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Unconscious Experience: Relational Perspectives

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In this paper I review key principles of contemporary Kleinian technique and relate them to their source in the theories of Klein and Bion. I note that the analyst's subjectivity is undertheorized in this approach. I then present a detailed account of my use of technique in work with a patient who was lacking in affect and found it difficult to engage in the process. I describe how she evoked a flat response in me initially and how we worked together to form an engagement. Her vivid dreams are given as examples of shifts in her state.

In the early days of her practice, Melanie Klein advocated the use of immediate, “deep” interpretations (Klein, 1932). She believed that these would bring instant relief, particularly from unconscious anger and anxiety. When her technique spread out to Kleinian psychoanalysts, it led at first to a particular assumption: The unconscious is directly available for immediate scrutiny and interpretation.

The more sober side of Klein’s theory is well known. She explored, in raw detail, exceptionally difficult aspects of human aggression and adopted Freud’s controversial theory of the death instinct (Freud, 1920; Klein, 1933). Against this background, advocating immediate, “deep” interpretations could appear to imply a confrontational technique, and indeed some early clinical literature of Klein’s followers was haunted by a judgmental quality that endangered Freud’s essential principle of suspending moral judgment. In spite of this, Klein’s theory itself is not a moralizing one.

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Furthermore, with time, developments have greatly refined Klein’s basic thinking on technique. Following the ideas of Bion and Joseph (Bion, 1962, 1963, 1965, 1970; Joseph, 1989), the concepts of “positions” both paranoid-schizoid and depressive, have been adapted to account for here-and-now fluctuations in the session. The patient is understood to be continually moving toward, and away from, a live connection with the therapist’s psyche, and subtle shifts of this kind are a focus for analytic awareness. They represent, in microcosm, the global pattern of the patient’s unconscious object relationship. At certain moments, does the patient move toward greater openness or withdraw into a persecutory, excluding state? What, within the session, has led to such shifts?

How does the patient’s movement between “positions” reveal his unconscious state to the analyst? To consider this, it is worth briefly reexamining a crucial element of Klein’s theory: her formulation of the death instinct as a powerful force in unconscious life.

As is familiar, Klein took from Freud (Freud, 1920; Klein, 1933) the idea of an instinct that is essentially regressive and that pulls the organism backward toward fragmentation and undoing. She also took from Freud the idea that this destructive instinct is projected outward in a bound form, leading to sadism or masochism and accounting for destructive and self-destructive behaviors. Although Klein was certainly interested in the idea of a destructive instinct, in her texts she repeatedly went back to her own special emphasis, the infant’s primal fear of death. Klein described how the death instinct is experienced internally as an annihilating force. When it is projected onto an actual depriving breast, it adds to it a death-bearing dimension. To the infant’s frustration is thus added a fear of death. A reintrojection of the feared, depriving breast goes toward creating an archaic bad object.

As is also familiar, Klein considered the objects of unconscious phantasy to be none other than the “psychic representative[s] of instinct.” Instincts, to be grasped at all, need to take on an anthropomorphic existence in the unconscious. This is in keeping with the human tendency to embody and personify in order to grasp. Psychic process is thus experienced internally as the anthropomorphic activity of objects and given coherence through their relational activity.

In Klein’s account, the death instinct, much like the life instinct, is ever present, giving rise to constant primitive anxieties that focus on a dangerous, persecuting object. The life and death instincts come into constant conflict, experienced unconsciously as an anxiety-provoking relationship between good and bad objects. This focus on primitive anxieties in the
transference has spread into Kleinian practice more generally, and it was particularly amplified by Bion (1962), who described the infant’s fear of death.

In today’s practice, observing the here-and-now fluctuations in the transference is still carried out with an attunement to primitive anxieties, some of which are felt to be rooted in catastrophic primal terrors, felt as a dangerous internal object. Yet such unconscious anxieties are not encountered in a direct cognitive fashion, as Klein supposed. The “here-and-now” means a discovery of unconscious patterns when they are in an emergent state—for example, when the bad object is about to be lived out—and the resulting persecutory object relationship enacted between patient and therapist.

The analyst cannot apprehend unconscious communication except indirectly. It is first known about when two participants in a relationship find themselves drawn to enact an unconscious pattern. For example, the patient can, through projecting something unbearable, lodge inside the analyst’s mind states of hate, which in turn provoke her to become sadistic or judgmental. If she were to react to this provocation and identify with the patient’s internal bad object, she might enact with the patient sadomasochistic cycles. Yet patient projections that provoke the analyst also enable her to monitor countertransference pressures. For example, what is she invited to do with the relationship? Is she provoked to sound punitive? To close her mind? To comfort away feelings quickly or deny their seriousness?

