THE GENERATION OF PSYCHOANALYTIC KNOWLEDGE: SOCIOLOGICAL AND CLINICAL PERSPECTIVES PART TWO: PROJECTIVE IDENTIFICATION - THE OTHER SIDE OF THE EQUATION

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Michael Rustin has proposed that the equivalent of Pasteur's `laboratory' in psychoanalytic research has traditionally been the consulting room. It has been the consulting room that contributors to the development of psychoanalytic thinking have turned for evidence of psychoanalytic phenomena. It has become accepted as `good science' within the field of psychoanalysis that new ideas should be supported by clinical evidence in the form of case material. There has also been a long psychoanalytic tradition of turning to literature for further support or elucidation of some aspect of unconscious life (the poets saw it first) and, of course, it may be that a poem, novel or play first sensitizes the clinician to clinical phenomena that he or she is currently struggling with, or, that it makes suddenly transparent something that seemed previously opaque.

But it has traditionally been the consulting room where hard evidence has been found or sought, where codification and purification of procedures have been developed. I would like to propose that material from psychoanalytic infant observation, as originated by Esther Bick (1964), be considered equivalent to case material from clinical work, both in its potential for the generation of new ideas, amending current theoretical constructs and clinical technique, but also with regard to the specification and standardization of what takes place in the infant observation setting.

The setting for psychoanalytic infant observation is prescribed just as it is in clinical work: one hour on a particular day of the week is negotiated with the observed family. The requirements of the observer are also clear: the observer should not give advice, influence the family's behaviour, initiate interactions or look after the baby. The observer, like the analyst, is not responsible for what unfolds (in infant observation, the unconscious interpersonal relationships between infant and other family members) but the observer is responsible, like the analyst in the consulting room, for struggling to take in what is seen and heard, and to allow it to have a life in the mind and then, subsequently, to record in as much detail as possible after the observational hour. To each setting psychoanalytically informed thinking is brought, characterized by a wish to understand unconscious phenomena and a recognition of the importance of valuing what is not understood. It is precisely because of these parallels that

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psychoanalytic observation is considered such a uniquely powerful pre-clinical experience by many training schools. No other setting, other than clinical work itself, exposes and prepares the student of psychoanalysis for the impact and power of unconscious forces.

In both settings we struggle to see what is there to be seen and not to look for what we think we might find. The infant observation seminar group supports and nurtures a link to ` truth'. It is the interaction between the observed material and the creative responses to it, via the countertransferences of individual members of the seminar group and the psychoanalytically trained seminar leader, that can illuminate some element of the observation. Hypotheses can be made as the observational material unfolds, and then subjected to testing within an observation, and from observation to observation. This seems to be a parellel to the interpretive process itself, each interpretation being understood as a working hypothesis, a description of our understanding at one point in time. Each observation in this way becomes, as the individual case study, a research study in its own right.

In psychoanalytic infant observation, just as in psychoanalytic clinical work itself, we are moved from being passive receivers of psychoanalytic theories to active involvement, via the infant observation seminar as a container for ideas, intuitions and responses to the rigorously observed details of an observation, to the potential for amending existing theories and creating new ideas. It is confrontation with the reality of unconscious phenomena that I suggest generates new psychoanalytic ideas.

I am also concerned within this paper with some preliminary thoughts about the obstacles and supports to the generation of psychoanalytic knowledge. Michael Rustin has described in Part One how new discoveries are characteristically presented in the form of *elaboration* or *mutation* of some element of an existing theory or technique combined with its use to explain a new clinical phenomenon. Each new patient can present a challenge to the existing conceptual framework of any psychoanalytic practitioner. It might be argued that, if we are only `open' to the unique presentation of each individual's internal world, then we must meet something new which challenges us to respond in a fresh way which may result in some mutation or elaboration of technique or theory. Most psychoanalytic knowledge, I suggest, starts first as `clinical intuitions'; that is, we respond to a patient's needs intuitively with an `inspired' change of the technique only subsequently to conceptualize what we have done. We may then either encounter, or seek to find, confirmation from other sources: other clinical cases, material presented for supervision and in clinical seminars, material presented in specialist clinical workshops and, I would add, material from psychoanalytic infant observation. I am suggesting that, firstly, material presents itself unsought and that, having seen something we have not previously observed, we are then sensitized and more open to its subsequent presentation. We may now be pushed to try to formulate what it is we have seen, carefully anchoring this new idea as a specific elaboration of an existing theory which is well established. In Latour's terms, these are theories which have acquired `black box status', supported by evidence in the form of detailed clinical descriptions, and in this paper I am also suggesting detailed descriptions from infant observations.

