When I was a little girl, I went through a time when I was mute. I was five years old, and my family had just moved from New York City to Athens, Greece. I went from spending my days primarily with my grandmother, who was unusually sensitive and attuned to me, to being in the midst of a huge crowd of family and friends. The atmosphere went from being quiet, contemplative, and connected, to one of a boisterous and exuberant party. I would usually hide under a table or behind a big tree that we had in the living room.

I was reacting to the dramatic shift in the type and level of consciousness around me. Mostly, people dealt with me by trying to cajole me into talking. One day, an uncle came over to meet me for the first time, and he did something different. We were staying in a hotel, there were a lot of people around, and the mood was loud and boisterous as usual. I was hiding behind a tree in the balcony, as usual. He came over, sat down near me, picked up a toy bird, played with it silently, and then went home without ever having said a word to me.

For a long time after that, I would talk only to him.

I instinctively knew, by the quality of his presence, that he would find me through the interior of his own heart. Paradoxically, the message I got by his silence was that he would value my words. So I felt safe to speak. Neither of us could have articulated what the problem was, why I wasn’t talking, but on another level, in an invisible, silent way, we were understanding each other.

I consider that my first experience with analysis.

Thanks to the work of many contemporary psychoanalysts, a different kind of voice is emerging in the field through more
authentic, connected, passionate, alive interchanges with our patients. We are touching a wider scope of pathologies than we had the tools to work with before. We are learning more about the psychological and neurological consequences of catastrophic disruptions in primary attachment and bonding, and the way we work is evolving.

By living through the raw, unintegrated panic—dissolving and evaporating right along with a person—we can begin to help transform the catastrophe of non-space that someone is living with into the genius of potential space.

Langston Hughes (1959) talks about the struggle to keep the spontaneous, true voice alive in this way:

*This is a song for the genius child.
Sing it softly, for the song is wild.
Sing it softly as ever you can—
Lest the song get out of hand.

Nobody loves a genius child.

Can you love an eagle
Tame or wild?

Wild or tame,
Can you love a monster
Of frightening name?

Nobody loves a genius child.

Kill him—and let his soul run wild.

When we look at patients suffering from primitive disorders, we see that on one level, they are living in a state of profound psychological disorganization and disintegration. They are trapped in the grips of a state of mind that attacks all links and all meaning.

But, if we spend enough time with them, we also notice that at the heart of the problem is actually an absent core. The profound deficit in their earliest experiences of primary attachment.
(whether due to external trauma, genes, or other factors) creates what the autistic woman Donna Williams describes in her autobiography as a feeling, at the core, of being a “Nobody, Nowhere” (Williams, 1992).

The work of Winnicott, Tustin, Grotstein, and Ogden is central to an appreciation of this other level of the problem—that is, the state of nonbeing itself, and the technical issues involved in working with this state. Our most basic feelings of being a nobody, nowhere, get stimulated by our contact with patients who have had severe early attachment trauma. There is a nonsymbolic dimension to the patient’s communications that is particularly significant when working in the area of deficits in primary attachment. Technically, this nonsymbolic aspect often shows up as the patient’s getting angry at, or not understanding, or not making use of, interpretive interventions. We often receive the patient’s communications about the disembodied state of nonbeing and the deficits in primary attachment, at first, more through countertransference enactments than through verbal exchanges.

McDougall (1989, 2001) talks about the intimate connection between early trauma to the sense of bodily integrity and its influence on true creative expressiveness. Much of what primitive patients bring to us are pseudo-symbols for pseudo-communication. Ogden (1982) describes the fundamental problem of primitive or psychotic patients as an inability to experience their experiences. These patients do not own their experiences, and they hold onto pseudo-destructive states of mind as a way to protect themselves from dissolving into nothingness (Grotstein, 1990a, 1990b.) As analysts, we often act too quickly to try to make meaning of these experiences (or what Ogden (1982) refers to as “interpreting meaning in a meaningless field”).