Contemporary Kleinian literature focuses on enactment as something that becomes manifest in words and behaviors that the analyst can find herself adopting or is tempted to adopt. This introduces an uneasy paradox into many papers on technique, because the very phenomenon on which analysts rely to discover the patient’s unconscious (i.e., enactment) simultaneously represents what is forbidden in the clinical relationship.

What is to be done about this paradox, other than to suggest some leniency toward the analyst? She is bound to end up being drawn into some enactment, or so the thinking goes. The best that she can do is continue to monitor her countertransference.

But if we are to bring greater conceptual rigor to this situation, we can be helped by a particular observation. Enactment does not have to become externally manifest as a piece of behavior or verbal exchange to have begun. The shifts that can lead to manifest enactment begin in the mental sphere, as a kind of mental enactment, based on the unconscious phantasy of the analyst. For example, during the beginnings of the therapy of a man in his
40s, I found myself forming a very strong impression that he was immature, and I expected to discover that he was barely able to cope with an ordinary life. In fact, I discovered that he was coping with a lot of adult responsibility very well, but the theme of his feeling like a “child” was to reemerge repeatedly during his treatment.

My suggestion is that when I was swayed to believe the version of him as immature, I had already performed a mental action. His projections had acted on my mind, and a view of him became actualized there. If, through lack of awareness, the analyst moves this purely mental action into the arena of a manifest attitude, she would have been drawn into open enactment. With the aforementioned patient, it would suffice for me to carry on his therapy in a state of mind that considers him a child, talking to him from within this outlook, for enactment to have happened, even if it could not be pinned down to specific acts or words.

One difference between an analytic state of mind that might lead to enactment, and one that might not, is the analyst’s ability to place a patient’s projection alongside other contents of her mind and thereby bring it into a relationship with something that is other. For this to happen, the analyst must draw on her own identity as a subject, and her own unconscious life. However, becoming overwhelmed by an exclusive projection is also a normal stage of listening and taking in. The analyst receives projections and, for a while, enacts a state of mind corresponding to them in her unconscious phantasy, much as I did when I became persuaded that my a patient was a “child.” Such a state of mind needed to be separated out from, and brought into a relationship with, the rest of my thinking.

This does highlight the fact that a psychoanalytic model requires a conceptual awareness of the intersubjective, that is, the patient’s alternative to seeing the analyst as purely a product of primitive projections. In Kleinian terms it would mean a move from equating the analyst with an internal object to recognizing her as a separate person. Indeed Klein suggested that during the depressive position, the infant is relieved from his fears when his actual mother comes into view and his reality testing can correct internal distortions.

The contemporary Kleinian model contains an implicit idea of the intersubjective and would not make sense without it. But this area remains undertheorized, even though it made a significant appearance in the works of Klein herself. In her definition, the depressive position presupposes the recognition of otherness in the form of a “whole” object, that is, an object that is not merely a piece of the individual’s psychic life but composed of
different independent aspects. The patient is supposed to evolve from treating the analyst as part-object and thus a mere extension of his projections to perceiving the analyst as a “whole” object and thus someone who is also a subject.

For my last point, I want to reflect on the long-standing philosophical issue of whether objects that we perceive in the world are products of our minds or whether they represent actuality as it is. Is the patient’s object purely “created” by projections or is it “found” because its actuality can be discerned? Winnicott’s contribution to this debate is particularly illuminating. He suggested that when a child uses a doll in play, she is doing two things simultaneously. First, she is giving expression to ideas and feelings that come from within her. Yet she is also doing more than simply expressing unrestrained omnipotent phantasy. This is because she has decided to move her phantasy impulses outside of her, and rather than simply give them free reign in daydreaming, she is subjecting them to the limitations imposed by a stable worldly entity—her doll. Her play is thus not purely internal, in the sense of being an uncontrolled omnipotence. But it is also not purely external, in the sense of relating to the doll as a simple item of wood covered in cloth. She is testing out her phantasy by taking account of the real-world limitations of an actual doll. This doll remains the same, no matter what the phantasy requires of it, and pretending is a solution that accepts this reality. Transference is a similar transitional space, with the analyst, like the toy, lending herself to manipulation and projection but simultaneously remaining an actual person.