In my contribution to thinking about the generation of psychoanalytic knowledge, I want to examine an important psychoanalytic concept, namely projective identification as outlined by Melanie Klein (1946), which I have found to be one of the most useful concepts in understanding the nature of certain kinds of experience occurring between

analyst and patient. However, I have also struggled with the `knowledge' that, as outlined by Klein and developed by others, particularly Bion (1959,1962a, 1962b), the concept of projective identification describes only one half of what I have found myself encountering in my own clinical practice, particularly with autistic patients, children in care and sexually abused children.

I will attempt to trace briefly the vicissitudes in my own disturbing encounter with the ` truth' of what I describe as *`the other side of the projective identification equation'*. My own inhibitions in contributing to psychoanalytic theory derive from my own sense that I am not a theoretician, and therefore do not have the right to question concepts as outlined by one of the great psychoanalytic theorists. This has been counterbalanced, however, particularly powerfully by the force of the truth of patients' experiences which cannot be denied and which, I believe, speak for themselves. A further support has been the influence of particular individuals who nurture a belief that knowledge emerges out of particular clinical situations, and the responsibilities of each of us as clinicians is then only to describe what we see as accurately as we can so that others in turn can engage in some discussion. What is paramount is the 'truthful description' of an encounter with a patient or observed infant, over and above any held theory or school of thought.

I would suggest that the generation of psychoanalytic knowledge is brought about by the tolerance of the absence of knowledge, and that this discovery of the absence of knowledge can occur both in the consulting room when confronted with a particular patient, and in viewing observation material from a particular infant. As we struggle to find ways of working with patients previously considered unsuitable for psychoanalytic psychotherapy, so we are confronted with increasing uncertainty when accepted theories and techniques prove inadequate to the task. I suggest that the capacity to bear knowing what we do not know is rooted in internal objects who value not knowing. These objects then provide essential containment, a crucible for the emergence of knowledge, which allows for a creative intercourse between the psychoanalytic practitioner and the work itself. To question is to disturb firstly our own equilibrium, and then that of others if we share our ideas. The tolerance for disturbance varies from person to person and with each of us over time. Who is allowed to question? What is their evidence and where can it be tested?

It seems noteworthy that most of the important theoretical developments of the last 50 years have come from the field of adult analysis. Child psychotherapists within the National Health Service are confronted with an enormous range of patients so that there is a constant challenge to the classical paradigms within which we work. Child analysts and child psychotherapists are in the privileged position of seeing the early stages of the development of pathological states and, because assessments are made of the child within the family, of seeing how and where emotional disturbance in the individual is related to emotional disturbance in the family. It is possible to observe, at first hand, the power of the transmission of *intergenerational* patterns of psychopathology via projective identification from the parents *into* the child.

For the child psychotherapist exposure to the realities of a patient's external world, *combined with* the reality of the child's internal world, confronts us with clinical evidence that is not available if one works solely with adult patients.

We are therefore in a unique position to contribute to the evolution of psychoanalytic theory. And yet it is significant that rather few contributions to the evolution of psychoanalytic ideas have come from the field of child analysis since

Klein and Anna Freud. Some psychoanalytic practitioners continue to hold the view that child analysis is not quite `proper analysis' and child psychotherapists risk the challenge that they in turn are not `proper child analysts'. It is noteworthy, I think, that in the outside world psychoanalysis is frequently under attack for not having changed since the time of Freud, whilst within the world of psychoanalysis it seems that any proposed *development* to the accepted theories can risk being seen as a challenge, equivalent to heresy. We can see the ` troubles' caused by any of the major psychoanalytic theorists, and Michael Rustin has noted how Klein and her supporters minimized their differences with Freud, and how Bion went to some lengths to establish his contributions as continuous with the traditions of both Freud and Klein.

In my contribution to our thinking I want to try and describe something of the development of my own ideas in relation to the concept of projective identification supported by material from clinical work with an autistic patient and material from an infant observation.

Projective Identification

The difficulty in recognizing and processing some kinds of projective identification via the countertransference is well recognized and has been written about extensively in the psychoanalytical literature. Bion (1961), for example, in *Experiences in Groups* writes: `The analyst feels he is being manipulated so as to play a part no matter how difficult to recognize, in someone else's fantasy' (p. 149). Here Bion was trying to describe the power to numb the innermost sense of reality in the analyst when he is the object of a projective identification from a patient.

