did she seem to have any inbuilt resistance to the idea of brakes, and the idea that her therapist might not enjoy being cross with her was pleasant, but apparently quite new. A few years later, such features in her behaviour might have been far more embedded in her character and far more difficult to shift.

I have given in this chapter examples of difficulties in cognitive functioning of three patients. Such deficits need as careful attention in psychoanalytic work as do the emotional conflicts, splits and projections more central in less disturbed patients. In the case of both Robbie and Cindy, I have tried to describe a profound lack in the capacity to maintain intentionality and in thinking in parentheses in a two-tracked way. I have tried to link this with object-relations considerations. In Cindy, a much younger patient, I have also tried to demonstrate some of the technical considerations which I believe enabled her to achieve and maintain intentionality fairly rapidly in her first year of treatment. In the third case, Rosie, I have drawn attention to a more partial, but nevertheless severe type of cognitive deficit where the therapist may have to contain as yet unthought thoughts, unborn ideas which may have to be given flesh and life by the therapist. In the case of Cindy, the preconceptions of certain ideas were sometimes already there. The therapist took a gently active role in assisting their realization. According to Bion, when a preconception of a breast meets with a realization, a conception is born (1962: 91) That model is mostly adequate for what happened with Cindy. But what about Rosie, who genuinely seemed at times to be spinning wildly out of control? Or what if, for example, after a premature birth, a baby is too weak to open its mouth and go rooting for the breast? Its preconception of breastness may need awakening. Mothers in such instances help the baby to feed by giving the breast before the baby thought of asking for it. Some new realities press themselves upon us before we have preconceptions ready to meet them. If the conditions are not too pressured, a new concept may still be given time to be born.

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8

A DEVELOPMENTAL VIEW OF 'DEFENCE'

Borderline patients

Bruner delineated the stages in the development of the capacity for co-ordination, or 'two-trackedness', which he suggested was the forerunner of the capacity to 'think in parentheses'. I have mentioned that when Robbie got beyond the stage of needing me to reach out to him in his far-off state, and could reach out himself, one of his problems was not knowing how to modulate and filter strong emotions. If he wanted to make contact with me by talking, he sometimes had to close his eyes, like Bruner's infants, so as not to lose himself in the process of gazing. By now he wanted to link up, but he still lacked most of the basic equipment to facilitate such linking. But closing his eyes was a start, both to defend himself against overwhelming excitement and also to preserve a more peaceful and solid form of contact. In the same way, stopping his ears against the noise of a Hoover was both a defence against terror and an attempt to find a place of safety. Gradually, he has become able to look and listen in more modulated and less drastically defended ways. This has involved developing functions which in a more mature, complex, structured personality may sometimes serve as 'defences', but in the case of Robbie and other psychotic or borderline psychotic, traumatized or abused children, may deserve a better name, one which stresses elements of a protective and developmental type. Notions of immaturity, of weak ego development, of deficit (Kohut), of equilibrium (Joseph) are helpful because they provide a sense of where the child is coming from and, even more important, where he has as yet not arrived (Bruner 1968; Kohut 1985; Joseph 1989).

THE BORDERLINE PSYCHOTIC CHILD

The case of the borderline psychotic child, where there may be some ego development, although of only a minimal or fragile sort, raises similar problems to those in the treatment of the psychotic child. The diagnosis is unfortunately not widely used among child psychiatrists who are not psychoanalytically trained. It does not exist at all in the ninth edition of the *International Classification of Diseases* (ICD-9). In the third *Diagnostic and Statistical Manual* (DSM-III) of the American Psychiatric Association, it is included as a sub-category of personality disorder, with its main features cited as: 'Impulsive, unpredictable, with unstable but intense interpersonal relationships. Identity uncertain, mood unstable, fearful of being alone, self-damaging' (Barker 1983: 145). I am using the term borderline psychotic in a much wider sense to include the other sub-categories of personality disorder such as compulsive, antisocial, paranoid, schizoid and avoidant, and so on. The psychiatric classifiers are, I suppose, uncomfortable with too wide a use of the word psychotic to describe children who are not flagrantly so, partly because the word still has pejorative associations in the lay (and organically minded psychiatric) mind. To the psychoanalytic psychotherapist, the notion of a psychotic part of the personality or the evidence of (hopefully brief) instances of psychotic thinking in everyone's life is perfectly comfortable, and so no more pejorative than the label personality disorder. Furthermore, when the quality and level of anxiety are understood (along with the content and form of some of the phantasies), the word psychotic attached to borderline seems perfectly appropriate. It also has important implications for theory and technique in relation to such children.