The transference as transitional space implies the expressing of internal states within the parameters of the world as represented by the consulting room. In this sense it always contains that presence of the real therapist. A doll is an inert object, but a live person continually changes. The analyst is changeable in the way that all normal people are when they express different aspects of themselves and move through time. The stable element provided by the analyst’s person is thus not a static personality but the realities of alterity. The patient needs to be able to experience the analyst’s normal changeability as governed by the principles of otherness rather than by his omnipotent phantasies.

This does not mean that the analyst’s otherness is always experienced as punishing, for example, as depriving through boundaries and limitations. The patient picks up very intimate details of an otherness that is enhancing and nurturing, such as the analyst’s manner of listening, her reactions to primitive and painful material, her ability to be in touch with another, and her ways of thinking.
I try now to show that Kleinian thinking about enactment, and Winnicott’s thinking about the transitional space, can be helpful in clinical work.

Clinical Example

The patient is 50 years old and a specialist in architectural restoration. She is one of three siblings; the others are younger twin boys. The patient told me early on in the therapy that she remembers clearly suffering a blow when her twin brothers were born. Although she had maternal attention before this event, she felt that her mother greatly withdrew afterward. The patient responded by retreating to watch television for hours at a time. Apparently no one came to seek or distract her.

The patient referred herself for feelings of unease about her isolated life. She was very successful at work but had no friends whatever and had never had a partner. She felt as if something was paralyzing her as soon as she was in the presence of a potential social situation or attractive man. She worked freelance and only spoke to people she came across as briefly as possible. She also worked alone and found cooperation difficult. In her spare time she completed household tasks or watched TV in what she described to me as a “mindless” way. At the end of the day she would be aware that she had deliberately isolated herself and was filled with self-reproaches. However, she did not really long for people in any obvious way and did not describe herself as lonely.

Since her 50th birthday she began to feel a strong sense of something missing and of time passing. Upon consulting her medical practitioner, she came to the conclusion that she would like to change. In the assessment sessions with me, she responded well to our meetings. She felt that something felt “empty” inside her, and she wanted to try and address this before it was too late. After we concluded our assessment she was very keen to start. We agreed to a three-times-weekly arrangement.

In the early weeks of the therapy I experienced a particular countertransference. The patient was very disengaged. She lay on the couch with a blank mind and a feeling of pointlessness. The positive feelings that had surfaced during the assessment sessions had vanished. She could not remember why she had chosen to come for therapy and thought she ought to stop. Although she did retain the idea that she wanted more people in her life, this now seemed a remote aim and not really worth the trouble. Each session began with her telling me that she did not want to be there. Her mind felt in a blur, and it seemed to be too much of an effort to try to com-
In the countertransference I felt lethargic and tempted to disengage. I found myself, more than once, on the verge of suggesting that maybe it had been a mistake and she should rethink. I was beginning to feel that because her life did not bother her, there was little point in seeking change. I found myself in sessions evaluating her life and thinking that perhaps it was not so bad. Although she was alone, her career was very successful. There was no harm in merely deciding to be isolated.

I suggest that when my mind drifted to such thoughts, I too lost touch with the reason for her referral. My characteristic valuing of relationships disappeared from my mind, and human contact suddenly became a distant issue of relatively little importance.

I regard this state of mind in me as an enactment within the psychic sphere. For a while, I lost my own characteristic beliefs and was enlisted into identifying with a projected part of my patient, which was therefore actualized in my thinking. This mental enactment dispersed my concern about her isolation and her lack of desire for human contact and intimacy.

After awhile of observing these trends in myself, and a few months into the therapy, I took up with the patient my impression that strong feelings seemed very remote to her and that perhaps she felt right now that this was for the best so she would not be troubled. I pointed out that she was portraying herself to me as incapable of intimacy and friendship, and she seemed to invite me to agree and disengage myself from her. Her response was a thoughtful silence, and then agreement. She livened up for the rest of the session in a way that I had not witnessed until that point.

On the next session she arrived to tell me about a dream that she had on the night after the session: In her dream she was in my consulting room and appeared to have a frightening bruise in her chest area. I was not there, and instead there were three other people. One was a very handsome and clever young medical doctor, and the other two were women about her age or maybe a little younger. The women seemed to be engaging the doctor in conversation and appeared very competitive for his attention. She was very anxious about her wound and wanted to approach the doctor and ask for help. She felt in the dream that he would respond. However, something paralyzed her and she could not raise the subject or somehow find an opening. She was on the verge of speaking to him several times, and even opened her mouth, yet nothing happened. Then one of the women said to the doc-
tor that she had a knee injury and asked for his help. He immediately agreed to help, and they both went to hospital. My patient was left behind and became very distressed in the dream, knowing that she had missed her moment forever.