Whilst projective identification has been written about extensively in relation to the difficulties of adults trained as psychoanalytic practitioners in relation to their patients, it has largely been ignored when considering early infantile experiences. Object relations theory has concerned itself largely with the degree and type of the infant's projective identification into the mother and the mother's capacity to transform these (Bion 1962a, 1962b), and the consequence for the individual's development when there has been excessive projective identification into the object. My focus, then, is the other side of the coin - the consequences for the infant and for future adult development where it is the infant who has been massively projected into.

The Development of an Idea

In 1970 I began seeing 5-year-old Anna, my first autistic patient, in a group together with four other children. Anna presented as a classically autistic child. She ran around her nursery class flapping her hands, avoiding contact with anyone, her head down. She had no speech and revealed several obsessions, mainly focused on a preoccupation with cleanliness, her own and others, and with things being kept in order. She had no ability to play. When the nursery staff took their eyes off her for a few moments, she would quickly crawl out of the nursery into the toilet where the staff would then find her wedged round the back of the toilet bowl. In our sessions she would sometimes crouch and shield her head with her arms from an invisible assailant.

When I first met Anna's father, at the beginning of my work, he was in a state of mind that can only be described as one dominated by hatred for his daughter and lacking in any empathy. I was shocked by his treatment of her - he called her `stupid donkey' and pushed her along in front of him with his closed fist, every bit as if she

were a stupid, stubborn, dumb animal. Gradually, however, I learnt the family's story from father. Anna's mother couldn't bear to look after her baby; she complained she hadn't known babies were so dirty and she had Anna potty-trained by six months. Anna was left for hours on end alone in her cot and, when she became more mobile as a toddler so that mother was less able to ignore her, Anna was locked in the toilet for hours at a time. Father worked night-shifts in order to be available to do some of the childcare, but he was tired and exhausted by nightwork, worried about his wife, and lonely in a foreign country. He admitted he was often short-tempered with Anna and sometimes hit her.

Anna, once in group psychotherapy, swiftly began to show interest in others, to speak, to play, and then she began to learn to read and to write. At the time I was delighted by these changes in her but not unduly surprised - I didn't know that autistic children were not supposed to recover and Mattie Harris did not tell me so until well into the work! I was fortunate in having Mattie Harris as my teacher. She advised me not to turn too quickly to the psychoanalytic literature for my answers but, first of all, to struggle to find out for myself how to reach this strange little girl. I have come to value more and more her interest and respect for the `truth' of what emerged from my encounters with Anna, always keeping an open mind. Later, when I struggled to formulate my difficulties with projective identification, she did not dismiss this as due to inexperience alone, but rather encouraged me to keep on struggling, telling me that psychoanalysis was still in its infancy and much remained to be discovered. My point is that I was encouraged to question.

The work with Anna gave me considerable food for thought. Over the following years I puzzled over her rapid development and the link with her early history as told to me by father. My experience with Anna and with some of my other patients left me struggling with `projective identification', not just the concept itself, with which I was certainly struggling, but something more.

The difficulties first experienced with my patient Anna in relation to my understanding of the concept of projective identification came to be replicated over and over again in many subsequent experiences with other patients, particularly other autistic patients, children in care and my supervisees' patients, but still I was unable to formulate what it was I was seeing. I began to see more clearly the very problem with which I was struggling, vividly enacted in my psychoanalytic psychotherapy groups. Within the group setting I have become increasingly aware of some children's particular vulnerability to projections from other children. They seemed not only unconsciously to expect them but even to invite them. These children communicated a sense that this was the way of the world. My focus then is on the implications for development when a containing process fails; my interest here is not on the infant's propensity for projective identification in the paranoid-schizoid position, which has already been extensively written about and substantiated in the psychoanalytic literature, but on the infant's vulnerabilities to massive projective identifications on the part, primarily of the mother, but also of significant others.

