himself regarding his reasons for feeling that the analysis is a dangerous and doomed undertaking. Whatever the nature of the patient's psychological difficulties, his unconscious anxiety will be given form in terms of the danger he experiences in relation to the prospect of beginning analysis. The analyst attempts to understand the nature of these transference anxieties and to help the analysand put these fears into words.

In the final chapter, I discuss a specific form of primitive anxiety: the unconscious fear of not knowing. What the individual is not able to know is what he feels—and therefore who, if anyone, he is. The terror associated with this type of not knowing is warded off by means of the use of substitute formations (misnamings and misrecognitions) that create for the individual the illusion of knowing and of being. Defensive reliance on substitute formations further alienates the individual from himself, and fills the potential space in which personal meaning and desire might otherwise have come into being.

This type of fear of not knowing is by no means restricted to a small group of alexithymic or schizoid patients. It is a universal phenomenon, one that, to some degree, we continually bump up against; it is experienced, for example, each time we expose ourselves to the hazards of learning.

2

The Structure of Experience

The other one, the one called Borges, is the one things happen to . . . I know of Borges from the mail . . . It would be an exaggeration to say that ours is a hostile relationship; I live it, let myself go on living, so that Borges may contrive his literature, and this literature justifies me.

J. L. Borges, "Borges and I"

Borges's prose poem "Borges and I" (1960) delicately teases apart what ordinarily comprises the illusion of unity of experience. In an infinitely more clumsy way I would like to propose a psychoanalytic framework within which to think about the components of the dialectical process generating human experience. I will explore in this chapter the idea that human experience is constituted by the dialectical interplay of three different modes of generating experience: the depressive mode, the paranoid-schizoid mode, and the autistic-contiguous mode. The

concept of the first two of these modes was introduced by Melanie Klein[1]; the third represents my own synthesis, clarification, and extension of ideas introduced primarily by Frances Tustin, Esther Bick, and Donald Meltzer. Each of these modes of generating experience is characterized by its own form of symbolization, method of defense, quality of object relatedness, and degree of subjectivity. The three modes stand in a dialectical relationship to one another, each creating, preserving, and negating the others. The idea of a single mode functioning without relation to the other two is as meaningless as the concept of the conscious mind in isolation from the concept of the unconscious mind; each is an empty set filled by the other pole or poles of the dialectic.

I will describe each of the three modes of generating experience with particular reference to the analytic experience. What I hope will become apparent is that every psychological event is overdetermined, not only in terms of layers of unconscious content, but also in terms of modes of experience generating the psychological matrix within which mental content exists. Psychological change ("structural change") will be discussed in terms of shifts in the nature of the dialectical interplay of modes of generating experience.

Paradoxically, the elements of the synchronicity of experience will, for the sake of clarity, be presented

[1]Although I am not a Kleinian, I have found many of Klein's ideas—when viewed independently of her developmental timetable, her concept of the death instinct, and her theory of technique—to be pivotal to the development of psychoanalytic thought. Two of her most important contributions to psychoanalysis are the concepts of the paranoid-schizoid and depressive positions. However, neither concept has been integrated into the main body of the American psychoanalytic dialogue.

sequentially in this chapter. Like a novice juggler who requires the patience of his audience while he gets his first baton into solitary flight, I ask for the reader's indulgence while I launch the initial sections of this chapter. In the end, the reader must become the juggler holding in generative tension the multiplicity of modes constituting human experience.

Experience in a Depressive Mode

The concept of the *depressive* position was introduced by Melanie Klein (1935, 1948, 1958) to refer to the most mature form of psychological organization. Although this organization continues to develop throughout life, Klein believed that it has its origins in the second quarter of the first year of life.[2] Bion (1962) modified this concept to emphasize not its place in a developmental sequence, but its place in a dynamic relationship with the paranoid-schizoid position. In this chapter, my focus is on the depressive mode not as a structure or a developmental phase, but as a process through which perception is attributed meaning in a particular way. This is what I have in mind by a mode of generating experience. The qualities of experience in each mode are interdependent, each providing the context for the other.

In the depressive position, the mode of symbolization termed *symbol formation proper* (Segal, 1957) is one in which the symbol re-presents the symbolized and is experienced as different from it. Symbolic meaning is

[2]As will be seen, the debate over Klein's developmental timetable loses much of its significance when her "positions" are viewed not as developmental phases, but as synchronic dimensions of experience.

generated by a subject mediating between the symbol and that which it represents. It could be said that it is in the space between the symbol and the symbolized that an interpreting subject comes into being. It could also be said with equal validity that it is the development of the capacity for subjectivity, the experience of "I-ness," however subtle and unobtrusive, that makes it possible for the individual to mediate between symbol and symbolized. Both are true. Each constitutes the conditions necessary for the other; neither "leads to" or "causes" the other in a linear, sequential sense.

The achievement of symbol formation proper allows one to experience oneself as a person thinking one's thoughts and feeling one's feelings. In this way, thoughts and feelings are experienced to a large degree as personal creations that can be understood (interpreted). Thus, for better or for worse, one develops a feeling of responsibility for one's psychological actions (thoughts, feelings, and behavior).

As one becomes capable of experiencing oneself as a subject, one at the same time (via projection and identification) becomes capable of experiencing one's "objects" as also being subjects. That is, other people are viewed as being alive and capable of thinking and feeling in the same way that one experiences oneself as having one's own thoughts and feelings. This is the world of whole object relations in which the individual exists as more or less the same person over time, in relation to other people who also continue to be the same people despite powerful affective shifts and mixtures of affect. New experience is added to old, but new experience does not undo or negate the past. The continuity of experience of self and other through loving and hating feeling states, is the context for the development of the capacity for ambivalence.

