"Fear of Breakdown": Staying Close to the Terror

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Whakarāpopotonga

E kī ana te kaituhi o tēnei pepa, me 'noho tata ki te tarawewehi' he whāinga pūtake mō te mahi haumanu hinengaro, inārā i te wā e mahi ana i te taha o ngā tūroro e maru ana i ngā nohowehenga o te whetuki ngaukino. Ka tūhurahia he huinga tātarihanga hinengaro ā-Hungiana me te ariā tāmi hai ringa āwhina arataki i te kaihaumanu hinengaro e whakapā ana ki te aratika mō tēnei mahi pūtake, inā koa ki te whakaarohia ake ngā mahi whakawehiwehi whakararuraru ā-hinengaro takitahi, takirōpū puta mai mō te tūroro me te kaihaumanu.

Abstract

In this paper the author proposes that a central task of psychotherapeutic work is to "stay close to the terror," particularly when working with those patients whose inner world is populated by often dissociated states of traumatic horror. The paper explores a range of psychoanalytic, Jungian, and trauma theory that might assist in guiding psychotherapists regarding how we might engage with this central task, particularly given the often terrifying intrapsychic, interpsychic, and interpersonal disturbances such therapeutic work entails, for both patient and therapist.

Key words: terror, countertransference, reparation, intrapsychic, repair, grief

Introduction

> Thoughts connected as we feel them to be connected are what we mean by personal selves. (William James, 1892, pp. 153-154)

Bateman and Fonagy (2004) suggested that for those who have experienced severe trauma in early life the process of projective identification is an unconscious act of psychic and physical survival. Such patients experience not only a failure of affective attunement to their internal emotional and somatic infant and childhood states (what Bateman and Fonagy termed the constitutional self), but moreover the torture of an external other who

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actively terrorises the child's vulnerability. Russell Meares (2000) in his articulation of the conversational model similarly suggested that core to such experience is the devastating interruption of the capacity for internal reverie; the capacity to have one's own thoughts and feelings and to reflect upon one's own thoughts and feelings, this being the foundation of what William James (1892) described as the "personal self" (pp. 153–154). The absence of another's mind to receive and mirror these internal states leads inevitably and tragically to an inability to symbolically represent ourselves to ourselves; to feel inevitably and despairingly alien to our own inner world.

Even more devastating, a traumatic early relational environment characterised by profound intrusive attack, physically, emotionally, or sexually, and/or profound absence and neglect, leaves the infant with no choice but to introject not only an alien experience of themselves incongruent with their primary emotional and somatic experience, but also to introject representations of the traumatically attacking other. Thus projective identification, the process by which the infant and later adult patient evacuates alien states of helplessness and persecution into another, is the psyche's creative attempt to survive this internal persecution via the relief of experiencing it, if only temporarily, in another, and in so doing relieving their own inner world of these persecutory horrors, or at least attempting to do so.

Their formulation graphically captures the experience of internal persecution. I hate myself and everything about myself. I have taken this in from a traumatising attacking environment that not only fails to congruently recognise the internal states I experience, but actively attacks these states, invading me with an alien self that persecutes my very being. My only relief is to find a potentially caring other, with whom I can get close enough to hate. If another comes close, they represent the deep longing I have that someone somewhere might care enough to reach my terror. And yet they also represent the inevitability that this so-called caring other will become another persecutor determined to attack, abandon, abuse and hurt me. So, I will hurt them first. With all my might. I will attack the attacker that I know is in them. And then they can feel my powerlessness, and I will be relieved, if only briefly, of the terrifying terrorist and their powerless, dissociated victim within me. Sadly, of course, the relief of projective identification is always temporary; the attacker and its accompanying terror can never be permanently violently evacuated, no matter how forceful the psyche's attempt to do so.

So, what is the therapeutic task in the violence of such disturbing processes? In this paper I will suggest that a central challenge is to stay close to the terror. Both our own, and our patients. And that ultimately it is when our patients and we as therapists can stay with, bear and understand the terror, that transformation is possible, as fear transforms to grief, and the possibility of creativity emerges. I will grapple in this paper with how we might undertake this very disturbing challenge, and the therapeutic principles which might guide such difficult but potentially transformative work.

A Central Therapeutic Task: Staying Close to the Terror

In his seminal paper "Fear of Breakdown," Winnicott (1974) described the phenomenon in which we encounter in the patient the terror of a breakdown which has already occurred, in

the patient's traumatic childhood, but for which the patient was not able to be present so terrifying was this disintegration. Winnicott noted, "the clinical fear of breakdown is the fear of a breakdown that has already been experienced. It is a fear of the original agony which causes the defensive organisation which the patient [now] displays" (p. 104). He suggested that whilst the breakdown has already occurred, it has not "happened" to the patient because the patient was not able to be present to experience it. Similarly I suggest that in the patient's confrontation with the unconscious, with an alien tormentor to whom our vulnerability is addictively bound, there is the possibility that the patient is returning to a vulnerability which has previously been disassociated, obliterated into impotence and powerlessness, a terror that has never been formulated (D. B. Stern, 2009). As Winnicott (1974) observed,

> If the patient is ready for some kind of acceptance of this kind of truth, that what is not yet experienced did nevertheless happen in the past, and the way is open for the agony to be experienced in the transference, in reaction to the analyst failures and mistakes … There is no end unless the bottom of the trough has been reached, unless the things feared have been experienced… The patient needs to remember this, but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to … The only way to remember in this case is for the patient to experience this past thing for the first time in the present. (p. 105)

Winnicott suggested that therapy offers an opportunity for the patient, midwifed by the mind of a containing other, to experience the breakdown as if for the first time; the therapist's mind being available in a way that a mind was not able to be present during the original breakdown, to symbolically represent the experience of primitive terror, and thus for the patient for the first time to be able to represent these original agonies to themselves. However, Winnicott noted that the task is challenging, and the inevitable transference enactments which allow the patient to remember such early horrors is deeply disturbing for patient and therapist alike.

Yet the gold at the heart of this potential transformation is the creativity that can arise from such profound grieving. The possibility that we might symbolise what has never been symbolised before, and more than this, that the shared labour of intrapsychic and relational mourning may give rise to something new. To accept this opportunity, or at least receive it, is an act of extraordinary emotional courage on behalf of both therapist and patient. To do so we must navigate the emotional terror of our own inner world as well as that of our patients, and the often fraught interpsychic encounter that emerges between therapist and patient.

In the next section of this paper I will briefly review early writings regarding the aetiology of internal persecution and annihilatory dread, and the reparative impulses such destructiveness evokes, before considering the specific challenges for therapists working with such disturbing terror.