Patients who have had ruptures in their earliest attachments need us to live their experience with them first—as they live it: to touch them nonsymbolically first—to embed ourselves in their experience without making meaning of it first—to surrender to the experience—so that a true starting point can then begin to be found, for the first time, with us.

A patient I saw many years ago in analysis taught me a lot about this.
The presenting problem was that she was trying to write a book. She actually had a lot of other disturbing problems—cutting, burning, anorexia—but that is not what brought her in. What brought her in—and what was most profoundly disturbing to her—was that although she was extremely bright, she had no sense of her own voice. She felt she could not write an authentic word. Staring at the blank page brought her as close to her inner blankness as she had ever been, and precipitated her coming terrifyingly close to committing suicide. Any attempt at putting words down was met with a swift and violent internal attack that each time left her torturously blank again.

She had been a premature baby. She spent the first three months of her life outside the womb in an incubator almost continuously under bright lights. She had been a very lethargic baby, cut off, unable to feed, no cries. She was not held during that time, and did not want to be held after she came out of the incubator.

It seemed that she, like most sensible babies who are subjected to continuous bright lights and incubators and the trauma of the rupture in her primary attachment experiences, had learned to remain inside—with every window and door of her mind closed.

PHASE I: ROBOTS

What was striking with this patient in this state of early collapse was a kind of indifference to her own experiences. It seemed as if one feeling was as good as the next. Success as good as failure. There was an absence of something vital in her. She had an inert, robotic quality that made it hard to feel connected to her and was hard to sit with.

There is a sentence in a short story by James Joyce (1914) that characterizes this early stage of the analysis: “Mr. Duffy lived a little distance from his body, regarding his own acts with doubtful side-glances. . . .” At this period we were like two disembodied Mr. Duffys trying earnestly to talk to each other but getting nowhere because the real action was taking place a little distance from where we were.
I found myself tending to make more of things than she did. I would make interpretations about the meaning of things that she clearly did not feel. I found it hard to stay with the blankness. I would ask her how she felt about things, which she clearly did not have the capacity to answer. I would sometimes focus too much on either the destructiveness or the protective-ness of her behavior, rather than simply on her formlessness. By doing these things, I made it very hard for her to try things with me. I was not a safe person for her to be real with.

Premature infants have a profound vulnerability due to their immature developmental state in which they have a very narrow band of consciousness (more inert) compared to the six more defined levels of consciousness of the full-term infant. They are neurologically disorganized, there is a randomness in their physiological states, and there is an extreme sensitivity to light and sound (Blackburn, 1995; Hulseman & Norman, 1992; Mercuri et al., 2003; Msall et al., 1991). In addition, a whole host of studies has shown that infants with early attachment trauma have neurodevelopmental impairments in right hemispheric affect regulation (Schore, 2001, 2002).

It is no wonder, then, that hypersensitivity to sound, light, randomness, and disorganization, along with a restriction in levels of consciousness and right hemispheric affect dysregulation, are some of the distinguishing characteristics of these patients as adults (Grotstein, 1990a, 1990b; Schore, 2001, 2002).

Patients who have been traumatized at such a very early point in life come into the world so ill-fitted to find their bodies/ hearts/minds. What is it that they need from us?

My experience has been that patients with these early types of trauma require more right brain to right brain communication. They can end up functioning for us as initiates into different forms of consciousness. That is, they require a sort of double consciousness from us: to be awake and aware in the ordinary, practical sense, and, at the same time, to be open to other, deeper, more dreamlike, more magical forms of consciousness. We begin to feel and intuit invisible presences in each other, dark and light presences, in a different way, and the work drops down to a deeper level.
PHASE II: WORDLESS DESIRE

There are certain types of silkmoths that do all of their eating as caterpillars. Once they become moths, they have no mouths. They spend a few nights procreating, and then die. This was how we contacted each other at first: in the dark, wordless night of our minds. Sometimes literally, only in our dreams.