Bion, in 1959, described experiences with a patient who `resorted to projective identification with a persistence that suggested it was a mechanism of which he had never been able to avail himself... The patient felt that parts of his personality that he wished to repose in me were refused entry by me'. Bion recognized that `The patient had to deal with a mother who could not tolerate experiencing such feelings and reacted either by denying their ingress, or alternatively by becoming a prey to the

anxiety which resulted from introjection of the baby's bad feelings.' In `Attacks on linking', speaking of the schizophrenic, Bion writes:

> The disturbance is twofold. On the one hand there is the patient's inborn disposition to excessive destructiveness, hatred and envy; on the other the environment *which at its worst*, denies to the patient the use of the mechanism of splitting and projective identification. (Bion 1959, p. 106)

Thus Bion recognizes the influence of the environment in relation to projective identification but thought that *at its worst* it denies the use of the mechanisms of splitting and projective identification. Bion did not see children in analysis; perhaps that is why, if what I am proposing is correct, this was as far as his clinical evidence could take him. I would contend that *at its worst* the environment/mother projects excessively/massively into the infant (as with my patient Anna) and thus also, consequently deprives the infant of adequate experience of the use of projective identification into a containing environment/mother. That is, where there is excessive projective identification from the mother into the infant, there is also a *consequent* deprivation for the infant of sufficient opportunities for projective identification and consequently of introjective identification. The mother who unconsciously uses her infant as a receptacle for her own massive projections cannot be open to the infant's projective identifications. Thus the infant is simultaneously both massively projected into and deprived of opportunities for projective and introjective identification leading to an adhesive personality structure, false self, poor self image and, at the extreme end of the spectrum, autism.

Bion tells us that in `reverie' the mother contains the infant's projective identifications or beta elements through her own use of alpha function and, in doing so, transforms the projective identifications or beta elements of the infant into something which is returned to the infant in thinkable form. The consequences for the cognitive development of the infant are enormous when the infant is not only deprived of adequate opportunities for projection of his own beta elements but, worse, is subjected to projections of the should-be containing object's own beta elements. We thus have in this model the infant full of beta elements, unthinkable experiences, perceptions and sensations, both his own and his object's. It is not surprising, therefore, to find that many of the infants, young children and adults, whom I would describe as having been subjected to massive projective identification from their objects, have consequent learning difficulties.

Projective identification into an object unable or unwilling to perform a containing function results in a loss of self/object differentiation both for the self and for the external object. The child feels controlled and the mother is indeed controlling. She cannot allow freedom of thought and action to her child because he contains so much of herself. The problem is exacerbated because, of course, neither party understands that this is what has happened. The child feels crushed, restricted, has poor self image (because the self has been so projected into aggressively that the child's sense of self is damaged). The mother in turn must keep a close eye on the child because he contains so much of herself. She also becomes confused and angry when he does not comply with her expectations of behaviour.

In my 1978 paper on group work with children, I began to refer to `children who have been projected into'. I became increasingly convinced that the implications in terms of technique for work with such children were enormous. With children and

adults who have been massively projected into, they first need to be freed and only then to take responsibility. This has been vividly illustrated by work with sexually abused children where they have had psychotic parts of others forced into the self, and need to be helped to understand their vulnerability and incapacity to protect themselves either from the actual abuse or from the projection of psychotic parts of adults, frequently their own parents. It must be emphasized that they have already been held responsible by the abusing adult, which brings me back to Bion; we know from psychoanalytic work the power of a projective identification. At least we have our training and analysis and the possibilities of consultation with our colleagues. I want here to suggest that some children and adults whom we see as patients have been subjected to just those same powerful projections but into an infantile self only incipiently differentiated from another.

I began to realize that it was inappropriate to speak of children who had been projected into since I am suggesting from my work in infant observation, and from being a parent and meeting with other parents and children, that all infants are, to some degree, projected into and that this by its ubiquitous nature can only therefore be described as normal. I therefore want to make the distinction between normal experiences of being projected into by those adults who should be containing projections, and the experience of the infant who has been *massively* projected into. Within the moment-to-moment changing and evolving relationship between a mother (and father and siblings) and infant there are the ordinary vicissitudes of a containing relationship. The ordinary everyday *temporary* failure to contain caused by mother's tiredness, preoccupation, irritability and so on which have their impact. We can even argue that it is essential that she does so, that for his own growth the infant needs accurately to perceive mother as having limits; as working, struggling and sometimes failing, in order that the infant have available for introjection a struggling but sometimes failing object. That is, an infant needs to have an identification with an object who wishes to succeed but knows that she will sometimes fail. A mother's loss of capacity to contain must have an impact: the temporary projection into her infant is temporarily devastating but becomes ordinary, bearable and thinkable because it is buffeted by more of those kinds of experiences of a thinking, containing mother. Her failures to contain may also help the infant to reflect upon those times when he is being too much for mother and might actually struggle more with his own difficulties. Where it is combined with ample experience of containment it becomes a useful push to growth and development.