Historicity is created in the depressive mode as the individual relinquishes his or her reliance on omnipotent defenses. When, in a paranoid-schizoid mode, one feels disappointed or angry at an object, the object is no longer experienced as the same object that it had been, but as a new object. This experience of the discontinuity of self and object over time precludes the creation of historicity. Instead there is a continual, defensive recasting of the past. In a depressive mode, one is rooted in a history that one creates through interpreting one's past. Although one's interpretations of the past are evolving (and therefore history is continually evolving and changing), the past is understood to be immutable. This knowledge brings with it the sadness that one's past will never be all that one had wished. For example, one's early relationships with one's parents will never be all that one has hoped. At the same time, this rootedness in time also brings a depth and stability to one's experience of self. One's relation to the history that one has created interpretively is an important dimension of subjectivity, without which one's experience of "I-ness" feels arbitrary, erratic, and unreal.

In a psychological state in which other people are experienced as subjects and not simply as objects, it is possible to care about them as opposed to simply valuing them as one would value a prized object, or even such essential objects as food or air. Objects can be damaged or used up; only subjects can be hurt. Therefore, only in the context of the experience of *subjective others* does the experience of guilt become a potential human experience. Guilt has no meaning in the absence of the capacity for concern for other people as subjects. Guilt is a specific sort of pain that one bears *over time* in response to real or imagined harm that one has done to someone about

whom one cares. One can attempt to make reparation for that about which one feels guilty, but this does not undo what one has done. All the individual can do is to attempt to make up for what he has done, in his subsequent relations with others and with himself. Empathy becomes possible in this mode of experience, since others are experienced as subjects whose feelings can be understood to be like one's own.

Once the other is experienced as a subject as well as an object, one acknowledges the life of the other outside the area of one's omnipotence. In a world of subjects whom one ambivalently loves and cannot fully control, a distinctly new form of anxiety (not possible in the more primitive modes of experience) is generated: the anxiety that one's anger has driven away or harmed the person one loves. Sadness, the experience of missing someone, loneliness, and the capacity for mourning become dimensions of human experience as a consequence of the interplay of the qualities of experience in the depressive mode described above. As will be discussed, in a paranoid–schizoid mode, magical restoration of the lost object short-circuits these experiences. There is no need to, or any possibility of, missing or mourning a lost object when absence can be undone through omnipotent thinking and denial.

The nature of the transference in a depressive mode has its own distinct qualities. In a paranoid-schizoid mode, transference is based upon the wish and the belief that one has emotionally recreated an earlier object relationship in the present relationship; in a depressive mode, transference represents an unconscious attempt to recapture something of one's experience with an earlier object in the present relationship. This latter form of transference is rooted in the context of the sadness of

knowing that the relationship with the original object is a part of the past that one will never have again. At the same time, the past is never lost completely in a depressive mode in that one can repeat something of the experience with the original object in a relationship with the new object (Ogden, 1986). This, for example, under normal circumstances, makes the waning of the Oedipus complex possible. The little girl, for example, experiences sadness in her eventual acceptance of the fact that she will not be able to have the unconsciously wished-for romantic and sexual relationship with her father. The pain of this renunciation is bearable in part because the experience with the father is kept alive transferentially in relationships with new objects, and will form an important core of her mature, adult love relationships (cf. Loewald, 1979; see also Chapter 5).

The depressive mode of generating experience that has been schematically described constitutes a dialectical pole that exists only in relation to the paranoid-schizoid and autistic-contiguous poles. In the never-attained ideal of the depressive mode, analytic discourse occurs between interpreting subjects, each attempting to use words to mediate between himself and his experience of the other.

This discourse between subjects is frequently blocked by unconscious thoughts and feelings that the subject finds too frightening or unacceptable to put into words. I am referring here not only to frightening and unacceptable sexual and aggressive wishes, but also to other sorts of fears such as the unconscious anxiety that aspects of oneself are so private and so central to an endangered sense of being alive that the very act of communication will endanger the integrity of the self. Still another form of anxiety that disrupts the intersubjective discourse is the fear that one's life-sustaining ties

to one's internal objects may be jeopardized through any sort of discourse in which one relinquishes control over one's internal object world by sharing knowledge of it with another (Ogden, 1983).

The analyst and analysand attempt to understand the "leading edge of anxiety" that constitutes the principal source of the disruption of the intersubjective discourse at a given moment. In a depressive mode, that anxiety is always object-related in that the unconscious reasons for feeling fearful, guilty, ashamed and the like have to do with overdetermined unconscious phantasies[3] involving internal and external objects. The derivatives of these unconscious object-related phantasies constitute the content of the analytic transference–countertransference experience.

The analyst has no means of understanding the patient except through his or her own emotionally colored perceptions of and responses to the patient. Of these perceptions and responses, only a small proportion are conscious, and it is therefore imperative that the analyst learn to detect, read, and make use of his own shifting unconscious state as it unfolds in the analytic discourse. For example, early in his analysis a patient, Mr. M., was talking with apparently great intensity of feeling about his affection for and loyalty to his wife, and the fulfillment he found in their sexual relationship. I had no conscious reason for doubting his sincerity. However, I

[3]Fantasying is a mental activity with conscious and dynamically unconscious dimensions. In this volume I use the term *phantasy,* spelled with a *ph,* to denote the unconscious dimensions of this mental activity. *Fantasy,* spelled with an *f,* is used to refer to the more conscious facets of this psychic activity, for example, daydreams, conscious childhood sexual theories, and conscious masturbatory narratives (cf. Isaacs, 1952).

noted a passing thought of my own that was as ephemeral as a dream as it recedes while one is awakening. I made a conscious attempt to struggle against the weight of repression in an effort to recapture it. The thought that I was repressing was infused with a somewhat smug pleasure in the self-protective privacy inherent in the role of analyst vis-à-vis the analysand. I was feeling safe in this peculiar relationship in which only the patient's "dirty laundry" is "aired." My thoughts then went to the question of what dirty laundry I suspected I was pretending to be free of at that moment.