For example: One day, I was on the phone talking to a mechanic about my car, and he asked me for my phone number. I rattled off a number which was totally foreign to me. I quickly corrected it, but I was struck by the way this unknown number had rolled off my tongue with such ease, as if it were my own. I was haunted by the phone number all day, and I asked my husband if he knew that number. He said he did not, and suggested that maybe it was one of my patient’s numbers. I looked in my phone book, and it was hers. I had no idea that I even knew her number.

The next day she came in and said she had wanted to call me but could not bring herself to do so. Then she reported a dream:

A little girl was trying to talk to a woman, but her words were coming out all garbled, like she was under water. It was interesting because the woman was understanding her anyway, even though you couldn’t really hear the words.

PHASE III: ONSLAUGHT

Her second attempts at contact with me were more fierce. It was as if, having found me in the night to be a friendly presence, she was determined to stab me and cut me out during the daylight, convinced she would find out I was an imposter. I found it very hard to think during those times, and my body was often in a state of agitation when she walked into my office, before she even said anything.

Whereas during the inert, robotic stage, there was more of an absence of projective identification, and during the transitional, “moths in the night” stage, there was a kind of wordless desire and presence, now there was an onslaught of violent projective identification.
After a while, I felt worn down by her endless attacks on herself and on me, which left us always back where we started.

As time went on, I came to learn that when I felt attacked, or when she attacked herself, it meant that she had just contacted me in the night, that she had just allowed herself to experience something for a moment. I began to welcome the attacks, I began to see them as the first signs of life, something like the first lusty cry of the newborn after nine months of dark, wordless contact, which she did not, as I learned much later in the analysis, have the opportunity to experience.

Like most people who have had perinatal trauma, birth and death, being born and killing, were connected for her.

I report here a session from that time as I was beginning to learn from my mistakes about this, with her. I will include my private thoughts—my comments to myself on the process as it is happening in the session:

PATIENT (P): *(Comes in, lays down on the couch)* I didn’t want to come here today. Yesterday I threw up all day. *(Silence)* I’m really dying today. . .

ANALYST (A): Struggling to think?

P: No. *(More silence, then gets annoyed)* Well, there you have it, that’s the end of that.

A: *(Comment to myself: It’s clear that my having introduced the idea of thinking when she was dying was off—and felt like a killing on my part.)*

P: I never ask how I’m supposed to push the button. I just do it.

A: Is it hard to ask?

P: *(Gets annoyed, and then very angry)* Look, I don’t know what you want me to do. If you wanted to tell me something, you’d tell me. I don’t need to ask—I feel ambushed by that question. I feel sick, like I’m going to throw up again. I don’t know what you’re talking about right now. I don’t know how to do that . . . I’m feeling dizzy.

A: *(Comment to myself: I can see that my bringing up the idea of her asking me a question was off again. How can she possibly ask me a*
question when she’s not even alive?) You feel gotten rid of. It feels like I’m demanding something from you that you can’t do.

P: I feel like I’m on Mars. Now you tell me—I’m supposed to be asking you. I didn’t know.

A: What I meant—(Cuts me off—the sound of my voice and the reference to meaning are aggravating to her)

P: I feel obliged to answer your questions. I’m doing this all wrong. Now you tell me. I’m supposed to ask you questions.

A: Feeling very criticized and pressured by me.

P: Well, I don’t know what I’m supposed to be doing. Now I’m hearing that I was supposed to tell you how I feel. Everything just gets thrown right back in my face. I don’t know where I am with you.

A: I’m not finding you, I’m not understanding you.

P: I don’t know what the rules are. I don’t know what it’s OK to want.

A: You want something from me, but you’re not sure if it’s OK to want that.

P: I don’t know if I’m supposed to ask you or wait for you to tell me. What am I supposed to say when you say, “Do you want me to tell you?” Yes . . . I want you to tell me what you’re thinking—right now—

A: OK . . . is there something specific about what I’m thinking that you want to know?

P: I don’t care! Look, if there’s something specific you need to tell me, go right ahead! Do what you want.

A: (In the countertransference, I’m beginning to feel confused. I’m forgetting who was asking who, what. It’s clear that the idea of a specific thought felt premature and, again, understandably, like an attack from me.) Well, I can let you know what’s on my mind, and if, while I’m talking, you want me to do something different, you can let me know, if you can, if it’s possible to do that.