Bion differentiated normal from abnormal projective identification (Bion 1959, 1962). It is clear that what I am describing here is the abnormal - that is, where the aim, usually unconscious, is to evacuate violently a powerful state of mind. I have described before, in my paper on assessment (Reid 1990), the existence, in depression in mothers, of two kinds of depression. For simplicity's sake I will describe them as (1) an active depression and (2) a passive depression. I think that infants who have been massively projected into can be either the recipient of violent projections from an actively depressed mother or have absorbed massive projections *atmospherically* from a passively depressed mother.

Massive projective identification seems to happen *firstly*, when the mother, father, nanny or other important care-giver has never had his or her own projective identifications sufficiently contained in infancy to be able to sustain, or even attain, a depressive state of mind, a prerequisite in adult life for a capacity to contain infantile projections.

Secondly, it seems to occur also as a result of traumatic events. I have observed this phenomenon in the following situations - for example, (1) where mother's own mother has died just before or after the birth of an infant, (2) where the mother has suffered any miscarriages or stillbirths where these have been unmourned, (3) where the mother's marriage is breaking up around the time of birth, *(4)* where there is a profound loss of security and well-being in the family at the time of birth due, for example, to loss of employment or even moving house, *(5)* where the baby is handicapped in some way, (6) where there is mental illness in the parents' family and where there is anxiety during pregnancy about its reappearance in the new-born, (7) in refugee families, and (8) where traumatic experiences have occurred in the grandparent generation which have then been ` passed on' as projective identifications, first into the parents and then into the infant.

In all cases where the increase in projective identification occurs in the primary object towards the infant, this occurs where there has been (a) insufficient time to process the trauma before the birth of the infant, (b) the individual was already too ill *before* the traumatic event to allow for processing, or (c) the traumatic event by its very nature is so horrific that it cannot be processed (see, for example, Pat Conroy's novel *Beach Music (1995)).*

Clinical Example: The Assessment of Isaac

The P family had sought an assessment because their son, Isaac, had been diagnosed autistic and they had heard of other children with autism from their community who had been helped by us. They arrived *15* minutes late for their appointment with no apology. Mr P, an orthodox Jew, advanced toward me in the waiting-room, his hand outstretched. Momentarily thrown, I extended my own hand. `I don't shake hands,' he said. I found myself apologizing. The experience of being wrong-footed persisted throughout the session. In my room I began to explain what I had in mind, indicating toys which were there should Isaac be interested. ` Go and play,' snapped Mrs P. Isaac did not move. I explained that they should not feel that he had to play for me as I just wanted an opportunity to get to know him and how he usually functioned in the world. Mother gave me a withering look as if I was quite crazy: `No, he'll play'. She continued to give orders to her son who, whilst he did not move to do her bidding, began to whimper. The sense of what I had provided being misused, and used in such a way that I felt I was an accomplice to cruelty towards Isaac, persisted throughout the first meeting.

Father spoke to Isaac in Yiddish; I explained that I could understand only a couple of words of Yiddish and, having ascertained that both English and Yiddish were spoken at home, I asked that they speak in English so that I could follow. Father agreed to do so but immediately returned to speaking in Yiddish. I suggested that this might be a way of showing his concern (remembering the outstretched hand), that I might not understand the family's culture. This idea was dismissed. `Isaac understands Yiddish better,' Father told me, and so, throughout the session, Father spoke only Yiddish to Isaac.

My attempts at getting to know Isaac and his family were punctuated by both parents giving orders to their son, sometimes in chorus, and ignoring his lack of response. My own sentences were constantly interrupted, or corrected, or finished for me. Suddenly after about fifteen minutes, Father got up and announced that he was taking Isaac to the toilet, and this he then did at ten-minute intervals throughout the

session, in spite of Isaac not indicating in any way that I could perceive that he wished to use the toilet. On each occasion this completely disrupted my flow of thoughts and also served to remind me that any sense I had that I might be making a link to the parents' experiences was entirely illusory. As the session progressed I became increasingly `tongue-tied'. I had become increasingly unable to think and then increasingly unable to speak coherently. At one moment I found myself in the middle of a sentence having no idea how I had intended to finish it. At another my sentence petered out as I became aware of feeling foolish since neither parent showed any interest in what I was saying, and made it clear that they considered my observations worthless and nonsense. In my countertransference I felt myself first of all withdrawing and then feeling a loss of a will to continue as something like despair enveloped me. I looked at Isaac standing abjectly in the middle of my room, his eyes glassy, his arms hanging limply at his sides, hands open. I listened to his parents' litany of complaints that Isaac didn't speak, whilst allowing for no response from me. I thought to myself, 'No, I wouldn't open my mouth either if I were you'. I knew what it felt like to be Isaac, both by observing him and his response to the situation, and from experiencing the *same* projections of massive hostility and contempt in my countertransference I felt a strong empathic link to Isaac: his lack of speech, the sense of having abandoned his body, felt meaningful both from my observations of Isaac and his parents and of my own countertransference. His lack of development, like Anna's, seemed related to the hostile bombardment by his parents. If I, an adult trained in psychoanalytic psychotherapy, could not withstand the bombardment, then how could Isaac possibly manage?