These questions helped alert me to the possibility that the patient was at the time disavowing his anxiety in relation to the ideas he was discussing. As Mr. M.'s associations continued, his fears concerning his wife's genitals were very subtly hinted at as he discussed the sexual intercourse they had had the previous night. He said that he very much enjoyed their lovemaking in "complete darkness" and mentioned in passing that he had washed his penis afterward.

This use of the intersubjective resonance of unconscious processes occurring in individuals experiencing one another as subjects is paradigmatic of the unconscious-preconscious level of empathy in a depressive mode. This process can be thought of as involving the analyst's unconscious projection of himself into the patient's unconscious experience of himself and his internal objects; the analyst's unconscious identification with the patient's unconscious experience of himself and his internal objects; and the creation of an unconscious intersubjective third ("the Other" [Lacan, 1953]) between the patient and analyst. However it is described, it is a process in which the analyst makes available to the patient his own unconscious chain of symbolic meanings through which he

attempts to experience something similar to the unconscious experience of the patient, but in a less intense way and in a less conflicted and less powerfully repressed or split-off way.

Having described a conception of the depressive mode of experience, it is necessary to reiterate that no such entity exists; every facet of human experience is the outcome of a dialectic constituted by the interplay of depressive, paranoid-schizoid, and autistic-contiguous modes. As will be discussed later, even symptomatology generated in response to a conflict of subjective desire (for example, conflicted Oedipal desires, fears, and loyalties) is only partially constructed in a depressive mode. At this point, I will delineate features of each of the other two poles of the dialectic of experience. Again, for purposes of clarity, this will be done as if each mode could be isolated from the other and viewed in its purest form.

Experience in a Paranoid-Schizoid Mode

The *paranoid-schizoid* position is Melanie Klein's (1946, 1952a, 1957, 1958) conception of a psychological organization more primitive than the depressive position. Klein (1948) conceived of the paranoid-schizoid position as having its origins in the first quarter of the first year of life. Again, the emphasis in this chapter will be shifted from Klein's diachronic conception of a sequence of structures or developmental phases, to a consideration of the dialectical interplay of synchronic modes.

The paranoid-schizoid mode of generating experience is based heavily upon splitting as a defense and as a way of organizing experience. Whereas the depressive

mode operates predominantly in the service of containment of experience, including psychological pain, the paranoid-schizoid mode is more evenly divided between efforts at managing psychic pain and efforts at the evacuation of pain through the defensive use of omnipotent thinking, denial, and the creation of discontinuities of experience.

In a paranoid-schizoid mode, the experience of loving and hating the same object generates intolerable anxiety, which constitutes the principal psychological dilemma to be managed. This problem is handled in large part by separating loving and hating facets of oneself from loving and hating facets of the object. Only in this way can the individual safely love the object, in a state of uncontaminated security, and safely hate without the fear of damaging the loved object.

Splitting defensively renders object-related experience of a given emotional valence (for example, the relationship of a loving self to a loving object) discontinuous from object-related experience of other valences (for example, the relationship of a hating self to a hating object). Each time a good object is disappointing, it is no longer experienced as a good object—nor even as a *disappointing* good object—but as the discovery of a bad object in what had been masquerading as a good one. Instead of the experience of ambivalence, there is the experience of unmasking the truth. This results in a continual rewriting of history such that the present experience of the object is projected backward and forward in time creating an eternal present that has only a superficial resemblance to time as experienced in a depressive mode.

The defensive use of discontinuity of experience (splitting) is commonly encountered in work with patients

suffering from borderline and schizophrenic disorders. When the patient is disappointed, hurt, angry, jealous, and so on, he feels that he sees with powerful clarity that he has been duped by the analyst and that he is finally perceiving the reality of the situation as it is and as it always has been: "The fact of the matter is that I've deluded myself about you for a long time. It is obvious to me now that you have absolutely no regard for me, otherwise you wouldn't forget fundamental things about me like my girlfriend's name that I've mentioned a thousand times."

Rewriting of history leads to a brittleness and instability of object relations that are in continual states of reversal. There is no stable, shared experience of the history of the patient–analyst relationship that can form a framework and container for present experience. In this mode of experience there is an almost continuous background of anxiety deriving from the fact that the individual unconsciously feels as if he or she is perpetually in uncharted territory in the presence of unpredictable strangers. Analytic theory need not appeal to the concept of the death instinct to account for the anxiety occurring within such a brittle container for psychological experience.

In a paranoid-schizoid mode, there is virtually no space between symbol and symbolized; the two are emotionally equivalent. This mode of symbolization, termed *symbolic equation* (Segal, 1957), generates a two-dimensional form of experience in which everything is what it is. There is almost no interpreting subject mediating between the percept (whether external or internal) and one's thoughts and feelings about that which one is perceiving. The patient operating in a predominantly paranoid-schizoid mode may say, "You can't tell me I

don't see what I see." In this mode, thoughts and feelings are not experienced as personal creations but as facts, things-in-themselves, that simply exist. Perception and interpretation are experienced as one and the same. The patient is trapped in the manifest since surface and depth are indistinguishable. That which would be viewed as interpretation from the perspective of the depressive mode, would be experienced in a paranoid-schizoid mode as an attempt to "twist the facts," to distract, deceive, and confuse through the "use of psychological bullshit."