Most writers in the field tend to describe adult borderline patients as existing on a continuum between psychosis and neurosis. This vertical dimension, which describes both the degree of pathology and the level of ego functioning, is useful as a rough guide in unknown territory, but it should not be allowed to narrow one's focus, for most of the writers are in fact referring to an extremely broad range of illness. The categories – on the horizontal axis, as it were – tend to include everything from the psychopathic character disorders through the immature personality, the narcissistic disorders, severe neurotic conditions with psychotic features, excessively severe depression, to what used to be called latent schizophrenia but

would now more likely be termed borderline schizophrenia (LeBoit and Capponi, 1979). The child psychotherapist might want to add many severely deprived, abused and traumatized children who sometimes have much in common with psychotic children, but in other respects are very different. They are different from borderline adults because psychotic illness in children, however temporary or however much only a threat from beyond the border, interferes with normal psychological development and therefore often produces developmental arrest and developmental deficit. Child psychoanalytic psychotherapists from the Autism Workshop at the Tavistock Clinic would also feel comfortable with the notion of borderline autistic conditions, although of course many organicists would not.

Therapists in the Anna Freud (then Hampstead) Clinic's borderline Workshop attempted to formulate the meaning of the concept 'borderline' in 1963. Kut Rosenfeld and Sprince concluded that the illness resides 'both in the quality and level of ego disturbance and in the precarious capacity for object relations' (1963). In a second paper (1965), on technical issues, they stated that they found that borderline children had an unusual reaction to interpretations: they experienced them as permissive, and interpretations of phantasy often caused phantasy and anxiety to escalate uncontrollably. Their conclusion was that it was necessary, therefore, to facilitate the very defence mechanisms which in a neurotic child one would attempt to undo: for example, repression and displacement. But there were differences among the members of the workshop as to how much ego support, reassurance and encouragement of the positive, as distinct from interpretation of the negative, should take place. Chethik and Fast, of the Borderline Workshop at the University of Michigan, do not agree with the notion of facilitating repression and displacement. They state that they no longer focus on getting rid of the phantasy but on helping the child grow out of it by delineating the underlying fears and anxieties. On the other hand, they do not recommend 'precipitating the child into an overwhelming state of non-pleasure' (Kut Rosenfeld and Sprince 1963, and 1965; Chethik and Fast 1970).

LeBoit, in a summary of the technical problems with borderline adults, concluded that 'the borderline patient in the past created a problem for psychoanalytic treatment, because he was deemed unable to form an object transference'. (He was thought to be unable to withstand the deprivation and 'abstinence' involved

in classical analytic technique.) LeBoit continued, 'Currently the borderline individual is allowed to form the transference of which he is capable, usually a predominantly narcissistic transference, which develops into symbiosis.' LeBoit believes that during this early period of the treatment, the analyst may have to include modifications in classical analytic technique – that is, interventions other than interpretation, particularly those which indicate agreement of thought and feeling between analyst and patient, and those which reflect acceptance of the patient's unconscious wishes and understanding of his maturational needs (LeBoit and Capponi 1979: 57). Child psychotherapists are familiar with the kind of pressure child patients put on them when they come up in a friendly open manner and say 'My favourite colour is red. What is yours?' The therapist often feels compelled to offer a depriving type of interpretation – Grotstein has called it a weaning type of interpretation (Grotstein 1983) – in order to curb the child's omnipotence or intrusiveness, and in order to avoid gratifying the child's phantasies in a collusive or seductive way. However, I believe the argument over gratification versus deprivation is a false, a dangerously false, dichotomy. It is false because an interpretation may deprive the patient of real gratification of the information asked for, yet not be experienced as depriving at all. It may, in fact, be quite gratifying if it is an interpretation which is receptive to the child's wish to assure himself that the therapist and he have something in common, or like some of the same things, or belong to the same species. An interpretation can communicate understanding of this without being collusive or seductive. The dichotomy is dangerous because a too defensive interpretation may be experienced by a suspicious or already deprived child as cruelly rejecting of what may be his first overture of friendliness. I would suggest that the same question might have very different implications depending on the child: in one child, it may well be an attack on or a defence against separateness; in another child, it might be a first step in getting together with his object. In the first case, the child may be too close, too inside, and may need to be more separate; in the second, the child's object may be too remote, and he may need to feel it is approachable. This does not necessarily mean you have to tell the patient what your favourite colour is!