What I could not know after one session was how what I had seen happening with Isaac and his parents had started - although I believe there was sufficient evidence from that session and subsequent sessions to indicate that what I had seen had had its origins before Isaac's birth. In time it became possible also to feel compassion for Mr and Mrs P.

I shared the material with my colleagues in the autism workshop where it produced comparable material from colleagues and students.

I have chosen this clinical vignette from the assessment of a young autistic boy, not because it is substantially different from many others but because, at the time I saw the P family in 1983, the experience hit me with such force that it refused to be ignored and acted as a catalyst in bringing into sharp focus the phenomenon I am trying to describe.

I want to return to Michael Rustin's point about the evolving field of psychoanalysis in the consulting room, with reference to the clinician's need to cope with the unexpected. In working with autistic patients, one of the major differentiating features of autistic from other patients is the lack of an observable transference to the analyst, along with the lack of the capacity to project on the part of the patient. This leaves the analyst in a very particular and peculiar position. The most important paradigms on which psychoanalysis has developed are found to be absent. The usual *recognizable* struggle to contain the patient's projections and, after consideration, to formulate an interpretation are replaced by an apparent indifference and even unawareness on the part of the patient to the very existence of the analyst. Now in this situation it seems to me there are three possible options: one can say that most autistic patients are not suitable candidates for psychoanalysis or, secondly, press on regardless, and interpret to the autistic child using classical theory and technique. (This, I would suggest, has led

to some of the psychoanalytic failures in the past with autistic children and with those other children who do not appear to 'fit' the more classical structures). The third option is to tolerate the possibility that something is missing, and to bear the subsequent disturbance of feeling like a psychoanalytic heretic in finding a way to meet the needs of a patient, when one knows one has been forced to abandon temporarily the more recognized and accepted ways of working.

Here, confirmation of one's own findings from colleagues working with other groups of patients but encountering the same phenomenon can be an important support. For example, discussion of my idea with colleagues elicited the discovery that my colleague, Gianna Williams, was struggling with the same phenomenon in her work with patients with eating disorders. The similarities in technical difficulties with both groups of patients and in our clinical descriptions were encouraging to each of us.

An infant observation unexpectedly gave confirmation to the phenomenon I had so far been aware of in the clinical setting. The observations, beginning before the baby's birth, gave a vivid account of unconscious massive projective identifications from a mother into her infant and their sequelae. For this reason I have quoted at length from the observation material. For any reader unfamiliar with the practice of psychoanalytic infant observation, it is important to say that concerns about this infant were addressed by health professionals who were involved with the family.

Example from the Observation of Freddy: The Development of Autistic Defences in an Infant

In 1984 an observation of a baby whom I have called Freddy was brought to my infant observation seminar. This observation was as dramatic in its impact upon me in the furthering of my thinking about infants who have been massively projected into, as the material I have quoted from the assessment of Isaac. It is a particularly clear example, I think, of the impact of the mother's state of mind on the emotional, cognitive and physical development of an infant. The observer noted in her first meeting that mother seemed overwhelmed; she poured out to the observer in an uncontained way all her thoughts, feelings and anxieties with no acknowledgement that the observer was a stranger to her, nor that her 5-year-old son, Norman, and 18-month-old daughter, Frances, were present throughout. The observer from the beginning had the experience of being given no space. She was not allowed to finish a sentence, and mother's own wish for the baby to be born was quickly projected into the observer when mother said that she would `try and have the baby as quickly as possible so that you can get on with your observations' - a statement which left the observer feeling guilty, confused and stuck.

In the first meeting mother told, unprompted, stories of the birth of her two children which were rather horrific and given in detail. She also reported that her own mother had advised her to have the baby with which she was now pregnant aborted; she had even gone into the clinic to have an abortion - but had decided not to go through with it.