Transference in a paranoid-schizoid mode has been termed *"delusional"* (Little, 1958) or *"psychotic"* (Searles, 1963) transference. The analyst is not experienced as *similar to* the original childhood object; he *is* the original object. For example, a therapist made some inquiries during a therapy hour about the details of a physical complaint that his patient, A., was discussing. The patient experienced this as an anxious, intrusive overreaction on the part of the therapist that led the patient to experience the therapist as having *become* her mother (not simply as being like her mother). The following day the patient consulted her internist who later in bewilderment called the therapist and said that A. had introduced herself by saying, "I'm A.'s mother. I'm very worried about A.'s illness and would like to ask you some questions about it." In this way, the patient became her therapist-mother and enacted the overanxiousness and intrusiveness of the therapist-mother.

In the absence of the capacity to mediate between oneself and one's experience, a very limited form of subjectivity is generated. In a paranoid-schizoid mode, the self is predominantly a self as object, a self that is buffeted by thoughts, feelings, and perceptions as if they were external forces or physical objects occupying or

bombarding oneself. An adolescent schizophrenic patient would violently turn his head in order to "shake" (get rid of) a thought that was tormenting him. Another schizophrenic patient requested an X-ray film in order to be able to see what it was inside of him that was driving him crazy. Still another patient "took a big shit" in the therapist's waiting room toilet before each session in order not to harm the therapist with his toxic inner contents during the session.

When working with patients generating experience in a predominantly paranoid-schizoid mode, one must couch one's interventions in language that reflects the concreteness of the patient's experience; otherwise, patient and analyst have the experience of talking in a way that, in the words of one such patient, "completely misses one another." One does not talk about the patient's feeling that he is like a robot, one talks with the patient about what it feels like to be a robot; one does not talk with the patient about his feeling that he is infatuated with a woman, one talks with him about what he feels when he believes he is possessed or haunted by a woman; one does not talk about the patient's wish to be understood by the therapist, one talks about the patient's conviction that the therapist—if he is to be of any value at all to the patient—must think the patient's thoughts and feel the patient's feelings.

Psychological defense in a paranoid-schizoid mode is based in large part on the principle that one secures safety by separating the endangered from the endangering (cf. Grotstein, 1985). This is the psychological meaning of splitting. All defenses in a paranoid-schizoid mode are derived from this principle; for example, projection is an effort to place an endangering (or endangered) aspect of self or object outside of the self while retaining the

endangered (or endangering) aspect of self or object within. The other defenses in this mode of generating experience—introjection, projective identification, denial, and idealization—can be seen as variations on this theme.

The paranoid-schizoid mode is characterized by omnipotent thinking through which the emotional complexities of loving and hating are magically "resolved," or—more accurately—precluded from psychic reality. In this mode, guilt (as it exists in a depressive mode), simply does not arise; it has no place in the emotional vocabulary of this more primitive mode. Since one's objects, like oneself, are perceived in this mode as objects rather than as subjects, one cannot care about them or have concern for them.[4] There is little to empathize with since one's objects are not experienced as people with thoughts and feelings, but rather as loved, hated, or feared forces or things that impinge on oneself. Other people can be valued for what they can do for one, but one does not have *concern* for them—as one does not have concern for one's possessions, even the most important of them. As described earlier, an object can be damaged or used up, but only a subject can be hurt or injured.

In a paranoid-schizoid mode, what might become a feeling of guilt, is dissipated through, for example, the use of omnipotent reparative phantasies. The injury to the object is denied through the use of a magical remedy

[4]Because the paranoid-schizoid mode never exists in isolation from the depressive mode (and the autistic-contiguous mode), the concept of the self-as-object (completely dissociated from the experience of self as subject) is phenomenologically meaningless. Due to the dialectical structure of experience, self-experience is never completely devoid of a sense of "I-ness," and one's objects are never simply objects altogether devoid of subjectivity.

that is intended to expunge from history the harm that one has done. History is rewritten and the need for guilt is thereby obviated. For instance, a patient operating heavily in a paranoid-schizoid mode often would laugh and say that he was only kidding after having said something extremely cruel to his wife. Having said, "You know I was only kidding," he felt that he had undone the damage by magically changing the assault into something humorous (by re-naming it). When his wife refused to participate in this magical rewriting of history, the patient would escalate his efforts at joviality and begin to treat her with contempt, accusing her of being a baby for not being able to "take it."

This attempt to make use of paranoid-schizoid defenses (magical reparation, denial, and rewriting of history) for the purpose of warding off depressive anxiety (guilt and the fear of the loss of the object due to one's destructiveness) constitutes a manic defense. Loewald (1979) has described the way in which self-punishment can be similarly used to dissipate feelings that threaten to become an experience of guilt. In this case, one uses an omnipotent phantasy that the self-punishment eradicates the present and past existence of the crime and therefore there is no reason to feel guilty.

Similarly, in a paranoid-schizoid mode one does not miss a lost or absent object; one denies the loss, short-circuits the feeling of sadness, and replaces the object (person) with another person or with oneself. Since the new person or aspect of self is emotionally equivalent to the lost object, nothing has changed; there is no need to mourn what is still present (cf. Searles, 1982). For example, a patient explained that my vacation turned out to be a "blessing in disguise" since he had learned through it that he was not nearly so dependent on me as I had led

him to believe. In this case, an aspect of self was used to magically replace the absent object. In my work with this patient, each of my absences was regularly followed by an enactment of manic defenses of various forms, such as threatened disruptions of treatment (which he "no longer needed") or grudging agreement to continue analysis "if that's what you think is best."