Aetiology of Internal Destructiveness: Early Writings

Of the early psychoanalytic writers, it is Melanie Klein (1923, 1929, 1935, 1940, 1946, 1975) who first grappled most disturbingly with the intrapsychic attack and consequent annihilatory terror that she perceived haunts the psyche of all infants. In doing so Klein did not put the same emphasis on the relational response to such terror that we find in contemporary developmental theory, instead placing a greater emphasis on the intrapsychically terrifying inner world of the baby that inevitably experiences their somatic distress as inherently persecutory.

Klein (1923, 1929, 1935, 1940, 1945, 1946, 1975) built on ideas of identification, introjection and projection in her graphic explorations of the primitive persecutory terrors of the infant, and the necessities of splitting in order to prevent the phantasised destruction of the good by the bad. Klein's infant experiences their somatic distress of hunger, pain, tiredness et cetera as intrapsychic attacks which produce internal annihilatory terror, perceiving the attack as coming from the external "bad breast," the frustrating other hatefully attacking the self. Such terror threatens what Winnicott (1963) described as the infant's experience of "going on being" and thus produces annihilatory dread. As the ego matures Klein (1946) hypothesised that paranoid schizoid splitting reduces, with the movement towards the depressive position, as the infant comes to realise that the loved object is also the hated and aggressed against object, leading to "depressive affect," that is guilt, and ideally the capacity for mourning, the belief that aggression will not overwhelm love, that the bad will not overwhelm the good, and/or that repair of the object is possible if damage occurs. By contrast she notes the impulses towards manic reparation when guilt and anxiety regarding previous paranoid schizoid sadistic attacks overwhelms the psyche. As Klein (1935) commented,

> the ego feels impelled (and I can now add, impelled by its identification with the good object) to make restitution for all the sadistic attacks that it has launched on that object. When a well marked cleavage between good and bad objects has been attained, the subject attempts to restore the former, making good in the restoration every detail of his sadistic attacks. (p. 149)

Hinshelwood (1989) described Klein's distinction between manic reparation and a deeper more creative reparation. He commented:

> In her 1940 paper Klein showed there to be various forms of reparation: (i) manic reparation, which carries a note of triumph, as the reparation is based on a reversal of the child-parent relation, which is humiliating to the parents … ; (ii) obsessional reparation, which consists of a compulsive repetition of actions of the undoing kind without a real creative element, designed to placate, often in a magical way; and (iii) a form of reparation grounded in love and respect for the object, which results in truly creative achievements. (p. 413)

Henri Rey (1994), building on Klein, similarly distinguished between manic reparation and what he terms reparation proper, noting:

> The role of the internal object is the key to reparation proper. … It is the internal object that must respond to the reparative efforts … the achievement of forgiveness through the internal object seems to be a vital aspect of reparation proper. … This raises the question of what ordinary good characteristics the internal object must achieve in order to consider that a good working through of the depressive position has been achieved. This would mean that both mourning and tolerance and the capacity for maintenance and care have replaced intolerance and depression. (p. 223)

Reparation proper in Kleinian theory "belongs to the depressive position" (p. 213), and requires that whole objects can be recognised as being able to be both good and bad, loving and hating, and yet "good enough" (Winnicott, 1953). The superego is experienced as compassionate, accepting of self and other, and psyche retains faith that the object has not been destroyed by prior aggression, and/or is capable of true repair. As Rey (1994) observed:

> Only when the superego becomes less cruel, less demanding of perfection, is the ego capable of accepting an internal object that is not perfectly repaired, can accept compromise, forgive and be forgiven, and experience hope and gratitude. Perhaps it is then that love has won the day … The cruelty of the primitive superego, and guilt feelings thus diminish considerably in intensity so that guilt feelings thus become more appropriate … There appears the first traces of forgiveness instead of revenge, of hope instead of despair, gratitude instead of envy. The establishment of a good inner object capable of all these activities, including maintenance and care, contributes to make reparation possible. (p. 227)

Steiner and Schafer (1993) noted the centrality of the painful process of mourning in this process of reparation, as reality is faced, and loss of omnipotent control is experienced.

> If [the patient] can … acknowledge both his hatred, which leads to his wish to destroy the object, and his love, which makes them feel remorse and regret, then development can proceed … he is able to struggle with those rich and painful experiences connected with loss which we associate with mourning. (p. 77)

Suicidal Impulses

Perhaps the emotional disturbance of lethal suicidal and homicidal impulses is the most disturbing manifestation, for the clinician, of the persecutory dynamics which Klein described. Freud (1917/1950a), in his seminal paper "Mourning and Melancholia," wrote perceptively of the process by which an aspect of self might attack another aspect internally, suggesting that in melancholic states the patient's internal self-attacks reflect an attempt to retain the lost object, with the patient's ambivalent hostility to the lost one manifesting as an attack on themself. As Rey (1994) commented:

> When the melancholic indulges in constant criticism about himself he is also continuing his attacks on the object with which the ego is now identified. … the guilt

> of the continued attack prevents any working through and coming to terms with the loss. (pp. 211, 212)

Freud's paper has been highly influential in understanding depression as in part involving aggression turned against the self and paved the way for Anna Freud's (1966) later conceptualisation of the process of identification with the aggressor. Bell (2001), in building on Sigmund Freud's and Klein's ideas, explored the inner world of suicide and suggested that with every suicide there is a homicide. As Sigmund Freud observed, "The ego can kill itself only if … it can treat itself as an object" (cited in Bell, p. 23), and Anna Stekel commented "No one kills themselves who has never wanted to kill another, or at least wished the death of another" (cited in Bell, p. 23). As Klein (1935) noted:

> Suicide is directed against the introjected object, but, while in committing suicide the ego intends to murder its bad objects, in my view at the same time it always aims at saving its loved objects, internal or external. To put it shortly: in some cases the phantasies underlying suicide aim at preserving the internalised good objects and that part of the ego which is identified with good objects, and also at destroying the other part of the ego which is identified with the bad object and the id. Thus, the ego is enabled to become united with its loved objects. (p. 160)

Bell (2001) developed these ideas in describing four inner situations of suicide:

1. An attack on one's own need;
2. An attack on the primary object (the introjected caregiver, who is attacked for its failings);
3. Splitting processes in which the suicidal patient attempts to preserve and save the good and loved object by ridding itself of the bad; and
4. An attempt at release from the persecuting primitive superego.

In all these a primitive attack by one part of the self is enacted upon another part of the self. As Bell (2001) observed:

> Some suicidal patients, and this is typical of severe melancholia, are continuously internally persecuted by an archaic and vengeful superego from which there is no escape: psychic claustrophobia. Its punishing quality is merciless. It inflates quite ordinary faults and failures turning them into crimes that must be punished. In this situation suicide's submission to the internal tormentors may be felt as a final release. (p. 27)

Contemporary Developmental Theory

As we know, subsequent developmental theory and research has placed much greater emphasis on the early relational environment than that which Klein considered, early relational experience now being perceived as midwife to the emergence of the self, or indeed

of selves. For example, Bion (1962), in interpersonalising Klein's originally intrapsychic emphasis regarding projective identification, placed more emphasis on the mind of mother as a containing other; Winnicott (1965) emphasised the necessity of maternal preoccupation and the facilitating environment; whilst Kohut (1979) focused on the essential need of self-object provision, a mirroring, idealising other, enabling a coherent self to develop.