P: Never mind . . . I’m sorry. I do not know—
A: That’s OK, that’s what we’re trying to do here, just trying to help you figure this out. (As the words “figure this out” come out of my mouth, I wince, knowing that I’ve just done it again—attacked her with meaning.)

P: I don’t even feel like we’re on the same planet right now. You’re like one of these giant computers with all those buttons and I’m supposed to know how to work this thing and I have no idea what’s going on. I push this button and you make it rain. I don’t know how I got here—OK, now I would like to ask you what you’re thinking.

A: Well, right now, I was thinking that there’s something very confusing about getting close to me, pushing the button, making contact—wanting to, but it’s scary—not sure if it’s OK with me.

P: I feel like I’m trapped in a vacuum cleaner.

A: How is that?

P: I don’t know. I just want to get out of here. I don’t know how to talk about this.

A: Out in the vacuum (I say this in a kind of vacuous tone of voice—and then she turns around and looks at me, quietly, like she thinks something’s the matter with me)

P: What do you mean?

A: (In the countertransference, I feel embarrassed—like I’ve been caught dreaming, talking in my sleep, and I have to come back to the conversation. I wasn’t asleep here, but I had drifted off in my mind, I think I was having a profound feeling of emptiness and I wasn’t even aware of it. I was speaking in a disconnected, disembodied way. I try to recover. I mean a kind of blankness. (As if this makes anything any clearer—I still have no idea what I am talking about)

P: Yes! (As if she feels that I finally now understand her)

A: (In the countertransference, I’m feeling confused. I can’t very well ask her what I meant by that. Then I start reflecting on how I got there, and I realize that I have been ruminating in the back of my mind about the image of being trapped in a vacuum. It
feels incongruous to me. Trapped and vacuum...I’m ruminating until she speaks.)

P: A vacuum feels like being unwanted—that’s not it—but blankness—yes.

A: (It seemed to me as if she wasn’t so much responding to the words that I had used in that moment, but that she picked up on the collapse that had just taken place in my body and mind—that I had finally lost myself, that I was feeling a primitive bodily resonance with her, that I had finally lost the ability to even try to make meaning of things (a sort of countertransference psychosis), and that I could begin with her at her true starting point. Her whole mood shifts here. She becomes more thoughtful, no hard edge to her voice)

P: I want to start over. (Pause) I don’t know where to start. (Slowing down) I feel empty.

A: When you slow down you feel the emptiness.

P: Yes. And then all the craziness starts in my mind again.

A: The craziness helps you to not feel the empty void inside.

P: (Slowing down, quiet) Yes.

A: There’s nothing holding you together right now.

P: (Nods. Quiet) Actually, I feel OK now that we’re talking, but it’s just the idea of going back and starting over.

A: (Note to myself: She finally feels that we’re talking—now that I’ve stopped trying to talk to her.)

P: I don’t know what to do. I don’t know how to start over.

A: Like a blank feeling.

P: Exactly! I come up blank every time.

A: Behind all these other crazy feelings is really a kind of blank terror.

P: I’ve felt that all my life. People ask me, “What are you writing about?” I don’t know. Everybody else always knows what they’re thinking. I never know. There’s nothing there. (Sits up and looks
at me very intently) I want to tell you this: When I was in New York, I didn’t feel crazy. I felt really calm. Someone said, “Are you sure it wasn’t just that you were on vacation?” I didn’t feel that. It wasn’t like I was on some wild Caribbean vacation here. I just felt so comfortable. I knew they understood me.

A: When you feel someone is really there with you, feeling what you are feeling, it holds you together in a way that you can’t hold yourself.

P: Yes. I was so open with them. I know when I leave today I’m going to feel really bad. This is why I didn’t want to come today. I didn’t want to feel this. It feels kind of good to hear your voice, though. Something comes over me when I hear it. (Pause) I’m so glad my mentor is back. He’s talking to my department. Nobody listens when I talk. It’s like I have a voice with him.

