers. In my view, Kanner started a regrettable fashion in seeing them as being 'cold and intellectual'. Ever since he said this, phrases such as 'refrigerator mothers' have been bandied about to describe them. I do not subscribe to this view" (**1986**, p. 61). Consistent with Tustin's attitude, it is perhaps essential to take into consideration the possibility of either a failure in the environment, a failure of constitution, and/or a combination of both: what I have referred to as a 'coincidence of vulnerability' in the infant-mother couple **(Mitrani, 2003)**.

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When we begin to reach some genuine understanding of the specific plight of the infant in the adult patient in analysis, the protective wraps that make up the encapsulation may further loosen their hold and intermittently fall away, gradually allowing ordinary human experience to penetrate **(Mitrani, 2006)**. It is, however, important to keep in mind that the terrors of slipping away into nothingness or bursting open with excitement — provoked especially by absences and reunions — do re-emerge with regularity, followed by the redeployment of the old, faithful and familiar protections. This inevitable cycle renders the process of 'working through' **(Freud, 1914)** both painstaking and protracted.

One patient, Julia, was able to help me to get a sense of the seamless quality of the protective fabric within which her infant-self was swaddled. She was put in mind of the film *The Alien* and described how the creature —a monstrous infant — came to the surface, breaking out of the belly of its host, destroying him and threatening those who tried to help. She likened this scene to my efforts to be in touch with what she called her 'original self.' She was convinced that we would both be destroyed in the process. Indeed, Tustin (**1988**, personal

communication) said of the autistic barrier: “When this brittle self-sufficiency can no longer be maintained, the situation is devastating for [the patient] because the basic sense of going-on-being is felt to be dependent upon maintaining such a barrier.”

I believe that an in-built assumption of the analyst's vulnerability, for which patients frequently find evidence, may be linked with this problematic **(Mitrani, 2007b)**. Such evidence sometimes leads to an exaggerated *fear of the analyst coming in contact with the infant-self* that has been experienced as an alien, ‘frightening and bad thing,’ which must be kept silent and closed off in order to prevent the mother-analyst from becoming overwhelmed. One example of this kind of situation comes to mind from the analysis of a man with whom I was working at the time of the big earthquake in Los Angeles in 1994.

### Leonard

Leonard, a man in his 40s, whose mother had suffered a psychotic breakdown subsequent to his birth, had been in analysis with me five days per week for several years. Over time, he had built up, from experience, a firm conviction regarding my reliable resiliency, which had allowed him to relinquish many of his autosensual protections. Leonard both lived and worked more than an hour's drive from my office. With regularity he traveled over one of the main east-west arteries through the city to attend his analysis at the end of each day.

The earthquake, the most destructive in many years, had caused the collapse of this highway and there had been an announcement of a curfew to be imposed after dark for the entire Los Angeles area. Around noontime, eight hours after the earthquake struck, Leonard rang me up to ask if I would be in my office. He wondered if he could safely come ahead to his hour, and expressed concern that he would not get through or, at the very least, that he might be delayed. Ordinarily, I might have confirmed that I would be there for his hour whenever he arrived and would have taken up

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his doubts during the hour. Instead I said: “Perhaps with the collapse of the road and the security precautions, it may be unadvisable to come ahead.” Noticeably taken aback, Leonard replied that he would let me know what he decided later in the day. Indeed he left me a message, just prior to the time he would be leaving work to come to see me, stating that it sounded like it would be best for him to return home and try again tomorrow.

The next day Leonard began the hour saying that, with the collapse of the highway all the streets were packed, no way to come through. He wondered how we could continue until this was repaired: “Maybe it will never be the same, and how can you trust them to rebuild it so it doesn't happen again. I could have fallen off and been killed. I guess the stress and the weight of everything was too much.”

Leonard then became very withdrawn, sleeping through much of the hour. I thought it likely that he had taken what I said on the telephone the previous day to be a sign that, like the highway that connected us, I too had ‘collapsed’ in the quake under too much strain. Perhaps while feeling that I was protecting myself from his substantial concerns at a time when my own were just too much to bear, he had withdrawn from contact and had given up his approach to me. In the ensuing hours, we were able to adequately address this expression of mine and his interpretation of it in earnest, taking up his initial call as an attempt at reality testing and an expression of his need for reassurance. Gradually we repaired the emotional earthquake that my ‘collapse’ had created for Leonard, first in the transference and later in the context of his initial experience of mother, which had lead to the protective encapsulation and arrest of his original spirit and had obstructed the path of his mental development.