Attachment theorists beginning with Bowlby (1969) explored the crucial need for secure attachment figures. Stollerow el al. (1994) postulated their intersubjective perspective in which self-experience arises out of interpersonal contexts, and Bateman and Fonagy (2004) emphasised that the mentalising capacity essential to psychic health arises out of the self-reflective capacity of the minds of the infants' caregivers, whilst relational theorists like D. B. Stern (2009) and Bromberg (1996) questioned the notion of a singular unitary self and instead proposed that the "self" consists of innumerable self-states. Jungian analyst Michael Fordham (1963, 1993), in an attempt to accommodate Jung's original conceptualisation of the transpersonal self, posited the notion of a primary self a priori of the earliest relational encounters. Fordham nevertheless emphasised the importance of the early relational environment if the potential of the primary transpersonal self is to be realised and offers a model of de-integration and reintegration of the self when relational attentiveness to the infant self is sufficiently attuned to affectively charged infantile states of distress and excitement, and, by contrast, a process of intrapsychic disintegration when the infants' needs and vulnerabilities are not sufficiently attended. Similarly the Jungian analyst Jean Knox (2009) emphasised a relational and developmental perspective, whilst moving away from Fordham's archetypal lens in relation to the notion of a primary self.

The Wounded Healer and the Interpsychic Challenge of Staying Close to the Terror

Whether intra-psychically, relationally and developmentally, or transpersonally focused, all of the above writers attempted to understand the experience of internal terror and hatred which persecute many of our patients. And it is not just the patient who is filled with the anxieties of self-persecution. Many though not all therapists experienced themselves as children as being loveable only when engaged in acts of service, if not submission or self-sacrifice, towards the other. In line with Jung's archetype of the wounded healer, the child in the therapist is often in their earliest relational experience required to care for the very adults on whom their very survival depends: an extremely disturbing environment from which to internalise what D. N. Stern et al. (1998) termed "implicit relational knowing" (p. 905). This early "relational knowing" involves the uncompromising injunction that my job is to care for the other and to disavow my fear and my aggression towards the other, lest I damage the one whom I need to survive.

Thus when the wounded patient meets the wounded therapist, the unconscious to unconscious interaction of these wounds, leaves open the disturbing possibility that in the emotional forcefield of projective identificatory dynamics the patient who communicates to the therapist that "you are a dangerous abusing other" may well meet the wound in the therapist that says "I am bad if I am not providing love." Such unconscious to unconscious communications are highly likely to lead to states of manic reparation swirling between

patient and therapist. When the damaged self-attacking patient appears there is the significant possibility that the patient's self-hatred evokes in us the one whose job it is to save the damaged other. Our own anxieties of doing damage, should we fail the damaged other, are evoked when the patient projectivity identifies their persecutor into us, and we feel the powerless horror that we may be doing harm. The impulse then to react with manic attempts to serve and save the other is sometimes overwhelming. We can be compelled in the heat of the clinical moment towards manic reparative action to restore the homeostasis of the disrupted interpersonal therapeutic relationship, whilst avoiding grappling with the much more disturbing challenge of repair of the inner world. Rey (1994) wrestles with this dilemma. Regarding manic reparation he commented:

> The psyche in states of manic reparation, seeks to defend against the internal attack of the punishing super ego by seeking to enlarge the ego via defences of omnipotence and omniscience, enabling the self to thus feel superior to the menacing and punishing object by being bigger than the object: by making the attacking object smaller. (p. 209)

Messler-Davies and Frawley (1991/1999) noted that the therapist working with the traumatised other is always on the brink of becoming the abuser of the patient's past. Thus in the swirl of such disturbing transferential and countertransferential dynamics the wounded inner world of the therapist is always in danger of submitting both to the patient's internal persecutor and to their own persecutory inner world, as the patient projects out their hate into the therapist, making the therapist the bad one, and the therapist, in states of unconscious cooperation, apologises for his or her badness and engages in the manic reparative impulses of "super therapy," seeking to quell both the intrapsychic and interpersonal hatred coming their way.

Tom Main (1957), in his seminal paper "The Ailment," examined working in a therapeutic community in which he noted that certain "special patients" evoked very strong feelings amongst the staff, often along split lines, in which some felt they were the only one who understood that special patient, that they had what was necessary to save the patient, whilst others were cruelly failing them. (Main very honestly noted his own susceptibility to this countertransferential temptation, commenting in regard to a particular patient who appeared to idealise Main, that "I emerged from my visit with [the patient] with the knowledge that I had a better feel for her emotional difficulties than her own therapist. I realised in all fairness that this was not his fault: for I could not blame him for being less sensitive than I"! [p. 140]). By contrast other staff perceived this saviour therapist as impotent, allowing the patient's destructiveness to rule the roost. Main observed:

> Denial of guilt was accompanied by compulsive reparative efforts and omnipotent attempts to be ideal. When these efforts failed to still the patient's reproachful distress, further guilt was experienced, which together with hatred, was further denied and projected and further grand efforts were made at super therapy. As a persecuting damaged object, the patient received frantic benevolence and placating attention until the controls of increased hatred and guilt in the staff became further threatened. (p. 140)

As Rey (1994) noted:

> an essential aspect of what I will call paranoid schizoid reparation … the object must (a) be repaired exactly as it was before the damage, or (b) the situation must be restored by denial that the damage has happened, that things are as they were before. Omnipotence must be preserved in both cases and seriously paralyses progress which demands the gradual giving up of omnipotence and acceptance of reality. (p. 217)

Encounter With the Unconscious

The meeting of the tormented internal world of the patient and the wounded healer within the therapist is a potent mix. It has, I suggest, enormous potential for truly transformative change but also for the manic activity of super therapy that avoids and lacks faith in inner transformation. As Milton (2017) observed, a lack of faith in the possibility of true inner transformation, and an avoidance of the grief such faith requires, is characteristic of many failed therapies. Similarly Neville Symington (2003, 2007) in exploring the conditions that allow for transformation in psychotherapeutic work, noted that the therapist is faced with a deep emotional struggle if they are to negotiate the powerful injunctions of the most primitive aspects of their own superego. He wrote eloquently of the tendency of therapists to be obedient to the dictates of their own superego, of avoiding the necessity to go beyond these internal commands, to find an emotional truth, and to speak from this place. He perceived that the injunctions of theory and technique to be the "good" therapist hamper the expression of an emotional truth, similar to Bion's (1963) "selected fact," that might arise if the therapist can courageously find their own mind. Symington (2003) noted:

> There is one group of therapists who embody an imprisoning attitude, and another group who, when they are confronted with the patient's own imprisoning attitude, do not address the problem, do not hear the patient's declaration of what is hampering his or her freedom. So, we get, within the psychotherapy world, those schools of psychotherapy who imprison their patients through embodying the inner disapproving critic, and the other school that does not help the patient face and transform their inner tyrant. The first school looks persecutory and is so: the other school, in oppositional revolt, is kind and benign to patients. But in each case the core problem remains: the patient is imprisoned through a powerful inner critic. If therapists of all kinds value freedom and have a concept of it in them, then when it is being hampered, they would address the issue. (p. 22)

Symington (2007) described this as the therapist's act of inner freedom:

> When the patient first comes to the analyst's consulting room it is probable that a fusing takes place of the analyst and patient via the superegos of each … the act of understanding is rooted in what is most personal, in the ego, but the false ideas are

> located in the superego. At the moment of insight, expressed in interpretation, the allusions or false ideas are banished in both analyst and patient. A personal ego to ego contact is established and replaces an allusion or false belief that held the two together until that time. … Each time as resistance was overcome it was then possible to reach further into what I truly thought or felt and then he was able to separate himself a bit more from the analyst and from his maternal object intrapsychically. My greatest problem in his analysis was to reach those feelings that were most truly mine. (pp. 64–65)

Symington was suggesting that often therapists avoid the emotional strains of such a demanding therapeutic task, either failing to get beyond the dictates of superego demands to be "a good therapist," or the opposite, to enact persecutory and reactive attacks on the patient, fuelled by unconscious complimentary countertransference, or alternatively, captured by a compulsion to provide perceived compassionate empathic understanding, failing to forcefully assist the patient to face their own self-destructive attacks, in so doing often avoiding the patient's persecutory self-hatred, and thus avoiding the kind of therapeutic engagement which might be required if true transformation is to occur. By contrast Symington (1996) advocated,

> I follow Fairbairn (1958) in saying that emotional contact is what people deeply yearn for … Such contact however is only effectively made through a signal emitted from the true self of another. I therefore contend that the only interpretations that are effective are those that proceed from the true self of the psychotherapist. (p. 11) … patients sense whether interpretations have been arrived at through internal struggle … When a patient senses that it is the product of [internal struggle], he feels at a deep level the union of souls in a common endeavour (pp. 21-22) … The analyst's task is to reach his own feelings … To reach his own feelings means pain and loneliness. If, however, he reaches his own feelings, it frees the patient and favours his emotional development. This inner task is a life's work for the analyst. (p. 34)

Whilst truth of course is a complex notion, the emotional and phenomenological experience of truth speaking is of intimacy.

We are all at times at risk of being unconsciously persecuted into therapeutic action, whilst avoiding the often excruciating task of staying with the unbearable states of others as they are communicated (in)to us. I certainly am. Yet transcending this risk is essential if the potential for true healing is to be realised. For it is this which enables us to empathically reach and be with the unformulated states of our patients, states that have never been reached. States which feel deeply disturbing for the therapist. To do so, I must be willing to feel this disturbance, to allow it to enter me, to feel states of terror, hatred, love, sexual desire, primitive anxiety, and desperate persecution, all as they intermingle with the internal states of my own mind, populated by the states of hatred, love, sexual desire, and persecutory terror as they have emerged in my own life.

Central to the repair of the inner world within the therapist is the capacity for faith in the possibilities of inner transformation, and the capacity for internal forgiveness. Rey

(1994) has been mistaken for describing forgiveness between patient and therapist as an interpersonal experience. However, Rey's emphasis (in some ways similar to Symington's above), was on the capacity of the superego within the therapist and patient to soften, to accept and forgive the humanity and vulnerability of what Rey termed the ego, and I describe as the self. Steiner and Schafer (1993) similarly emphasised the centrality of intrapsychic forgiveness in the process of reparation. This process of self-acceptance, self-forgiveness, self-compassion, is the same task for us as it is for the patient. Such tenderness towards ourselves allows us to also trust our more potent aggressive states, to use these in service of describing and introducing the patient to their own tortured inner world, neither fleeing from the forcefulness of our own mind, lest we fear a potent clinical authority might damage the already damaged other, nor unconsciously projecting our vulnerability and fear into the patient, and seeking to save the damaged other from the challenging work of softening their own intrapsychic attack and allowing what initially arrives in our clinical room as self-persecution to become a capacity for self-protection and agency.

An evocative and moving possibility. But how do we, in the potency of the emotional swirl of the heated clinical moment, contribute to the softening of this violent inner world? What if we are not to be obedient to such powerful internal demands? What if, rather than seeking a quick resolution of interpersonal disturbance, we seek to have faith that we can be in aggressive states with each other, and the relationship survive and strengthen, as we face the deep disturbance of the persecuting other? In the remainder of this paper I outline some principles which guide my attempt to contribute to the repair and transformation of the terrorising and terrorised inner world of the traumatised patient.

What Assists Us to Stay Close to the Terror?

Allowing the Patient to Influence Us

Jung (1966) noted that the first and foundational therapeutic task of the psychotherapist is to be willing to be influenced by the patient's psyche, whilst Clark (2006) noted that it is our own woundedness that provides the portal through which we receive our patient's intrapsychic disturbance, and which enables the patient's own damaged inner world to impact upon and influence us. As Jung (1966) presciently observed,

> Doctor and patient thus find themselves in a relationship founded on mutual unconsciousness … [The doctor] too becomes affected and has as much difficulty in distinguishing between the patient and what has taken possession of him as has the patient himself. This leads both of them to a direct confrontation with the demonic forces lurking in the darkness. (pp. 176, 182)

It is this intermingling, and the willingness to stay present to such states in myself and in my patient, a capacity which so many of our patients experienced as being unavailable to them in their own relational childhood experience, providing company for that which has never previously been accompanied, that offers the hope for empathic resonance, gradual symbolisation and formulation of that which has been unformulated. To do so, enactments,

often mutual enactments, are inevitable, and I must bear in myself that which feels unbearable, including my own impulses of homicide and suicide, hatred and love.