A: Maybe you’re beginning to hope that you can have a voice in here.

P: Yes.

DISCUSSION

So, I began to learn that I had to take several steps back.

I began to learn that I had to give up on my desire to understand. I had to let go of my manic, do-gooder, literalized, unimaginative, interpretive mentality: that it was superficial and without reflection. She needed to know that she could make contact with me in an alive, human way.

I would need to contact her not through logic and understanding, but through the interior of my own heart—through my body. This is the place within which is more invisible but nonetheless quite real presences would begin to be felt.

Precocious understanding leads to a lack of a subjective voice, a collapse of imagination—a subject without dimension, attacks on linking. The patient needs us to find a way to hold the collapse—and to hold the shadow. Not to push them towards precocious maturity (by asking them things like How did you feel about that? or What are you thinking? or making interpre-
tive links that they cannot possibly follow unless they drive that short distance away from their bodies.)

There is a beautiful quote by Bion (1974) on this subject:

Instead of trying to bring a brilliant, intelligent, knowledgeable light to bear on obscure problems, I suggest we bring to bear a diminution of the light—a penetrating beam of darkness—a reciprocal of the searchlight. . . . The darkness would be so absolute that it would achieve a luminous, absolute vacuum. So that, if any object existed, however faint, it would show up very clearly. Thus, a very faint light would become visible in maximum conditions of darkness. (p. 18)

I began to learn that her violent projections were actually an expression of a tremendous leap in her ability to imagine someone out there, in the dark vacuum, to feel these feelings with her. That there might be some usefulness in that, although, for the most part, what the use would be was still a complete mystery for her at this point. The way in which she was relating to me was very different from her earlier blank noninteractions, or her later stolen moments in the darkness.

Here, there was the beginning of an idea of a container. It was the beginning of the formation of a link. As I was able to shift internally, and see this more as a communication of the violence with which she felt each new birth of an experience, I became more of a safe harbor for her, and she began to get a small hint of how a container might be able to be used. The blankness began to be an entity in the room, which could be referred to.

This was helpful and hopeful for a while, but then it was beginning to become clear that something else was now getting stimulated as this new entity was being given a name.

PHASE IV: WORDS AND NEED

Naming the experience brought on a period during which she could not think at all. Her concreteness became even more pronounced and had a psychotic feel to it. She began to be very reactive to my vacations. In fact, during this time I had to maintain phone contact with her every day during my breaks.
She was at least able to feel her need for me, and to begin to find ways to tell me about it. I did feel sometimes that she was more of a person in great pain and great need, not so much the inert feeling, nor the “moths in the night” feeling I had before.

With this experience of need also came a greater awareness of the meaningless, repetitive nature of her existence. She became acutely suicidal during this time. As she began to feel her blankness, she also felt despair at the idea of living this way for the rest of her life. She felt no point in living this lonely, “put one foot in front of the other” existence.

One day she called to ask if I could switch her appointment from 4:00 p.m. to 2:00 p.m. I called back to say that I did not have that time available. She then left a very angry message:

See, that’s what I mean about not wanting to ask you anything. Now I feel like I’m not a person. I don’t even want to see you anyway. And I don’t need you. You just say you can’t see me anyway so what’s the point? It doesn’t matter what I need because I never get it. It’s not available. Now I’ll go through the whole day feeling stupid and you just get to do what you want. Maybe that’s not even the point. Maybe there is no point. I don’t even have a point. I don’t even have a purpose. I don’t even care. I wouldn’t even care if you called up and said you don’t have 4:00 p.m. available anymore either. I don’t care. I’m not coming today. Goodbye.

I felt quite helpless. I was terrified that she would kill herself. She had several different medication consults at this point, but none of them seemed to help. She was left having to feel this terrifying void, this pointless existence, in which she felt she did not even have the dimensions of a point, almost all alone.