The first observation after the birth took place when Freddy was *five days* old. The observer was struck by the impersonal way in which the baby was held - on the edge of mother's knees, back towards her, with the bottle held out in front of him, so that he could not see his mother at all. The observer recorded that she felt very uncomfortable throughout the observation. Throughout the feed mother talked to a visitor. The observer noted that, when mother removed his feeding bottle before it was empty,

Freddy resisted and held on strongly. As soon as the feed was over Freddy was put unceremoniously into the observer's arms. The observer noted, 'he is a calm baby who quickly moulds himself into the shape of my body'. Throughout the observation mother stirs Frances's jealousy of the baby referring dramatically to the need to `put him in a cot hanging from the ceiling out of harm's way'. When she puts Freddy into the one and only cot at the end of his feed she dramatically locks the door of the room saying that it is the only way to protect him from Frances.

The observer noted how shocked she was when Frances punched the locked door, finding it difficult to keep in mind that Frances was only 18 months old. Frances, swelled by mother's projections, had become a little monster. Over the course of the observation Frances came more and more to resemble a puppet manipulated into aggressive attacks on her baby brother by some loaded word from mother. Whenever Frances attacked Freddy, mother laughed.

The conjunction between external and internal reality was striking. In external reality the family flat was small but this also seemed to be replicated by mother's internal incapacity to make a space for her baby. Indeed, she told the observer that she had found it hard to believe she was pregnant and felt convinced that she was just overweight.

From *20 days* onward the observer, with increasing frequency observed Freddy lying on the dining-room table on a cloth. Mother was usually holding Frances, or otherwise engaged. The observer noted that even at 10 days old Freddy struggled to roll himself up on the table and, when this failed, he tried to stick himself to the little blanket and turned his head from side to side with his mouth open until he found his hand and sucked on it for a long time. This seemed to keep him calm for some time before eventually he burst into tears, quickly becoming congested. Mother told him he was bad and Frances then smacked the baby, which amused mother. The observer reported that she had the greatest difficulty in not picking the baby up in her arms.

As the observations continued, Freddy's position on the table felt increasingly cruel to the observer and the infant observation seminar alike. A member of the seminar associated Freddy's situation to that of an infant exposed on the hillside, left to the elements. We were reminded of the mother's initial impulse to abort the pregnancy.

At *two and a half months* the mother's mother was present at an observation. The observer noted that the grandmother held the baby on her lap in exactly the same position as mother always did, that is, on the edge of her knees. By this point in the observation the observer still noted how surprised she was by Freddy's capacity to be calm, but now she also noted his suffering expression. Whilst he fed she observed that he was quiet, one hand on top of the other, completely motionless with an expression which she described as ` looking lost in an empty space', an expression that seems adequately to illustrate Freddy's experiences. When mother held the baby in the way that she did, on the edge of her knee, unconsciously she gave him the experience that at any moment she might lose her small grip of him, and that he would then fall over the edge of her lap into nothingness.

By *three and a half months* the observer noted something peculiar about the baby's body posture: `the top half of his body seems hard and stiff whilst the lower half of his body seems floppy'. He had also stopped sucking his thumb and had, instead, begun to lick the back of his hand. He held it open like a fan and licked it with great relish in a way that caused the observer to feel disturbed. Perhaps the stiff top of Freddy's body illustrated his attempt by the use of his musculature to hold himself together and to

protect himself against attack, whilst the floppy bottom half might be seen to represent his abandonment, his unheld state. The failure to find a nurturing, containing object which provides for pleasurable contented sucking seems to have been replaced by sensual licking. The flattened hand might represent his flat unresponsive object who cannot allow him anything nurturing because `Frances wants it all'. It is reminiscent of the auto-erotic states seen in many autistic patients.

By *four months* the family paediatrician was concerned about Freddy, telling mother that Freddy must have toys to play with and a chair to sit up in and that he should not be lying on the table all the time. The health visitor was also openly concerned, and she and the paediatrician both shared their concern that Freddy might be mentally handicapped. For much of the observation after four months Freddy sat motionless in his chair, sometimes just moving one of his feet. Nothing seemed to impinge on him any longer.

By *five months* mother was also expressing concern about her baby. Mother bought Freddy a toy but worriedly told the observer that he didn't seem *any longer* to be able to hold onto things. (She too recognized that he had had a capacity, which he had subsequently lost.) 'Mother tried to put the toy into Freddy's left hand, he opened his hand, rested it on the toy's handle but seemed not to be able to grasp it, he lost interest and after a few minutes the toy slid from his hand.'