At times, in response to dangerous acts of self-harm, including potentially lethal impulses, I struggle to make use of rather than to be encumbered by my shame, fear, and anger. Trauma, both cultural and personal, intrapsychic and interpersonal, interact with the matrices of my own known and unknown relational histories, separate and shared, emerging between myself and my patients as the lost fragments of experience; vulnerability, hatred, love, care, sadistic and masochistic aspects revealed to ourselves and to each other. I find myself thinking, "how can you do this to yourself?" I find a refusal to understand why my patients do what they do; a refusal to understand myself as their tender, hated and hateful selves. A temptation to shut off: "this is sick." Their hate and my mind fuse as they invite me to let their vulnerable selves and its attacking other find a place in my mind. To accept the invitation to receive the other's disturbed internal states, I have to give something up; I had to give up the stable coherence of my own mind. Orange (2011) advocated making a space of hospitality in our mind for such suffering. In so doing I allow myself to keep my patients company in their shame, powerlessness, dissociation, and despair.

Ghent (1990) explored the deep potential of this capacity in his articulation of the necessity for surrender (but not submission) by both patient and therapist, a capacity which he defined as "the sense of giving over, yielding the defensive superstructure, being known, found, penetrated, recognised" (p. 118). He noted that surrender involves an act of faith, one which I suggest is enabled by the capacity for faith in the possibility of inner transformation (Milton, 2017, Rey, 1994, Steiner & Schafer, 1993). Ghent (1990) suggested, as Winnicott (1969) emphasised, that surrender requires the therapist experience the patient within their own mind, including the patient's attack, neither retaliating nor submitting, and crucially that the therapist survives. As Winnicott described regarding his concept of use of the object, "I destroyed you, I love you. You have value for me because of your survival of my destruction of you" (p. 713, cited in Ghent, 1990, p. 123). The transformational possibility that terror, and the hateful attack which disguises this fear, might be transformed into love, is movingly evoked by Ghent's exploration. In so doing he noted the uniquely disturbing yet profoundly rich opportunity our profession offers,

> What other occupation requires of its practitioners that they be the objects of people's excoriations, threats and rejections … Yet I suspect that a deep underlying motive in some analysts at least, is again that of surrender, and their own personal growth … When the yearning for surrender is, or begins to be, realised by the analyst, the work is immensely fulfilling and the analyst grows with the patient … [This] involves an act of surrender and risk-taking on the part of the infant (or later, patient), as well as a degree of surrender on the part of the facilitating care giver, or later analyst. (pp. 133-134)

Creating a Space to Find One's Own Mind

Having found a willingness in myself to be influenced by, indeed to surrender to, the psyche of my patient, I seek to find my own mind. Ogden (2004) referred to this process as the

interplay of the dialectic of oneness and twoness. The twoness being the relational co-creation between patient and therapist, and the oneness the capacity to find my own thoughts in service of enabling a thinking mind for the thoughts without a thinker. Foundational to Wilfred Bion's (1962, 1963, 1967/1988, 1970) exploration of this capacity for thinking under emotional pressure was his experiences as a very young tank commander in the First World War. As Brown (2012) noted:

> Nowhere is this war of nerves more prominent than in Bion's 1997 description of his entrapment in a shell hole during the war of Amiens with his young runner, who he calls Sweeting. … The pair had taken shelter from the German attack with Sweeting holding close to Bion when the runner asked: "Why can't I cough, why can't I cough, Sir?" And then:
>
> > Bion turned around and looked at Sweeting's side and there he saw gusts of steam coming from where his left side should be. Shell splinter had torn out the left side of his chest. There was no line left there. Leaning back in the shell hole, Bion began to vomit unrestrainedly, helplessly. (Bion, 1997, p. 255)
>
> Sweeting started incessantly to beg Bion to be sure to write to his mother and these appeals appeared to grate on Bion's already frayed nerves, "Oh, for Christ's sake shut up," shouted Bion, revolted and terrified" (p. 255). Then later, "I wish he would shut up. I wish he would die. Why can't he die?" … Sweeting's horrific injury and his panicked desperate entreaties for Bion to contact the boy's mother confronted Bion with an overwhelming in vivo experience from which he learned about the nature of alpha function and its limitations. (Brown, 2012, p. 1199)

This incident "illustrates not only the sheer horror of war but also Bion's attempts to think amidst overwhelming sensory bombardment and his ultimate failure to do so" (Bion, 1997, p. 256, cited in Brown, 2012, p. 1199). From these terrifying war experiences Bion (1962, 1963, 1967/1988, 1970, 1997) spent the rest of his life reflecting on the nature of thinking, how we might find thinking for "thoughts without a thinker," and symbolise beta elements of somatic, emotional, affective, horror. It is striking that this war experience involved a call for the mother. Bion (1962) famously paralleled the experience of thinking in clinical work with the maternal dyad of baby and mother. His notion of "containing" describes an ongoing process of experiencing the other in one's own mind. As Biran (2015) noted:

> When the mother provides a correct translation, she is thinking for her baby. Later on, he will learn, through her, how to think verbally on his own. She is helping to acquire this important function and to learn to deliver his messages to the world in a clear way, leading to joy and satisfaction … this function shows us the extent to which Bion conceives of the container as a thinking container … which does not simply absorb, but also thinks and transforms, endowing the material entrusted to it with further meaning. Bion believes this manner of thinking is an action: therefore, the container is seen as an active agent, rather than a passive absorber, as it is often mistakenly depicted. A container with the capacity to contain is an active, dynamic,

> seeking, wondering, examining, and questioning container. This means that thinking is an act, and action. Thinking through the process of finding the right word is a complex, subtle, and devoted activity. (p. 4)

I find this description of containing essential, as it gestures to the emotional work required of the therapist, within the clinical encounter, when thinking under emotional pressure. Symington (2003, 2007) noted the enormous pressure human beings put on each other. Thus in the heat of the clinical moment, if I am not to succumb to manic reparative impulses, I must continually seek to create a space in my own mind, to think my own thoughts, under the emotional pressure of the twoness of the clinical encounter. Milton (2017) suggested that a core aspect of working with patients persecuted by intrapsychic attack is the need to transform the mind of the patient dominated by persecutory phantasies which perpetuate intense anxiety within insecure attachment relationships. But as Milton noted:

> Instead of transforming the mind the patient insists on trying to change the environment. This is doomed to ultimate failure … it means that the client is not in fact working on transforming their mind but using multiple strategies to change/shape the response of the therapist. This often takes the form of intense pressure to configure the relationship with the therapist so that the therapist acts in such a way that it directly relieves the pain and intense enduring anxiety: i.e. to seek and obtain soothing gratification rather than working on [inner] transformation. (p. 7)

Milton therefore emphasised the importance of the therapist retaining their own mind and facing into the inevitable disruptions that arise as the traumatised patient demands that the therapist change their response, rather than that the patient transform their inner world. This emphasis has much in common with Bateman and Fonagy's (2004) concept of mentalising, and what Bion suggested is a containing and metabolising process, allowing myself to find my own mind in relation to the patient's mind, and to offer this to the patient in a way which gradually rebuilds the patient's capacity to symbolise their inner world. However, Bateman and Fonagy (2004) in their mentalising-based therapy emphasised staying close to the patient's phenomenological experience and inviting the patient towards what is only just beyond their own thinking/feeling mind, as opposed to more depth interpretive offerings. More poetically Meares (2000) emphasised "a form of conversation in which "aliveness" emerges out of deadness … a form of language, resembling the artistic process as Susan Langer (1957, p. 112) defined it, which strives towards the finding of "expressive forms to present ideas of feeling" (p. 145). I often discover a dialectical tension between offering my patients experience near, phenomenologically focused explorations, and offering more depth interpretive work, and that relaying between these two modes of intervention gradually enables a creative expansion of the patient's mind. To do so is not to succumb to the emotional pressure of the manic reparative impulses that Klein (1940) and Rey (1994) described, but to create space to think and feel together and to think and feel about our thoughts and feelings. In offering such understandings, I find the following formulations of the traumatised patient's tortured inner world a helpful roadmap.