The timing of it felt a bit like it came out of nowhere, because I had felt that she was “getting better,” coming alive in some sense. Which, in a very real way, she was, but also, I should have known, because it was this very aliveness that felt such despair at beginning to experience itself, and suffer pain and joy for the first time in a new way—in a way that registered. Of course that would lead to a suicidal impulse. Somehow, my mind at the time was still operating in a linear way, hoping for “prog-
ress,” which was a kind of evacuation of my own. Birth and killing, light and darkness, would have to go hand in hand in this case. We would always be balancing the problem of muting her voice with the problem of overwhelming her with the sound of her own voice.

Many years passed in this way, with moments of clarity feeling juxtaposed with great darkness and cut-off, hopeless ruminations. She was writing during this time, and the writing was a place where she was sometimes able to notice herself just being and thinking in a different way. (Although most of the time, the writing was its own private hell, a place where the blankness of the white page sometimes threw her into the free fall of the blankness of her own mind.) A complex dance between the black and white parts of the page ensued. In a concrete way, the black marks on the page (the typed words) were a sign of hope, that a piece of herself had been found. Her mind was not all blank pages. She did sometimes have the dimensions of a point, and even sometimes of a letter or a word. Here was proof.

She always made a point of typing on an old-fashioned typewriter rather than a computer. This gave her a sense of a bodily connection to the black marks on the page. Otherwise, they felt as if they were coming out of nowhere.

Whereas before, her need had been sealed off and co-opted by the Shadow (Andersen, 1847) now all the windows and doors were thrown wide open and her longing and need spilled onto the page. I now became the “aurora borealis surrounded by flowers” (Andersen, 1847). I became Poetry. And we stayed there for 3,000 years.

During this time, she typed out a card to me that read:

I want to hold you and never release you. Just thinking about this makes my body react. It fills my body with agonizing pain and longing. Yet I can’t abandon these images. I don’t want to abandon them. I don’t want you to make them go away either. I want you to feel my agony. I want you to be inundated by the intensity of my body. I want you to wrestle with my longing.

Writing to you now is different than before. The words are coming from a different place. They come from the struggle for life. It’s a place where there are no words or identifiable feelings, just movements and intense longing. All I can think about is survival. You are what I need to survive. Saying that feels raw. Not
all hidden and buried by a bunch of words. My body can no longer contain itself. It spills out of me and onto the paper.

When I type now, it’s like my body is flowing onto the white paper. I desperately need to know that you can hold me.

The warmth of your voice reminds me of your presence and reassures me of your willingness to reach out and grab me when I need you. The point of contact becomes everything, everything else falls away and is no longer a concern.

One day, during this time, she reported that she realized she actually had enough material for a book, and all that remained was for her to edit it. This felt miraculous to her because editing meant she had so much material that she had to cut some out, whereas her internal experience had always been that she had no material, no substance, no anything.

When the book was finally published, it was quite beautiful, and was very well received in her field. The person of the patient was beginning to emerge out from under the shadow of the psychosis, and, in a very concrete way, she was becoming the author of her own experience.

PHASE V: MOURNING

In one of the later sessions in the analysis, nearing the end of it, she began to be able to mourn. Just as dark and light, birth and death, went hand in hand for her, her ability to mourn marked a new period in the analysis during which there was tremendous growth. There was a blossoming of her capacity for appreciating and apprehending both aesthetic beauty and the transformational aesthetic of the psychoanalytic process itself (Bollas, 1977; Molofsky, 2002).

I report a session from that time:

P: Can you turn off the lights?

A: (I do.)

P: When I was born, there were so many sounds and lights. The light was so bright. (Says this in a way that sounds as if she is actually remembering this) It’s the best of me and the worst of me—this sensitivity. Sometimes I feel so ambushed by all the noise, all the lights—it’s like it’s killing me. But then, it helps me to pick things
up, notice things, little things. Like when your voice changes, almost like a song, or the light in your eyes. It feels good to feel these things. It feels good to be alive.

A: Even though all the sounds and lights are overwhelming, it also feels good to have been born—to be outside in the world—the beautiful world.

P: Yes! *(Silence, 15 minutes)*

A: *(I feel sad and distant. I am then reminded that I had a dream the night before that she was crying)*

P: Are you sorrow?