Object relatedness in a paranoid-schizoid mode is predominantly in the form of projective identification (Grotstein, 1981; Klein, 1946; Ogden, 1979, 1982b). This psychological-interpersonal process reflects many of the other facets of the paranoid-schizoid mode discussed thus far. It is based on the omnipotent phantasy that an aspect of self (which is either endangered or endangering) can be placed in another person in such a way that "the recipient" is controlled from within (Klein, 1955). In this way, one safeguards an endangered aspect of self, and at the same time attempts to omnipotently control an object relationship by treating the object as an incompletely separate container for aspects of oneself. This facet of the process of projective identification involves an evacuative method of managing psychological strain.

In projective identification, the projector—by means of actual interpersonal interactions with the "recipient"—unconsciously induces feeling states in the recipient that are congruent with the "ejected" feelings. In addition to serving defensive purposes, this constitutes a fundamental form of communication and object relatedness. The recipient of the projective identification can sometimes retrospectively become aware that he is "playing a part . . . in somebody else's phantasy" (Bion, 1959a, p. 149). Projective identification is a "direct communication" (Winnicott, 1971c, p. 54) in that it is unmediated by interpreting subjects; instead, it is pre-

dominantly a communication between the unconscious of one person and that of another. For this reason, it is often experienced by the recipient as coercive. There is no choice: one not only finds oneself playing a role in someone else's internal drama, one feels unable to stop doing so. The recipient feels controlled from within. If he is able to contain the induced feelings without simply dumping them back into the projector, a shift in the relationship between the projector and the recipient can occur that leads to psychological growth. The "processing" of a projective identification by the recipient is not simply a matter of returning modified psychological contents to the projector. Rather, it is a matter of altering the intersubjective mode of containment generated by the interacting pair, thus generating a new way of experiencing the old psychological contents. It is not so much that psychological contents are modified; it is the intersubjective context of those contents that is modified.

This conception of psychological change is not limited to the understanding of projective identification. Rather, what we have arrived at in the course of this discussion is a basic principle of all psychological growth including that which occurs in the analytic process. Psychological growth occurs not simply as a result of the modification of unconscious psychological contents; in addition, what changes is the experiential context (the nature of the containment of the psychological contents). Unconscious phantasy is timeless and is never destroyed (Freud, 1911a). It is therefore misleading to talk about the eradication of an unconscious phantasy since that implies that the old phantasy is destroyed or replaced by a new one. It is not the unconscious phantasy that is destroyed or replaced; rather, the phantasy is experienced

differently due to a shift in the psychological matrix within which it exists.

The idea that it is not only content but context that shifts in psychological growth was elegantly articulated by a schizophrenic patient when asked if he still had his hallucinatory voices. He replied, "Oh yes, they're still there, they just don't talk anymore." Similarly, in the course of analysis, one does not destroy the thoughts and feelings constituting the Oedipus complex (Loewald, 1979); instead one experiences the component object-related feelings differently. A patient, Mr. K., said in small bits over the course of his fourth year of analysis, "I am still aware that when I am with women teachers I could become extremely anxious if I were to allow myself to experience them (as I used to) as mothers whom I am afraid of having sexual feelings and fantasies about. But I do have some choice in the matter now and I realize that there was some pleasure and excitement in imagining that I could be sufficiently special (more special than my father and brothers) to get my mother to stop being a mother and start being a wife to me." What had been achieved by this patient was not simply a change in the content of his unconscious phantasy. The Oedipus complex had not been "destroyed" or "overcome." Rather, the psychological context for the experiencing of his Oedipal wishes and fears had undergone change. Previously, the set of unconscious Oedipal desires and prohibitions had been characterized by powerful concreteness and immediacy. Mr. K. initially said that he had no idea why he had anxiety "attacks" when talking with women teachers. "It is something that just happens to me and there is no reason for it. I know there is no real danger. The anxiety just goes through me like electricity." As a result, the

patient had developed compulsive study habits in an effort to become a perfect student, and he became terribly anxious before exams even though he had prepared in a way that he recognized to be "overkill."

Oedipal feelings and phantasies are always generated in part in a depressive mode. The Oedipal dilemma would have no power or poignancy if it were not the problem of a subject (for example, the boy) who hates—and thus wishes to be forever rid of—the same father he loves. In other words, it is a dilemma rooted in subjectivity, whole object relations, ambivalence, and historicity. However, important facets of this unconscious conflict and its resultant symptomatology (anxiety attacks for example) are experienced largely in a paranoid-schizoid mode. For example, Mr. K. initially experienced his anxiety attacks not as a form of, or reaction to, his feelings and fearful thoughts, but as a force sweeping over him that frightened him. The patient's female teachers were unconsciously experienced as not simply like his mother, but *the same as* his mother; otherwise the full power of the incestuous danger would not have presented itself in such a concrete way. (Dream material in this phase of analysis included the frightening shifting back and forth of the identity of older women figures, which resulted in a feeling on the part of Mr. K. that he "didn't know who was who.") The patient was clearly not psychotic; but the transference to his female teachers was simultaneously experienced in both paranoid–schizoid and depressive modes with a tendency for the dialectical interplay between the two to "collapse" in the direction of the paranoid-schizoid mode during anxiety attacks (Ogden, 1985b). In his attacks of anxiety, there was very little of a subject mediating between the patient and the terrifying thing happening to him.