Formulation of the Intrapsychic Pair Within the Traumatised Patient

I suggest that in working with traumatised patients we are often working with an intrapsychic pair that has been diverted from its developmental path by traumatic experience. On the one side there is aggression, essential to the infant's capacity to communicate its need. The infant, when hungry, tired, sad, scared, in pain, frightened, angry, communicates often unbearable affect through somatically aggressive gestures. As Sidoli (1993) noted, "A potential to generate meaning for affect-loaded discharges is innate in the human infant" (p. 176) but that in the early stages it needs to be "guided and sustained by the mother [and/or relational other]. She serves as a model for symbolic functioning whenever she is able to offer a safe container for the infant's instinctual attention" (p. 176). However, if the profoundly somatic bodily tensions are not "given a name by the mother, they have remained silent, are inarticulate, and have no access to pre-conscious or conscious thought or dreams" (p. 179).

If these aggressive states are well mediated by the infant's early relational childhood environment the infant gradually begins to build the personal self to which William James (1892) referred. This aggression is thus transformed from its primitive origins in early life to the potency and capacity for self-protection and agency which we all need in adulthood, the capacity to stand loyal to one's own need, to take potent creative action. But if these psychosomatic and relational communications fail to be received, the infant is left with no choice but to turn potentially creative aggression against themselves, to make their own need bad, and disavowed. In traumatised environments, this aggression is converted against itself. As Kalsched (2013) noted:

> With this traumatic splitting, aggression that should be available to the child to protect itself against its persecutors is diverted back into the inner world to attack the very vulnerability that threatens the 'old order' of control. As Fairbairn (1981, pp. 114–15) writes, the child, unable to express either its neediness or its rage, "uses a maximum of its aggression to subdue a maximum of its libidinal need." (pp. 83–84)

The complementary partner to aggression is vulnerability. In healthy developmental relational contexts this vulnerability is available to be felt as legitimate need, desire, attachment longing, vulnerability to which the psyche is called to be loyal. It is the fuel of the psyche which enables tenderness, honesty, and intimacy. Horrifically in traumatic environments this vulnerability is converted into states of powerlessness and dissociation. It is got rid of, made wrong and disappeared.

"Repetition Compulsion": Fear of Loss of the Traumatising Other

One of the great tragedies of childhood trauma is that when the child grows up with a terrorising other on whom they also rely for survival, the child is forced to turn their legitimate fear of the other because the other is dangerous to them to a fear that they might lose the other. This is the birthplace of the magnetic addictive bond which Bateman and Fonagy (2004) described; the infant is required to adhere to the traumatising other, to need

the one they fear, and their fear of the other's dangerousness is converted into fear that they will lose the other. The traumatising other becomes essential to the self's survival, and in later life it is this unconscious adhesive bond which leads to the ongoing recreation of traumatic dynamics in adult relationships, what Freud (1914/1950b) termed "repetition compulsion," and what we now recognise as the psyche's desperate unconscious need to hold on to the traumatising primary other; that separation, aloneness and isolation is far more terrifying, given the dissociated disintegration of the self which separation from the traumatising primary object threatens to evoke. As a patient put it:

> Self-attack seems to be my default mode; and it's hard to look after my vulnerability in any other way than attacking myself ... love, affection, connection, care ... I get those things by attacking myself or by getting someone else to be hurtful, rejecting towards me.

So often in these clinical presentations the patient introduces me to the triangle of their early life; the traumatising other, the traumatised child that they were, and the crucially influential, but often overlooked, destructiveness of the bystanding third, often the second parent, who out of their own terror withdraws and submits to the destructive aggression of the overt persecutor in the early relational environment, and in so doing fails to protect the traumatised child/patient from the disintegrating horror of the persecutor's attack. The failure of this protective function from the bystanding parent leads the traumatised child to introject absence, Andre Green's (1986) dead mother; where there should be protection there is only emptiness, dissociation, powerlessness and impotence, and thus the child is left to fend for themselves in the only way they know, to submit to the violence, and attend to, care for, the wounds of the other, abandoning their own need, just as they have been abandoned. A patient put it graphically, commenting that she had come to realise "the monsters in me." She then described the dementor within:

> During our session the day before, you had explained to me ... how I had kind of internalised the abandoning mum, the passive, non-intervening dad, the attacking mum ... I think the monster symbolises my mum when she was angry. And how her words could be so hurtful. ... My mum's anger and viciousness ... A Dementor is a dark creature, considered one of the foulest to inhabit the world. Dementors feed off human happiness, and thus cause depression and despair to anyone near them. They can also consume a person's soul, leaving their victims in a permanent vegetative state, and thus are often referred to as "soul-sucking fiends" and are known to leave a person as an "empty shell." I think that is what it sometimes feels like when I spend too much time with my mum. ... The blob ... is my dad. ... I don't think I'll ever be like how I might have been if I had had a nurturing, loving, well-balanced mum, and a dad that was more like you, more assertive and protecting.