Her associations led first to the idea that her bruise was in the area where the heart is. She also thought that in the dream the woman who asked for help with her knee reminded her of a time when one of her brothers fell and injured his knee. She remembered looking on and feeling puzzled by his very loud attention seeking and the way in which he was quickly consoled. Her other thoughts about the dream were that the doctor seemed like a perfect partner for her and reminded her of a time at which she had been attracted to a man at work. When this man tried to make conversation on one occasion, she found herself responding with her usual indifference and bringing the conversation to an abrupt end. In the following week he asked out another girl. She felt vaguely guilty about this, but not at all hurt, even though she knew he was attractive. Now, in the session, she felt that she ought to have made more of an effort with him.

I noted that she talked as if she was merely obliged, for the sake of some idea, or somebody, to seek an intimate relationship. She agreed. I went on to point out that in the dream it was different. She wanted very much to ask for help and to forge a connection with someone who could offer it and who could be loved. A paralyzing factor seemed to be the competitiveness of the two women. Although they could ask for help, she could not. There seemed to be an anxiety of remaining with heartache forever.

The response to this line of thinking was unexpected. The patient told me that she had as a child been extremely passive and that her parents contacted specialists about this; for a while an autistic disorder was suspected. A flood of memories ensued. She remembered, at an early age, both her parents encouraging her to respond to toys, music, and games. Their words “Look at me, look at the toy, look!” now echoed in her mind. There was also a special teacher who was really patient. She knew that they were all trying, but she kept finding that she was averting her gaze from them.

I pointed out that perhaps she felt that I had been doing just this since she had started her sessions with me, saying to her “Look at me, look at this therapy!” whereas she was averting her feelings from me. Perhaps this made her despair of the process, as perhaps she worried that she would never respond to me and that I would soon give up.

There was a silence, and she seemed in some emotional pain, and agreed. She then continued to think, and I was surprised at how she seemed keen to explore the material. She said she wondered if the two women in the dream
represented her brothers. There then followed a lot of memories about how much her brothers dominated her mother but also how different from them she felt because they were boys. She had believed as a child that only boys have such strong feelings and can express themselves so easily.

I want to now move to an account of this therapy much further down the line. The patient has been in therapy for 3 years and is feeling better. This feeling is expressed in a greater openness to the idea of human company and more actual contact with people in her life. This contact has brought relief of tension and anxiety that she hasn’t noticed in herself until now.

Here is a recent session: This was the first session of the week out of three sessions. She was on time and said that she was still feeling better. For a while she lay on the couch quietly, her hands folded on her stomach peacefully. I felt that the room was very still and calm.

I said she was enjoying feeling better, it was a calm feeling.

She agreed with evident warmth. After a short silence she added that there was nothing special on her mind. There was one thing that irritated her though. She had as usual made a list of things to do over the weekend and also wanted to watch TV “mindlessly” as she usually did. When she began to carry out her tasks, a woman, connected with her new freelance project, telephoned. They began to discuss a work matter and then drifted onto a broader conversation. She ended up spending half an hour on the phone. She therefore did not achieve all her allotted tasks that day and missed out on some of her mindless TV watching. She had quite enjoyed her conversation with the colleague, but she was also aware of not ending it quickly because of wanting to make efforts to be social, since this is her problem. Now in the session she felt angry that she could not allow relationships to interfere with the smooth running of her life. There was a silence, and her body fidgeted uncomfortably on the couch.

I said that she was happier in her life and also in here with me. But she was also irritated with me. I interrupted something in her life that had seemed smooth: the mechanical, task-oriented way of proceeding and the mindless TV watching that excluded human company. And this weekend this had troubled her. Perhaps she had wanted to forget our sessions and lose herself in smooth untroubled feelings. Instead her thoughts were interrupted by memories of our live conversations.

She thought for a while. Then she added that she knew that in reality it did not matter if tasks were not performed in a perfect way. This part did not really bother her. It was just that she was really not sure about people. She knew she did enjoy their company more, and it felt good. However, it was also worrying, and she did not know how to explain the kind of worry
that it was. When people talked and were very sure of themselves, she enjoyed their ideas but felt that her mind was easily swamped. She was afraid that she would end up thinking their thoughts instead of her own.