From this point of view, psychoanalysis is a method of treatment designed not only to help the patient modify unconscious phantasy content, but also, a process aimed at helping the patient to experience unconscious content differently. That is, psychoanalysis is a process directed at helping the patient shift the balance of the dialectical interplay between different modes of generating experience in relation to specific unconscious contents. What must happen in analysis is not a simple translation of psychological contents from one mode to another. The therapeutic process as I understand it involves the establishment, reestablishment, or expansion of a dialectical relationship between different modes of experience.

Before closing this section, I would like to briefly comment on the tendency among analytic thinkers, including Klein herself, to valorize the depressive mode and villainize the paranoid-schizoid mode. As Eigen (1985) has pointed out, the depressive mode is too often viewed as the full realization of the human potential. In the depressive mode, it is held that the individual develops the capacity for abstract symbolization, subjectivity and self-reflection, concern for others, guilt, and reparative wishes, all of which lead to cultural production. On the other hand, the paranoid-schizoid mode is understood as generating a psychological state in which the individual relies on splitting and projective identification for the purpose of evacuating feelings and denying reality. However, such a depiction of these modes is based on a diachronic conception of the relationship between the two, and fails to appreciate the fundamental dialectical nature of their relationship. The paranoid-schizoid mode and the depressive mode serve as essential negating and preserving contexts for one another. The depressive mode is one of integration, resolution, and containment,

and if unopposed, leads to certainty, stagnation, closure, arrogance, and deadness (Bion, 1962, 1963; Eigen, 1985). The paranoid-schizoid mode provides the necessary splitting of linkages and opening up of the closures of the depressive position, thus reestablishing the possibility of fresh linkages and fresh thoughts. The integrative thrust of the depressive mode in turn provides the necessary antithesis for the paranoid-schizoid mode in limiting the chaos generated by the fragmentation of thought, the discontinuity of experience, and the splitting of self and object.

The Autistic-Contiguous Mode of Generating Experience

The conceptions of the paranoid-schizoid and depressive modes discussed thus far represent ideas derived predominantly from the work of Klein and Bion. The conception of a dialectic of experience constituted exclusively by these two modes is incomplete, insofar as it fails to recognize an even more primitive presymbolic, sensory-dominated mode that I will refer to as the *autistic-contiguous mode.* The conception of an autistic-contiguous pole of the dialectic of experience represents an integration, interpretation, and extension of aspects of the work of Bick (1968, 1986); Meltzer (Meltzer 1975, 1986; Meltzer et al., 1975); and Tustin (1972, 1980, 1981, 1984, 1986). Each of these authors was strongly influenced by Bion's (1962, 1963) conception of the container and the contained, as well as by his theory of thinking. In this chapter, space allows for only a brief introduction to a discussion of this mode of experience. (In Chapter 3,

the concept of an autistic-contiguous position will be discussed in detail.)

The autistic-contiguous position is a primitive psychological organization operative from birth that generates the most elemental forms of human experience.[5] It is a sensory-dominated mode in which the most inchoate sense of self is built upon the rhythm of sensation (Tustin, 1984), particularly the sensations at the skin surface (Bick, 1968). The autistic-contiguous mode[6] of

[5]The autistic-contiguous position is conceptualized in this book not as a prepsychological (biological) phase of development in which the infant lives in a world cut off from dynamic relations with external objects; rather, it is conceived of as a psychological organization in which sensory modes of generating experience are organized into defensive processes in the face of perceived danger. Under circumstances of extreme, protracted anxiety, these defenses become hypertrophied and rigidified and come to constitute a pathologically autistic psychological structure. The development of a normal autistic-contiguous organization can occur only within the unfolding relationship with the mother as environment and the mother as object (cf. Winnicott, 1963a).

[6]I have termed the most primitive of the modes of experience *the autistic-contiguous mode* in order to roughly parallel the method of naming the paranoid-schizoid mode, which takes its name from both the form of psychological organization and the form of defense associated with it. In the autistic-contiguous mode, psychic organization is derived in large part from sensory contiguity, that is, connections are established through the experience of sensory surfaces "touching" one another. Breakdown of this organization leads to the implementation of autistic defenses that are described in this book.

It must be borne in mind throughout the book that the term *autistic* is being used to refer to specific features of a universal sensory-dominated mode of experience, and not to a form of severe childhood psychopathology. It would be as absurd to view infants or adults as being pathologically autistic while relying heavily on an

experiencing is a presymbolic, sensory mode and is therefore extremely difficult to capture in words. Rhythmicity and experiences of sensory contiguity contribute to the earliest psychological organization in this mode. Both rhythmicity and experiences of surface contiguity are fundamental to a person's earliest relations with objects: the nursing experience and the experience of being held, rocked, spoken to and sung to in his mother's arms. These experiences are "object-related" in a very specific and very limited sense of the word. The relationship to the object in this mode is certainly not a relationship between subjects, as in a depressive mode; nor is it a relationship between objects, as in a paranoid-schizoid mode. Rather, it is a relationship of shape to the feeling of enclosure, of beat to the feeling of rhythm, of hardness to the feeling of edgedness. Sequences, symmetries, periodicity, skin-to-skin "molding" are all examples of contiguities that are the ingredients out of which the beginnings of rudimentary self-experience arise. The experience of "self" at this point is simply that of a nonreflective state of sensory "going on being" (Winnicott, 1956, p. 303) derived from "body needs" which only "gradually become ego needs as a psychology gradually emerges out of the [mother–infant's] imaginative elaboration of physical experience" (p. 304).[7]

autistic-contiguous mode of generating experience, as it would be to think of them as being paranoid-schizophrenics while organizing experience in a paranoid-schizoid mode, or as being depressed while operating in a predominantly depressive mode.