Inviting the Patient to Reclaim Primary Affective States

In the attempt to transform such terrorising inner experience, we are up against a forcefield of fear, indeed of annihilatory horror, and survival terror. For the infant raised by a

traumatising presence is in a double bind: on the one hand being terrorised by the traumatising presence of the other, and on the other hand desperately needing the other's presence for their very survival. The therapist who challenges the destructive hate which infuses the traumatised patient's psyche is challenging the inner world of the terrorised patient to release the patient from their imprisoning magnetic bond, a connection to the persecuting other that the patient's unconscious is convinced is essential to their very existence. When we challenge this destructiveness, we challenge the patient's very survival, their experience of the capacity for "going on being" (Winnicott, 1965). Transformation of such destructiveness therefore often involves fierce, even ferocious, intrapsychic and interpersonal struggle. In the middle phases of therapy such therapeutic work requires an often heated battle between the aspects of the psyche disturbed and determined to destroy the patient, the vulnerability that feels it needs this destructiveness to survive, and the use of our own potent and protective aggression in service of this vulnerability; an often fierce confrontation with the destructiveness is needed. In this we are always at risk, as Messler-Davies and Frawley noted (1991/1999), of becoming the abuser of the patient's inner world, re-enacting the persecution of earlier times; the balance is a delicate one, as I attempt to reach the vulnerability, whilst forcefully challenging the destructiveness. Donald Kalsched (1996) noted:

> Often in this process we must struggle with our own diabolical impulses, developing enough neutralised aggression to confront the trickster's seductiveness of the patient and ourselves, while at the same time maintaining "rapport" with the patient's genuine woundedness and need. The struggle constitutes a genuine "moment of urgency" in the therapeutic process and many treatments have been shipwrecked on the Scylla of too much confrontation or the Charybdis of too much compassion and complicity with the undertow of the patient's malignant regression. If the patient's traumatised ego is to be coaxed out of its inner sanctum and inspired to trust the world again, a middle way will have to be found between compassion and confrontation. Finding this "middle way" provides both the daunting challenge and the enormous opportunity of psychotherapeutic work with victims of early trauma. (p. 40)

The Greater Conjunctio

Regarding the fierceness of the battle required in the service of inner transformation, Jung (1966) offered the potency of the alchemical metaphor: the rawness of prima materia, the transformations which arise as heat is applied within the crucible of the therapeutic dyad, with the hope that a distilled and precious taonga may emerge. Of course, the alchemical process is always an ongoing one. Edinger (1972) developed this metaphor with the notion of the greater conjunctio, comparable to Rey's (1994) reparation proper, in which there is a willingness to stay with the heat of therapeutic engagement, to retain faith in the possibility of true inner transformation, as prima materia is transformed from the terror of inner darkness, via therapeutic heat, to the hopefulness of creativity, whilst the lesser conjunctio gestures to the impulses to flee the heat involved in the fierce confrontation with destructive forces.

So often we flee from the terror in clinical work. As Winnicott (1974) noted, "the

clinical fear of breakdown is the fear of a breakdown that has already been experienced" (p. 104). However in our confrontation with the unconscious, with a persecutor to whom the vulnerability is addictively bound, there is the possibility that the patient is returning to a vulnerability which has previously been disassociated, obliterated into impotence and powerlessness, or even, as D. B. Stern (2003) noted, has never been formulated. Winnicott (1974) suggested that whilst the breakdown has already occurred, it has not "happened" to the patient because the patient was not able to be present to experience it. The crucial difference in therapeutic work is the possibility that now there is another mind and eventually two who can experience the terror that had already occurred. I suggest that inner transformation involves the return of that which feels persecutory and attacking to its original creative developmental state as potent and genuinely protective aggression, potency and agency in the service of rather than attacking towards vulnerability, in so doing enabling dissociated powerlessness to return to its original form as human vulnerability, tenderness, dependency, and attachment need, all in the service of the soul's creativity.

The Intrapsychic, Interpsychic, and Interpersonal, the Therapist's Vulnerability, and the Exploration of Enactments

Relational and interpersonal therapists are often set against those with a more intrapsychic focus. This is a false dichotomy. The intrapsychic is always interpersonal and vice versa. Therefore, whilst valuing contemporary developmental theory and its emphasis on how the inner world emerges from early relational environments, I also find Kleinian thinking resonates in its description of how, even in the most relationally attuned and responsive environments, the infant inevitably experiences states of terror and hate in relation to their psychosomatic early experience, and corresponding anxiety-generated unconscious phantasies. Juxtaposing these ideas with how primitive states of love, hate and terror may or may not have been well enough mediated by the early relational environment provides a rich intrapsychic, interpsychic, and interpersonal tapestry. The psyche that has not found a receptive home for states of love, hate and terror inevitably means that intrapsychic persecution is much more dangerous. The weaving of these ideas in relation to primitive states assists me to hold in mind that I am not only attempting to introduce the patient to their interpersonal ways of being, and the interpsychic dynamics that this creates between us and in their relations with others, but I am also inviting the patient to meet more fully the terrors and intrapsychic conflicts of their inner world. These multiple lenses are particularly helpful in the working through of enactments, as Jessica Benjamin (2009) described. She noted that in inviting therapists to recognise their part in traumatic enactments:

> When we acknowledge to the patient the felt experience of having recreated the original injury, we are, in effect, inviting the abandoned shamed and wounded part to become more vocal. We thus avoid repeating the part where the original abuser or bystander adult denied the child's reality. In my view, what usually solidifies and makes the intractable re-traumatisation in the analytic dyad is not the enactment

> itself but the analyst's failure to acknowledge it, which the patient correctly grasps as an avoidable failure. (p. 444)

When inevitably, particularly via the powerful forces of projective identification, I contribute to, and patients find in me, the traumatic relational dynamics of their early history, this is fertile ground for impulses towards manic repair, the mea culpa of the therapeutic apology, but also the potential for something deeper. Benjamin (2004) assists me with the interpersonal dimensions of this deeper challenge. Whilst Klein (1935) and Rey (1994) emphasised the intrapsychic aspects of transformation of the inner world, Benjamin's (2004, 2009) interpersonal emphasis provides a helpful map for interpersonal engagement with the patient. She noted:

> As analysts, we strive to create a dyad that enables both partners to step out of the symmetrical exchange of blame, thus relieving ourselves of the need for self-justification. In effect, we tell ourselves, whatever we have done that has gotten us into the position of being in the wrong is not so horribly shameful that we cannot own it. It stops being submission to the patient's reality because, as we free ourselves from shame and blame, the patient's accusation no longer persecutes us, and hence, we are no longer in the grip of helplessness. If it is no longer a matter of which person is sane, right, healthy, knows best or the like, and if the analyst is able to acknowledge the patient's suffering without stepping into the position of badness, then the intersubjective space of third may be restored. (p. 33)

Steiner (2001) described the intrapsychic and interpersonal tight rope which patients walk when they take the risk of allowing their traumatised vulnerability to first emerge from the psychic retreats in which it has been sequestered; shame and humiliation are often close by, as the patient feels the terror that the gaze of the therapist upon this vulnerability will be a shaming gaze, as it has so often been in the past. But, of course, this shame can also attack the inner world of the therapist. At times when we make clinical errors, we must tolerate our shame, but not submit to it, developing a capacity to notice its toxic intentions without becoming overwhelmed by the impulses to retreat, submit, or avoid, when difficult interpersonal and interpsychic moments arise in the heat of clinical work.