We could see in the infant observation seminar that, developmentally, Freddy had begun to regress. The baby who could hold on, grip, suck his thumb, lost the capacity before our eyes. He went flat, losing a sense of three-dimensionality. Freddy seemed to have withdrawn from a world which, far from being interesting, beautiful and worth reaching out for, he had often experienced as neglectful and contemptuous of his needs - not receptive and at other times openly hostile when, for example, his sister's physical attacks on him were actively encouraged by his mother accompanied by her cruel laughter.

In thinking about the reality of the world in which Freddy was growing up it became possible to see Freddy's withdrawal as a functional defence. In order to protect himself from real threats of annihilation by massive projective identifications from his mother and sister, I would suggest Freddy had 'gone flat'. This is illustrated by his hands which had flattened out and are no longer able to make a grip.

At *seven months* an observation gave the seminar group some hope. A noisy altercation between his siblings caused Freddy to become distressed. He arched his back and this time kept crying until mother picked him up. As his mother picked him up he immediately became calm and smiled and this made mother laugh, but she then turned and put him on her knees in the usual way. But Freddy arched his back and turned his face towards her and, meantime, with his little hand on his mother's cheek, he tried to turn her face towards him but mother seemed distracted and did not respond.

But by *nine months* there were times when Freddy's whole body shook when he saw the observer; when she moved close to him his hands and feet shook and his breathing became difficult in a way which felt excessive. Freddy, who had little experience of having his emotions recognized and contained, seems to find that emotions threaten to overwhelm and flood his small body. Pleasure could quickly become unpleasure to be discharged, shaken off or exhaled. (Many of the autistic children we see in therapy also show this excessive physical reaction to emotion when it impinges.) Like Freddy in the observation at four months, either nothing seems to get through or too much seems to get through and is unbearable.

Conclusion

We know as clinicians the power of a projective identification. We have at least our training and analysis and the possibility of consultation with colleagues. It is hoped that the brief examples from clinical material and from infant observations illustrate my hypothesis that some of the children and adults we see in our clinical practices have been subjected to just those same powerful projective identifications, but into an infantile self only incipiently differentiated from another, with potentially devastating consequences. I am suggesting that to ignore the other side of the projective identification equation can at best limit our capacity to help some patients and, in some cases, may even cause damage. The implications in terms of technique for work with those patients whom I have come to understand as having been the *subject* of rather than the *author* of excessive projective identification are enormous, and may be stated rather simplistically as the requirement to help certain patients to free themselves from the massive projective identification of others *before* they can be helped to take responsibility for the state of their internal world.

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References

Bick, E. (1964) Notes on infant observation in psychoanalytic training. In *International Journal of Psycho-Analysis 45:* 558-66. Republished in *The Collected Papers of Martha Harris and Esther Bick* (by M. Harris and E. Bick), pp. 168-76. Perth: Clunie, 1987.

Bick, E. (1962) Child analysis today. In *International Journal of Psycho-Analysis 43:* 328-32. Republished in *The Collected Papers of Martha Harris and Esther Bick, pp.* 104-13. Perth: Clunie. Also in *Melanie Klein Today: Developments in Theory and Practice. Vol. 2: Mainly Practice* (Ed. E. Bott Spillius), pp. 168-76, 1988.

Bion, W.R. (1957) *Second Thoughts, pp.* 43-64. London: Heinemann, 1967.

Bion, W.R. (1959) Attacks on linking. In *International Journal of Psycho-Analysis 43:* 306-10. Republished in *Second Thoughts, pp.* 93-109, 1967.

Bion, W.R. (1961) *Experiences in Groups.* London: Tavistock.

Bion, W.R. (1962a) Theory of thinking. In *International Journal of Psycho-Analysis 43:* 306-10. Republished in *Second Thoughts, pp.* 110-19,1967. Also in *Melanie Klein Today: Developments in Theory and Practice. Vol. 1: Mainly Theory* (Ed. E. Bott Spillius), pp. 178-86, 1988.

Bion, W.R. (1962b) *Learning from Experience.* London: Heinemann. Conroy, Pat (1995) *Beach Music.* [Nan A. Talese.] New York: Doubleday.

Klein, M. (1946) Notes on some schizoid mechanisms. In *The Writings of Melanie Klein, Vol.* 3, pp. 1-24.

Reid, S. (1978) Group psychotherapy with children in schools. Unpublished paper given to the Tavistock Clinic, London.

Reid, S. (1990) The assessment of the autistic child and his family. First given to the Study Weekend of the Association of Child Psychotherapists. Also in *Autism and Personality* (Eds. A. Alvarez and S. Reid) (in press).