## Resistance and Collusion: A Coincidence of Vulnerability Analyst and Analysand

In concluding, I will put forward one last consideration specifically regarding the countertransference. Since the patients I am referring to, perhaps more so than others, resist interpretations that directly address the infantile transference, they also stimulate the analyst's own resistance to being in contact with states of maximal dependence and vulnerability through this very rejection. At times, this stimulant can be so potent that the analyst may unwittingly collude with the patient by hardening herself, creating her own barriers to emotionality. Noticing the crucial juncture when what the infant-in-the-patient communicates resonates too strongly with what the infant-in-the-analyst has endured is key. This resonance may evoke a range of reactions rooted in happenings from the analyst's own beginnings, further complicated by those happenings in the early life of the patient as these are communicated unconsciously and often non-verbally.

For example, a patient's material may stir up repressed memories of our own physical injuries or disabilities, psychic trauma and the bodily and mental constraints that we have been subjected to as infants and toddlers. I recall a period with one analysand during which I was faced with a pattern of acting out that required patience for many months. During this period, I

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was profoundly disturbed by a sense of ‘nowhere to turn,’ which was represented in my dreams in such a way that often evoked long-buried memories of having worn leg-braces at night-time and during naptime to straighten out my feet between the ages of 1 and 3. These braces took the form of Oxfordtype shoes, separated by a steel bar that constricted my ability to turn over in my crib. I was convinced that these dreams (and other reactions and associations of mine that were consonant with the dreams) somehow held the key to the meaning and significance of my analysand's dilemma and that they constituted the essential material from which I might derive an interpretative intervention that could move us forward on the analytic path.

The struggle to tolerate feelings of constriction, defect, despair and helplessness was worthwhile as it eventually lead to the uncovering of (as well as the ways and means of teasing out) the transgenerational roots of one of the major dynamics in the patient's personality structure, which we were gradually able to trace both to the early traumatic beginnings of the patient's mother and her

adaptation to that trauma, as well as certain characteristics of the maternal grandmother. Rather than relying on adult experiences, professional competence, training and, most especially, theories to circumvent this kind of awkward happening in the countertransference, with determination and faith in the process the analyst may find the mettle with which she might forge those unbidden emotional reactions and physical sensations into useful tools for understanding.

Finally, although some patients may nudge us to attend only to what is occurring outside the room, and frequently try to put us off the trail (for example, when they tell us, 'This is not about you!'), the analyst needs to find a way to remain alive and attentive to the infantile transference and her role in it. To be carried off by current external events or diverted toward an historical past that is *already well traversed by both members of the analytic couple* may lead to a fortification rather than a relaxation of the patient's autistic barriers. The analyst's open-mindedness to communications from within 'the dark acorn of the heart,' when these momentarily surface, may contribute toward facilitating a wholesome emergence of self.

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## Translations of Summary

**"Trying to enter the long black branches": Die Analyse autistischer Zustände im Erwachsenalter — behandlungstechnische Weiterentwicklungen auf der Grundlage von Frances Tustins Werk.** Die Autorin empfiehlt eine Reihe technischer Erweiterungen/klinischer Anwendungen von Frances Tustins Arbeit mit autistischen Kindern für die Psychoanalyse von neurotischen, Borderline- und psychotischen Erwachsenen. Diese sind besonders für jene Patienten relevant, in denen frühe Erlebnisse, die nicht contained wurden (Bion), durch die Anwendung heimlicher autosensueller, mit autistischen Objekten und Formen zusammenhängender Manöver verkapselt worden sind. Obwohl solche Verkapselungen die emotionale und intellektuelle Entwicklung behindern können, sowohl im Beziehungs- als auch im Berufsleben vieler Analysanden Folgen haben und ihre Analytiker vor nicht endende Herausforderungen stellen, kann die Autorin Möglichkeiten aufzeigen, sie in

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einer übertragungszentrierten Analyse aufzuspüren und zu modifizieren. Sie legt eine detaillierte Differentialdiagnostik zur Unterscheidung zwischen autistischen Zuständen und neurotischen/narzisstischen (objektrelationalen) Zuständen dar und illustriert den Umgang mit einer Vielzahl elementarer Ängste — einschließlich der Angst, sich "aufzulösen" — anhand mehrerer klinischer Beispiele. Die idiosynkratische und perverse Verwendung des analytischen Settings und der Analytikerin sowie Aspekte der Motivationen der Analysanden werden erörtert und illustriert. Ein neues, "Objekte an der Peripherie" betreffendes Modell wird als Alternative zu den eher klassischen kleinianischen Modellen bestimmter Reaktionen und/oder Nichtreaktionen auf Übertragungsdeutungen vorgestellt. Ebenfalls konsequent diskutiert werden Fragen der Gegenübertragung.