[7]Stern (1985), from a psychoanalytic developmental-observational vantage point, states, "Infants [from birth] . . . take sensations, perceptions, actions, cognitions, internal states of motivation and states of (non-self-reflective) consciousness and experience them directly in terms of intensities, shapes, temporal patterns, vitality

Early experiences of sensory contiguity define a surface (the beginnings of what will become a sense of place) on which experience is created and organized. These sensory experiences with "objects" (which only an outside observer would be aware of as objects) are the media through which the earliest forms of organized and organizing experience are created.

Contiguity of surfaces (e.g., "molded" skin surfaces, harmonic sounds, rhythmic rocking or sucking, symmetrical shapes) generate the experience of a sensory surface rather than the feeling of two surfaces coming together either in mutually differentiating opposition or in merger. There is practically no sense of inside and outside or self and other; rather, what is important is the pattern, boundedness, shape, rhythm, texture, hardness, softness, warmth, coldness, and so on.

> A 29-year-old patient, Mrs. L., came to an analytic hour after having just spent time with her mother, and felt, for reasons that she "could not put her finger on," as if she were in a state of such severe anxiety and diffuse tension that the only way to end the state of tension would be to cut herself with a razor all over her body. It had taken great effort on her part to come to the session instead of cutting herself as she had done in the past. The patient cried uncontrollably during the hour. I interpreted as much of the situation as I thought I understood on the basis of what I knew about the patient's relationship to her mother and the connection between these feelings and the transference–coun-

affects, categorical affects, and hedonic tones" (p. 67). This earliest mode of experience operates throughout life "out of awareness as the experiential matrix" (p. 67) for all succeeding subjective states.

tertransference anxieties of the previous few sessions. Mrs. L. said that she felt as if she were "coming apart at the seams." I said that I thought she was feeling as if she were coming apart in the most literal way, and that she felt as if her skin were already lacerated in the way she had imagined lacerating herself.

It was late in the afternoon and getting cold in the office. I said, "It's cold in here," and got up to turn on the heater. She said, "It is," and seemed to calm down soon after that. She said that for reasons that she did not understand she had been extremely "touched" by my saying that it was cold and by turning the heater on: "It was such an ordinary thing to say and do." I believe that my putting the heater on acknowledged a shared experience of the growing coldness in the air and contributed to the creation of a sensory surface between us. I was using my own feelings and sensations in a largely unconscious "ordinary way" (perhaps like "an ordinary devoted mother" [Winnicott, 1949]) which felt to the patient as if I had physically touched her and held her together. The sensory surface mutually created in that way was the opposite of the experience of "coming apart at the seams"; it facilitated a mending of her psychological-sensory surface which felt as if it had been shredded in the course of the patient's interaction with her mother.

This sensory "holding" (Winnicott, 1960a) dimension of the analytic relationship and setting operated in conjunction with the binding power of symbolic interpretation (formulated on the basis of the intersubjectivity of the transference–countertransference).

Clearly, the experience just presented was not an example of "pure and undiluted" experience in an autistic-

contiguous mode. As is always the case, the autistic-contiguous mode "borrows from" (interpenetrates with) the paranoid-schizoid mode in the creation of phantasy representations for sensory-dominated experience, as well as borrowing upon features of a depressive mode including elements of subjectivity, historicity, and symbolization proper.

There is a crucial distinction between a purely physiological reflex arc and experience in an autistic-contiguous mode despite the fact that both can be described in nonsymbolic, bodily terms. Although the physiological reflex has a locus (from an outside observer's point of view), a locus is different from the beginnings of a sense of a place in which experience is occurring; the physiological reflex may to an observer have periodicity, but periodicity is different from the feeling of rhythm; the physiological reflex may have a temporal and spatial beginning and end, but that is not the same as a feeling of boundedness. The rudiments of the sensory experience of self in an autistic-contiguous mode have nothing to do with the representation of one's affective states, either idiographically or fully symbolically. The sensory experience *is* the infant in this mode, and the abrupt disruption of shape, symmetry, rhythm, skin moldedness, and so on, marks the end of the infant.

Tustin (1984) attempted to communicate the nature of experience at the infant's skin surface by asking us to try to experience the chair we are sitting on not as an object, but simply as a sensory impression on our skin: "Forget your chair. Instead, feel your seat pressing against the seat of the chair. It will make a 'shape.' If you wriggle, the shape will change. Those 'shapes' will be entirely personal to you" (pp. 281–282). In the autistic-contiguous mode, there is neither a chair nor one's

buttocks, simply a sensory "impression" in the most literal sense of the word. Tustin describes two sorts of sensory impressions constituting normal early experience: soft impressions which she terms *autistic shapes* (1984) and hard angular impressions which she terms *autistic objects* (1980). The difference between these experiences of sensory surface constitutes forms of definition of experiental content within this mode. Experience of an autistic shape is the feeling of softness that much later we associate with ideas like security, safety, relaxation, warmth, and affection. The words that seem to me to be closest to the sensory level of the experience are the words *soothing* and *comforting*. It is not a matter of mother comforting me—it is simply a soothing sensory experience.

A relationship to an autistic shape is different from a relationship to a transitional object (Winnicott, 1951) in that the "otherness" of the autistic shape is of almost no significance. In transitional phenomena, the experience centers on the paradox that the object is at the same time created and discovered by the subject, and that therefore the object always has one foot in the world outside of the individual's omnipotence. This is clearly not the case in relationships to autistic shapes and objects.