A: What would make me sorrow?

P: Because I don’t need you the same way I used to. It used to be when I would leave here, I would spend the whole time waiting until I could see you again. Now I’m feeling it more when I’m with you, and I miss you when I’m not here, but it’s OK. I can function.

A: Worried that it will make me sorrow when you don’t need me anymore?

P: Well, it’s nice to be needed.

A: The sorrow of a mother when her little baby is beginning to grow up.

P: *(Nods)* It began to change when you became part of my soul. First, I was trying to not feel anything or think anything, and you were trying too hard to understand everything.

A: Yes.

P: Then, you started to come inside me and find me and feel me—then you became part of my soul.

A: And how much both mother and baby cherish those experiences and long to return to them and stay there.

P: Yes. *(Cries a little, and I cry a little too.)*

A: But at the same time, they wouldn’t really want to deprive
themselves of the joy of watching the baby grow up and develop and blossom.

P: (Nods, touches her heart.) I think I’m going to be OK with the new time schedule. (She had just cut down from five to four times per week.) That was a big sacrifice, but I like this new position. I think I’m going to be able to do it.

DISCUSSION

Psychoanalysts have traditionally overemphasized the role of meaning and the spoken word (and underemphasized contact, vulnerability, and aliveness) in the analytic experience. This has left us with a wide gap in our understanding and capacity to work with the nonverbal, nonsymbolic, unmentalized, unintegrated layers of experience—and the distinct manner in which these layers of experience present themselves. Logical, analytical, verbal, linear, left-brain modes of thinking, alone, cannot possibly understand them nor communicate with them (Alharnati, 2002).

Alongside the dead and murdered states of mind, there are unborn states of mind; alongside a reversal of alpha function, there is a lack of alpha function; alongside dismantled states, there are unassembled states.

I think this patient was trying very hard to convey to me what she needed in order to have an analysis. I think she was saying that she could not comprehend my questions, comments, and interpretations, that they were not in a form that she could use.

I think in the beginning she was telling me that when I would jump too quickly to try to make meaning of her experience, she felt gotten rid of; she felt disconnected from me and from her body. These kinds of patients comprehend us through their bodies first—not their minds—and they need us to do the same. They need us to smell them and drink them and taste them and touch them and hear the music in their voices first. They need us to be drunk with their experiences to such a degree that it feels as if they are our own. This can get extremely uncomfortable in the countertransference. It can make us want to get rid of the patient.
They often try to comply with a more meaning-making and interpretive mode, but when they do, it is usually in the only way they can: by going back to precocious intellectualization, autistic maneuvers, or perversity. Where else can they go if they do not have the structure? This is a sign to us in the session that we need to take a step back.

CONCLUSION

So, what do you do when the feelings that get stimulated by the patient get to be too much for you to tolerate and to hold?

You Die—
Be the first one in the room to die—
“To die and so to grow—”
—Goethe, 1814

The patient needs to relive the death—the original collapse—within the context of a holding relationship with another person. Eigen (2002) talks about killing as a way of finding a birth you can say yes to. The analyst does not push for birth and life as much as hold the killing in such a way as to help make it tolerable enough to allow the creative genius—the true inner core of the personality (the infinite Unconscious; Grotstein, 2000)—to be untangled from the killing within which it has been embedded. To make its own distinct voice known, from which the natural process of healing and birth (natural evolutions in “O”; Bion, 1965) can be set in motion, through their primary connection with another human being and within themselves.

When we join patients in this concrete, unsymbolized, unfantasized, uncreated place, then they can slowly and gradually start to have an experience of creating their own analysis, of seeing the power of their own subjectivity.

Now, when they speak symbolically there is not the disconnect that comes from a precocious jumping over the trauma to develop. It is now connected from the inside out, starting with the body, starting with the formless, unintegrated bits and pieces of experience and building in a real, substantial way. Now the patient starts to come alive. And they enter a place of creation, imagination, and thinking of a different kind.
REFERENCES


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