DEFENCES AND DEVELOPMENTAL ACHIEVEMENTS OR OVERCOMINGS

Unfortunately, the useful elements in the notion of the theory of deficit are sometimes obscured by the technical modifications which many people seem to think must follow from Kohut's stress on deficit. One Kohut supporter, Ornstein, suggests it was probably a mistake over the years to think of deficit as a void that has to be filled, as Kohut implied (Ornstein 1983). Kohut believed it was important to develop what he called the normal narcissistic pole of the personality and he has been much criticized for gratifying the idealizing narcissistic transferences. It has been claimed that he was doing supportive psychotherapy rather than analysis, what some writers would call manipulating the transference rather than analysing it. That seems to me to be another too simplistic dichotomy, which could be clarified by considering some of the problems that may arise from the psychoanalytic concept of defence. In Kleinian thinking, for example, a paranoid-schizoid patient may be defending himself against the truths of the depressive position – that is, against his love or his guilt - but he may also be suffering from impaired development, so that he cannot yet proceed to the depressive position (see Chapter 10 for a fuller discussion). This brings up a vital practical question: what are the conditions under which development forward is possible at any stage? These considerations must shape whether the therapist interprets a patient's suspiciousness or detachment as a defence against a closer and better relationship, which it may be, or whether it is understood as a protection against what he perceives to be a genuinely attacking or intrusive or useless object. Joseph's term 'psychic equilibrium' provides us with a concept much subtler than that of defence. In 'On understanding and not understanding', she writes, 'The patient who believes he comes to be understood actually comes to use the analytical situation to maintain his current balance in a myriad of complex and unique ways' (Joseph 1983: 142).

In her novel, *Beyond the Glass*, Antonia White tells the autobiographical story of a young woman's collapse into madness and her subsequent recovery in an asylum. Clara has what seems to be a schizophrenic or possibly manic breakdown and is confined in a straitjacket and a padded cell. One day, after many months, the straitjacket is removed and she begins to emerge from her state of wild confusion. Remarkable things happen. Instead of going

through myriad changes of identity, she notices that she is always the same person called Clara. She has no memory of her previous life, but she does begin to know that she once had a previous life and her name was Clara in that life, too. Certain images from her daily life – the women's washroom, a creeper growing – begin to be fixed points of reference for her. As she puts it, 'A small space about her became solid and recognisable. In that space, objects and people were always the same, certain islands of time always the same.' Whereas before she felt she had fifty nurses, two emerge with some distinct and separate identities, and she writes, 'The red-haired one was Jones. *She must try and remember that*' (my italics). But the little islands of consistency continue to have no connection or thread of continuity between them. Thus, she says, 'It was extraordinarily difficult to remember things. Words like "before" and "after" no longer had any meaning. There was only "now". . . . Nevertheless she *continued to try desperately to piece things together, to find some connection between Clara here and Clara there*' (pp. 230–2, my italics). Eventually she does. She is moved to an open ward and then is allowed out to play croquet on the lawn. Somehow or other she remembers how to play croquet, and she realizes that none of the women will obey the rules and that they will play any old colour and any old way; she starts trying to tell them how to play properly. She cannot think why these women won't obey the rules, and it suddenly hits her that they are mad. After that, she recovers quickly (White 1979).

The notion of Clara developing defences is clearly not a useful way of looking at her attempts to emerge from psychosis. We should not, that is, confuse the building of the house with the building of the defensive fortifications which may eventually surround it. We build houses with walls to keep the weather out, but also to mark, frame and preserve that which may take place within. Surely it would not be useful to think of Clara's desperate efforts to piece things together, to concentrate on and remember the bits of clarity which are beginning to emerge from the mist, as obsessional defences against madness. Hoping against hope can be used defensively, but it can also be used for purposes of overcoming evil and despair. Robbie described a terrifying dream or hallucination he had had of hanging off the edge of a cliff, upside down, holding on to a piece of grass. Is the grass a defence against falling? Do we need lifelines only to escape death, or also in order to preserve life?

These issues may seem very clear-cut, but for the chronic

borderline case, who fluctuates back and forth between madness and sanity and where the amalgam of the psychotic part and the non-psychotic part may be very complex (see Grotstein 1979 and Steiner 1991), the issue is not quite so simple. It is important to know when obsessional mechanisms are being used defensively against an experience of a more living, free, less controllable object or feeling and when they signal perhaps the very first attempt, or at the very least a renewed attempt, to achieve some slight order in the universe. It is important also to distinguish between the moments when a manic experience of an ideal object or an ideal situation is used as a defence against a more sober reality and when it signals the first glimmer of emergence from lifelong clinical depression. Bion has taught therapists to distinguish between mechanisms designed to modify frustration and those designed to evade it. But is this a simple either/or situation or are there many developmental steps on the way between evasion and modification? There is, for example, the intermediate situation where a defensive evasion is necessary because the patient is not capable of managing the more mature modifications of his anxieties. His defences are all he has. What, then, are the conditions and even preconditions under which modification can begin to be possible?