**Tratando de penetrar las largas y negras ramas. Algunas ampliaciones técnicas del trabajo de Frances Tustin para analizar estados autistas en adultos.** La autora sugiere distintas ampliaciones/aplicaciones técnicas del trabajo con niños autistas de Frances Tustin que pueden utilizarse en el psicoanálisis de adultos neuróticos, fronterizos y psicóticos. Éstas son particularmente relevantes para los individuos en los cuales sucesos tempranos no contenidos (Bion) han sido encapsulados silenciosamente mediante el uso de maniobras autosensuales secretas vinculadas con objetos y formas autistas. Aunque dichos encapsulamientos pueden constituir obstáculos para el desarrollo emocional e intelectual, son fundamentales para muchos analizandos tanto en la esfera relacional como en la vocacional, y presentan desafios constantes para sus analistas. La autora plantea distintas maneras de detectarlos y modificarlos en un análisis centrado en la transferencia. Se describe un detallado proceso de diagnóstico diferencial entre estados autistas y neurótico-narcisistas (relacionados con el objeto) en adultos, junto con varias demostraciones clínicas de la manera de manejar una variedad de terrores primitivos, incluyendo el 'miedo a la disolución'. Se estudian e ilustran el uso idiosincrático y perverso del setting analítico y del analista por parte del analizando, así como cuestiones vinculadas con las motivaciones de este último. Se introduce un nuevo modelo relacionado con los 'objectos en la periferia' como alternativa a los modelos kleinianos más clásicos respecto de ciertas respuestas y/o falta de respuesta a la interpretación transferencial. A lo largo del trabajo también se incluyen cuestiones relacionadas con la contratransferencia.

**Essayant d'entrer les branches longues et noires: quelques extensions techniques pour l'analyse des états autistiques chez des adultes à partir du travail de Frances Tustin.** L'auteur propose un certain nombre d'extensions techniques/applications cliniques venant du travail de Frances Tustin avec les enfants autistiques et qui sont applicables à la psychanalyse des adultes névrotiques, état-limites et psychotiques. Celles-ci sont spécialement pertinentes pour les individus chez qui les événements précoces non contenus ont été silencieusement incarnés à travers l'utilisation des manœuvres secrets autosensuels liés aux objets et formes autistiques. Bien que de telles incarnations peuvent constituer des obstacles au développement émotionnel et intellectuel, qu'elles soient consécutif dans les sphères tant relationnelles que professionnelles pour beaucoup d'analysands et présentent des défis éternels pour leurs analystes, l'auteur démontre des voies par lesquelles il puisse être possible de les détecter et de les modifier dans une analyse centrée sur le transfert. Un processus détaillé de diagnostique différentiel entre des états autistiques et des états névrotiques/narcissiques (liés à l'objet) chez les adultes est dessiné avec plusieurs démonstrations cliniques du maniement d'une diversité de terreurs élémentaires, la terreur de dissolution incluse. L'utilisation idiosyncratique et perverse du cadre analytique et de l'analyste ainsi que des questions des motivations de l'analysands sont considérées et illustrées. Un nouveau modèle lié aux «objets dans la périphérie» est introduit comme un alternatif aux modèles plus classiques kleiniens de certaines réponses et/ou non-réponses d'interprétation transférentielle. Tout au long, les questions à propos du contretransfert sont considérées.

**Un tentativo di inoltrarsi nelle lunghe ramificazioni oscure: alcuni approfondimenti tecnici per l'analisi di stati autistici adulti**

**tratti dal lavoro di Frances Tustin.** L'autrice propone una serie di approfondimenti tecnici/applicazioni cliniche del lavoro di Frances Tustin con dei bambini autistici, applicabili alla psicanalisi di adulti nevrotici, borderline e psicotici. Si tratta di metodi attinenti in particolare a quegli individui nei quali iniziali manifestazioni incontrollate (Bion) sono state silenziosamente incapsulate attraverso l'uso di manovre autostimolanti nascoste legate a oggetti e forme autistici. Sebbene questi incapsulamenti possano costituire degli ostacoli a uno sviluppo emotivo e intellettuale, si manifestino — per diversi pazienti — conseguenze sia nella sfera relazionale che in quella attitudinale, e presentino delle sfide continue per gli analisti, l'autrice illustra dei modi per rilevarli e modificarli grazie a un'analisi basata sul transfert. Viene descritto un processo dettagliato di diagnosi differenziale tra stati autistici e stati nevrotici/narcisistici (legati all'oggetto), accompagnato da diverse dimostrazioni cliniche di gestione di una serie di terrori primitivi, incluso «il terrore di dissolversi». Vengono presi in considerazione e illustrati l'uso idiosincratico e irrazionale del setting analitico e dell'analista, e i problemi legati alle motivazioni dei pazienti. Viene introdotto un nuovo modello legato agli «oggetti nella periferia» come alternativa ai più classici modelli kleiniani riguardanti certe risposte

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e/o non risposte all'interpretazione del transfert. Sono inoltre analizzati i problemi relativi al controtransfert.

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