I talked about her ambivalence about the changes in her—they were welcome in one way. In another, they provoked suspicion of me and my motives, and she feared the kind of person whom she was discovering me to be. She worried that there would be no room for the two of us and no way of taking my words in without losing a sense of who she was.

She said, painfully, that this was true. It was hard for her to know who she was in any case. After a silence, she said she had a dream:

She and I were together in a child’s room. There were a number of mechanical toys there, the kind that needed to be wound up with a key. She wound up a toy doll, which moved toward another doll that was mine. Her mechanical doll then bumped into my doll, which was an ordinary doll. In the dream, we both found this funny and laughed. I then took up an ordinary toy car and playfully hurled it along the floor toward her toy car. But it turned out to be a very forceful movement. My car crashed into her car, and she thought that her car was going to be destroyed. Yet this did not happen. She was relieved, picked up her own toy car, and took a turn in hurling it along the floor toward my car, crashing into it. We both laughed again and were enjoying ourselves. A man she had never seen came into the room and began to scold us. He told us to stop our silly games and threatened to complain to her current employer.

Associations did not lead to particular memories with this dream, only to thoughts that the dream had stirred up. She thought that she had put herself in the place of a child (a child’s room) and that she played like a child. The zooming cars made her think of boys’ games and of her twin brothers. Their boisterous and loud games sometimes frightened her in inexplicable ways.

I thought to myself that in this dream she and I are felt to try to engage in a playful interaction. It seems to start off mechanically, with a wound-up doll part of her sent out to explore contact with me. This reminded me of her initial projections of something rather mechanical and lifeless into me, when I became disengaged from the therapy. I wondered to myself whether, as a result of her projections, she became worried that I would retaliate with forceful interpretations that would crash into her mind. Yet this did not happen, and once reassured, she risked a more lively kind of aggression with me.

I took up how our contact in the dream gave us pleasure and fun but also contained anxiety. She worried that if she would try something more lively
than a mechanical “bumping” into my mind, we would end up having an aggressive, crashing contact.

She was silent and thoughtful. She then brought up childhood memories of her brothers. It was easy for them—they were more aggressive and did not mind just being rough and loud when they wanted attention. They got excited about all sorts of things, such as special treats. At such times they would jump or hop from leg to leg and shout “Me first! I want it!” When she watched them, she often felt an inexplicable panic.

I wondered if she panicked at the thought that they could allow themselves to make excited demands. She agreed but said she felt very uncomfortable about the word excitement and wished I hadn’t mentioned it. She lay tensely on the couch and complained of a headache. I had a very precarious sense of the session at that moment, fearing that I had caused her anxiety. My temptation was to avoid the topic and change the subject. I waited silently, wondering if she would indeed talk about something else. However, she said nothing. The tension mounted in the room, and with it my sense that I had been far too “crashing” with her. She then broke the silence and said tentatively, “I wonder what this is all about, why all these things worry me.” I acknowledged how dangerous and “crashing” an excited contact with another could feel to her and how perhaps my very mention of it itself felt invasive.

There nonetheless followed an exploration of her fear of lively contact and her worry that it would lead to unbearable excitement. Excitement was felt to be an essentially masculine quality, manifest in her brothers and seen as dangerous.

Discussion

I used this case material to illustrate some of the ways in which the patient’s unconscious anxieties emerged in the therapy and were experienced by me. It seems that the normal excitements and desires of a live contact were feared by this patient as destructive and overwhelming in essence. I suggest that she split off and projected her dangerous-seeming liveliness and forcefulness into others in her environment and then avoided them in a somewhat phobic manner. This prevented her exploration of other people as subjects. She simultaneously deadened her own responses, and when obliged to interact, she projected a deadening experience that put off other people.

In the therapeutic situation, she began by projecting something deadening into me. A psychic enactment between us led me to form a state of mind
in which I was inclined to disengage and turn away from her. When this did not happen, she also experienced my alterity, and our contact gradually became livelier. However, with this shift, she began to project into me feelings of playful and aggressive contact in which she wanted to invade me excitedly. She then worried that I would retaliate and invade her mind.

The second dream shows how every kind of contact seems threatening to her—whether it dead and mechanical or live and exciting. Anxieties of annihilation are thus experienced in the minutiae of our relationship, indicating her fear of a completely intolerant maternal object. Through an awareness of their impact on me, I am able to glimpse some primitive unconscious states and explore them with her. At the same time, she also constantly comes up against my actual otherness and is thus able to explore new ways of being.

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