The Analysis of Defence records a series of discussions with Anna Freud in the 1970s on her book *The Ego and the Mechanisms of Defence*, which was published in 1936. In one of the discussions, Joseph Sandler distinguishes between defences *against* painful realities and defences *toward*, which exist in order to gain or maintain a good feeling of security or safety (protective device) (p.19). In one of the later meetings, when they are discussing the fact that repression is developmentally a fairly late mechanism of defence, Anna Freud says that projection is used long before repression. Then Sandler says, 'Presumably because repression needs a considerable amount of strength on the part of the ego in order to work.' Anna Freud replies, 'Well, it needs structuralisation of the personality, which isn't there in the beginning.' Then she says, 'If you haven't yet built the house, you can't throw somebody out of it.' Sandler adds, 'Nor keep him locked in the basement' (Sandler and A. Freud 1985: 238).

Clearly, it is important to think developmentally about these matters: sometimes when the weekend or the summer break is imminent, one can interpret that the patient is really 'somewhere' upset about the coming break, and so is simply repressing it, when

in fact he may have successfully split it off and projected it into the therapist. He doesn't feel 'somewhere he is missing her'; he feels *she* is going to miss *him*. Depending on the case, the feeling of missing may need to be contained and explored in the therapist for a lengthy period of time before the patient is ready to experience it as belonging to himself (see Joseph 1978: 112). In cases where the house isn't yet built, what may look like an attempt to throw somebody out of the house – to project the suffering infantile part into someone else – may really be a desperate attempt to find any house anywhere.

In their book *The Psychoanalysis of Developmental Arrest*, Stolorow and Lachmann suggest that it is important to distinguish between mental activity that functions principally as a defence and the superficially similar activity that is more accurately understood as a remnant of an arrest at a pre-stage of defensive development, characterized by deficiencies in the structuralization of the developmental world. Stolorow and Lachmann consider various 'defences' such as narcissism, idealization, grandiosity, projection, denial, incorporation, splitting, and compare the pre-stages of defence to real defences. They suggest, for example, that 'a functional conception of narcissism (i.e. one which sees it as fulfilling a need)' helps to alleviate the counter-transference problems that arise with narcissistic patients by enabling us to recognize that their narcissism is in the service of the survival of their sense of self. These ideas are important for work with deprived children who may present as very cut off and narcissistic and where an approach which is too confrontational may simply cause them to strengthen their defences. Stolorow and Lachmann also emphasize the difference between denial of something which is already known and 'denial' of something which is as yet not fully comprehensible. They write that 'when the analyst interprets as resistive what the patient accurately senses to be a developmental necessity, the patient often experiences the interpretation as a failure of empathy, a breach of trust, a narcissistic injury' (Stolorow and Lachmann 1980: 112). One is reminded here of Money-Kyrle's stress on the urgent importance of distinguishing between a projective identification motivated by destructive impulses and one motivated by desperation (1977: 463). He thinks analysts ignore this distinction at their peril, and surely in real life mourning is a gradual process. But when analysts and therapists urge patients to face their fears, their yearning, their sadness, long before they have the resources and imagination to do so, they may be asking too much.

A CLINICAL EXAMPLE

Some years ago I was treating a little borderline psychotic girl named Judy who suffered from asthma. She had never had an asthma attack in my presence, but one day she came in with a slight shortness of breath and said, in a very anxious voice, that she was having an asthma attack. I tried to show her that she seemed very frightened, as though she thought she was going to die. Her panic and breathing grew worse and I realized that, instead of helping her, my interpretation had escalated her anxiety. I thought quickly, and finally said something about the fact that she didn't seem able to tell the difference between a big asthma attack and a little one. It didn't seem to me a particularly profound interpretation, but she said, with surprise and relief, 'Ye.e.e.ss...' and her breathing improved. I was struck by the fact that a less anxious patient would have heard the implications in my first interpretation (that is, that she would not die) but that this terrified little girl could not. She had an extremely anxious and fragile mother, and I think she heard my first interpretation as though I, too, thought she was about to die. Although she panicked at every parting, however brief, I could never, in the early years, say that she imagined something terrible might happen to one of us during a weekend break: I had to turn the idea around, and talk to her about her difficulty in believing that both of us might make it through and meet again on Monday.