Central to the therapist's challenge not to submit to our shame when clinical "errors" and mutual enactments arise is our relationship to our own vulnerability. As Clark (2006) noted, it is our vulnerability which provides the lens through which we might empathically reach the vulnerability of the other. By contrast, if we as therapists do not retain connection to our own vulnerability, but rather in self-defence, given the deep disturbance evoked by the projected attacks of the tormented inner world of the patient, react by submission or retaliation, therapeutic derailment awaits. The more we have dissociated from, disappear, attack, hide, or otherwise disavow our vulnerability, the less we are able to access this essential resource in service of reaching the vulnerability of the other. The risks of mutual enactment (what D. B. Stern, 2009, described as disassociation interpersonalised, in which the therapist's own disassociated vulnerability interacts with the patient's), is always a disturbing challenge.

In this, the therapist's compassion towards their own inner world, and the centrality of faith in the potential for true repair of our own and the others' inner objects, is crucial. I find it helpful to combine these intrapsychic reflections regarding both patient's and therapist's inner worlds with Benjamin's (2004) interpersonal emphasis. As she noted, "My point is that this step out of helplessness usually involves more than an internal process: it involves direct or transitionally framed communication about one's own reactivity, miss attunement or misunderstanding" (p. 33).

When strong affect arises between me and the patient, I seek to take my time, neither to avoid my part in what has occurred, nor to collapse under the force of the patient's hate. I seek an explorative stance: "Something difficult has happened between us, can we take time to understand this together?" The work is slow, often very painful, and can take years to unravel. In this I am not shy to offer an apology if I find I have responded in a way that I regret, but I usually aim to leave some space for exploration first. More often together patient and I will slowly discover that we each contributed to something difficult, but that just because something difficult has occurred does not mean that something bad has occurred and that someone must be bad, either the frightened patient, or the inevitably human therapist. Rather there exists a possibility for each of us to discover the part we have each played in the difficult dynamics that have occurred between us. In the opportunity for genuine grief, in the giving up of omnipotence and omniscience, there is the possibility of the creation of something new between us: where there was disavowal and attack, there might now be acknowledgement, recognition, grief and shared intimacy. As Benjamin (2009) suggested, the co-construction of the symbolic third within the intersubjective matrix enables the possibility that,

> I can hear both your voice and mine, as can you, without one cancelling the other out: I can hear more than one part of yourself, you can hear more than one part of yourself—especially not only the part that is negating me, but also the complementary part that I have been carrying as you negate it. (p. 442)

The co-creation of a relational experience in which difficult interpersonal interactions can lead to the rediscovery and reclaiming of internal emotional states previously dissociated and disavowed usually evokes tender grief between me and my patient as we feel the losses that led to the disassociation of these vulnerable states in traumatic early environments. And the gold at the heart of this potential transformation is the creativity that can arise from such profound grief, the possibility that we might symbolise what has never been symbolised before, and more than this, that the shared labour of relational mourning may give rise to something new.

Mourning and Grief

We return to the beginning, to Freud (1917/1950a) and Klein (1935, 1940, 1975), and to mourning. At the heart of all the writing I have reflected upon, whether the focus is on the intrapsychic, interpersonal, transpersonal or intersubjective, is the possibility that if the traumatised psyches who inhabit our clinical rooms are able to face the terror of their inner

lives and gradually transform the persecutory hatred into creative potency and protective aggression, the dissociated powerlessness into human vulnerability and need, this is a profound act of grieving. The adult must grieve the child's losses, the hurts, pains and terrors of early life, but more than this they grieve the loss of innocence, and the possibility that omnipotent control can keep at bay such horror. In feeling the soft centre of our vulnerable humanity, facing the truth of the tender soul that we are, we have the possibility to live the life of creativity that can be born from the deep and profound acceptance of our humanity. As one patient wrote to me after an exquisitely tender session,

> After more than three years with John … I cried with him for the first time. And I cried. And cried. And John bore with me.
>
> He sat down on the remaining chair and respectfully allowed me my space by not looking directly at me and staying well away from my line of vision. We talked and we were quiet, and as the tears subsided, I could feel myself slowly being reformed. I had dreaded this moment for months, years even, for fear of falling apart and not being put back together … That if I would start to fall apart, I would disappear, for John wouldn't be able to glue the pieces back together … And yet today, this is exactly what seems to have happened.
>
> I … barricaded myself behind two chairs, where my quiet sobs would not be ridiculed, nor punished. John … just sat down and was gentle with the little girl sobbing on the floor and "held" and as much as he could, from one chair away.
>
> Today, I cried.

So much of what we face now requires the central capacity for grief. In individual clinical work true inner reparation arises out of this mourning. And in the terrors of the pandemic and climate crises that we all face, and in the cross-cultural violence that haunts humanity, is the challenge to mourn. So often we are terrified by the deeply disturbing losses we all face. We are so impelled to escape to fantasised omnipotence, the seductions of consumerism, technology, and independence from the earth and from each other, and to avoid the grief. Yet perhaps it is from the place of shared loss and relational mourning that we might reach each other and the earth, with honesty and care, rather than the escape to manic flight from the human vulnerability implicit in our dependency and place with the earth that provides our only home, and the inevitable and catastrophic fall this must entail.

Conclusion

Michael Balint (1952) suggested that:

> In my opinion, hate is the last remnant, the denial of and the defence against the primitive object love (or the dependant archaic love) … this means that we hate people who though very important to us do not love us and refuse to become our co-operative partners despite our best efforts to win their affection. This stirs up in us all bitter pains, sufferings and anxieties of the past and we defend ourselves against their return by the barrier of hatred, by denying our need for those people and

> our dependence on them. In a way, we reassure ourselves that these people, though important, are bad, that we no longer depend on the love of all the important people, that we can do without the love of the bad ones among us. (p. 358)

In the force field of projective identificatory dynamics, so much of what we experience feels destructively aggressive. It is easy for us, both patient and therapist, to lose sight of the terror which lurks beneath apparent hatred. As the patient evacuates into the therapist the internal persecutor of Bateman and Fonagy's (2004) formulation, in so doing re-establishing intrapsychic contact with the traumatising primary object to whom the patient's psyche is addictively bound, the power of such hatred, and the terror that it camouflages, can create pressure on the mind of the therapist in some ways akin to the emotional undoing Bion encountered in the killing fields of World War I. The capacity to think under such emotional pressure is severely strained. We need to receive and be influenced by such terror, whilst grappling to find our own mind, like dream thoughts, as Ogden (1999) described, slipping from our minds as we awake from the projective identificatory heat that envelops us. Yet if we are able to find our own mind whilst staying with the patient's terror, and gradually find a way to symbolise this terror, there is the possibility that slowly such terror may be metabolised, and that the grief of such early terror may be felt, together and alone; that with the softening of the internal persecutor which attempts to protect psyche from this terror, there may be the possibility of compassion, forgiveness and a surrendering to our own humanity, both our patients' and our own. And from this the creative potential for a life lived connected to our grief, and open to the rich possibilities which connection to our own tenderness might allow.

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