THE PARANOID-SCHIZOID POSITION AS A DEVELOPMENTAL PHASE

Klein first outlined her notions of the paranoid and depressive positions in two papers, 'Psychogenesis of manic-depressive states' (1935) and 'Mourning and its relation to manic-depressive states' (1940). It is probably well known that Klein did at first make some attempt to think in terms of phases and dates for these two very different states of mind – that is, she was thinking in terms of a developmental theory, following the tradition begun by Freud with his libido theory (Freud 1905b) and continued by Abraham (Abraham 1927). Gradually, however, the phase concept left Klein's writings altogether and she stuck much more closely to the notion of position. The idea of a position is, of course, a spatial metaphor and, in Klein's theory, it implied not just a different bodily location for the libido, but was, by definition, a relational, that is,

an object-relational term. In deference to Fairbairn, Klein added the schizoid concept to the paranoid position and the characteristics at the schizoid end of the position are thought to be excessive splitting and fragmentation, excessive projection (later, in 1946, she added projective identification), a consequent weak ego and a weak trust in a good object (Fairbairn 1952). Grotstein points out that in a pathological state various symptoms such as loss of appropriate affect and confusion may follow, whereas in the normal infant there is helplessness and relative unintegration (Grotstein 1981b). At the paranoid position, Klein describes excessive splitting into good and bad of both self and object, with therefore excessive idealization and excessive persecution. Klein described the excessive projection of bad parts of the self into the object and thus excessive phobic fears or feelings of a paranoid type. Feelings of persecution spiral and escalate, owing to projection into the object and re-introjection of the by now bad objects, producing the need to re-project and so on. It is important to remember, however, that in a footnote in that same 1946 paper, Klein also wrote of how good parts of the self may be projected excessively, with consequent weakening of the ego and feelings of being swallowed up by the excessive goodness and value of the object. This phenomenon is as much a feature of the paranoid position as is the one characterized by projection of the bad part. Constant projection of the good part also produces a vicious circle seen in some very delinquent children and certainly in many psychiatrically depressed children, who may feel incapable of meeting the demands of a needy or damaged object that is felt to be beyond their strength to repair. The blanket of despair seems much more total and all parts of the self and the object seem to be engulfed in it. It is also important to consider that in some very disturbed and deprived children, the good part and the belief in a good object may not necessarily be projected; it may, instead, be severely underdeveloped.

I have written elsewhere in this book about the fundamental theoretical and meta-theoretical advance in the Kleinian differentiation between processes designed to defend against and processes designed to overcome depressive anxieties. Klein made it clear that true reparation, as opposed to manic or obsessional reparation, was not a reaction formation against, or denial of, depression and guilt about damage. In Klein's and Bion's thinking, overcoming, as opposed to denial or defence, involves healing modifications, but not evasions or triumphs or denials. I have come to think that

a comparable distinction needs to be made when discussing the persecutory anxieties of the paranoid-schizoid position. Love has to be stronger than hate in order to overcome depressive anxieties. But what has to be stronger than fear to overcome, as opposed to defend against, persecutory anxieties? Here Bion's container is important, and so possibly is a closer analysis of the various functions of the 'good' object. The good object at the depressive position is an object loved and respected and capable of evoking concern. At the paranoid-schizoid position its goodness may also consist of its reliability, its assuring qualities, its solidity, its substantiality – that is, its good intentions, its protective qualities, its capacity to ensure feelings of safety; in a word, what Bowlby has called a 'secure base' (Bowlby 1988). Perfect love casteth out fear, but so, sometimes, does perfect safety.

I shall try to show in following chapters that Bion's work on projective identification as a communication and the work of the developmentalists have a number of implications for the treatment of psychotic and borderline children: first, we need a general concept of overcoming to stand beside the concept of defence for the paranoid-schizoid position; second, we need specific terms such as potency to stand alongside that of omnipotence; a sense of agency to stand alongside narcissism; relief, joy and hope to stand alongside manic denial; order, structure and predictability to stand beside obsessional defences against fragmentation, and many others besides. I shall try to show that these positive states of mind should not be seen as defences and need not wait for the developments of the depressive position. They occur in much more primitive positions of psychological development where it is not so much a question of splitting between good and bad being marked, but where what is at issue is the adequate development of, and belief in, the good. When Robbie and Bruner's babies close their eyes against distraction and borderline children begin to hold to the idea that Monday may really come, they may be engaged in an act of precious conservation and preservation. First, as Anna Freud says, build the house; first, as Klein says, introject the good breast; first, as Bion says, you have to have an adequate container; first, as Bowlby says, have a secure base.