> Mr. R. began analysis and found to his great distress that he literally could not think of anything to say. He felt utterly blank and empty. He had looked forward to the beginning of analysis but found the analytic experience terrifying. He had expected to be able to talk without difficulty. Mr. R. unconsciously managed to create a sensory base for himself by filling what he later called the "holes" both in himself (his inability to think or talk), and in the analytic relationship (which he experienced as nonexistent), by focusing intently on a rectangular shape that he discerned in the pattern of lines and texture on the ceiling above the couch. These "holes" were subsequently understood in part as derivatives of the patient's early experience of the "holes" in the early mother–infant relationship associated with his mother's profound postpartum depression for which she was briefly hospitalized. She told him during the course of the analysis that she had held him as a baby only when "absolutely necessary." He had been allowed to cry in his crib for hours on end while his mother hid in her room.

In contrast, the experience of an autistic object is the feeling of a hard, angular impression upon the skin that is experienced as if it were a hard shell-like quality of the skin. It is associated with the most diffuse sense of danger, and with what may be represented in a paranoid-schizoid mode by phantasies of a hard shell formed by the skin surface to be used as a protective armor.

> Mrs. M., a 35-year old attorney, developed—during an acute regressive phase of treatment—an extreme muscular rigidity that led to cramping of her muscles, particularly in the neck. She would frequently massage her cramped muscles during the sessions. These symptoms clearly had features resembling a catatonic state wherein defense against unconscious anger is usually central. However, the current transference–countertransference experience in this case did not center around the patient's fears of her destructiveness in relation to herself or to me. Rather, the material just prior to the acute regression had been organized around feelings of utter vulnerability represented in dreams by images of being a pincushion. This was

understood as a derivative of Mrs. M.'s feeling, which we had previously discussed, of being powerless to resist being taken over by her mother's (and my) projections of ourselves into her. As a result, over time I interpreted the acute regression in Mrs. M.'s analysis as an effort by her to create a hardness in her body that would serve as a way of resisting my attempts to get inside of her in order—as she perceived it—to control her and turn her into what I needed her to be for me. Mrs. M.'s massaging of her muscles was viewed both as a way of creating a sensory surface on which to locate herself, and as a way of reassuring herself that the surface was a hard protective one. (During this same regressed phase of analysis, the patient presented no phantasies or dreams of being invaded or of having a shell; experience was predominantly in a sensory mode.) The tension diminished as the sensory experience was reconnected with words by means of verbal interpretation.

I conduct all phases of analysis and psychoanalytic therapy (despite major shifts in the dialectical balance of the three modes of experience) on the basis of the principle that there is always a facet of the personality, no matter how hidden or disguised, operating in a depressive mode and therefore capable of utilizing verbally symbolized interpretations (Bion, 1957; Boyer and Giovacchini, 1967). Often the succession of the patient's associations, in conjunction with affective shifts in a given meeting or series of meetings, serve as evidence that the patient has heard and made use of the analyst's interpretation. Sometimes one must wait for years before the patient gives direct evidence (e.g., by reminding the analyst of an interpretation made at a time when the patient seemed

incapable of operating in a depressive mode) that he or she has utilized the interpretation.[8]

The breakdown of the continuity of sensory-dominated experience being described results in the anxiety that Bick (1968) and Meltzer (Meltzer et al., 1975), on the basis of their work with pathologically autistic children as well as with healthier children and adults, describe as the experience of one's skin becoming a sieve through which one's insides leak out and fall into endless, shapeless space devoid of surface or definition of any sort (see also Rosenfeld, 1984). Bion (1959b) refers to experience stripped of containment and meaning as "nameless dread." (Perhaps the term *formless dread* might better reflect the nature of anxiety in the autistic-contiguous mode since the experience of shapes, rhythms, and patterns are the only "names" that exist in this mode.)

Mrs. N., a 52-year-old woman with an extremely unstable sense of continuity of being, spent long periods of time in every therapy hour silently attempting to picture phone numbers, birth dates, street numbers, and so on of all of the people that she had known since childhood. In the middle of one of these extended ruminative silences, the phone in my office rang and was promptly answered by my answering machine. Mrs. N. was clearly shaken by this and left the office. This was the first time during the course of

[8]I believe that while there is always an aspect of the patient functioning in a depressive mode (a "non-psychotic part of the personality" [Bion, 1957]), there are always at the same time other aspects of experience that are defensively foreclosed from the realm of the psychological, for example, by means of the creation of psychosomatic illness (McDougall, 1974), alexithymia (Nemiah, 1977), and forms of "non-experience" (Ogden, 1980).

her treatment that she had done so. She returned in about five minutes. Much later in the therapy, Mrs. N. told me, with a mixture of shame and relief, that she had left the room on that occasion to go to the bathroom because of her feeling that she had soiled herself with feces or urine. This experience was not represented at the time in the form of thoughts and was primarily a physical sensation. Only in retrospect could the patient describe it as a feeling of having been "cut into" by the unexpected disruption of her ruminative thoughts. Mrs. N. had a long history, beginning in early childhood, of violent disruptions of her self-experience. For example, the patient reported that her mother would tie her arms and legs to her bedposts at night, when she was 6 years old, in order to prevent her from masturbating.

The terror ensuing from such disruption of the continuity of sensory experience calls into play forms of defense specific to this mode of experience. Bick (1968, 1986) describes a type of defense that she refers to as "second skin formation." This is a self-protective effort at resurrecting a feeling of the continuity and integrity of one's surface.[9] An example of pathological second skin

[9]Meltzer (Meltzer et al., 1975), building upon the work of Bick (1968), introduced the term *adhesive identification* to describe a form of identification more primitive than either introjective or projective identification. In an autistic-contiguous mode (which Meltzer refers to as the "world of two-dimensionality" [p. 225]), one utilizes adhesive identification in an attempt to create or defensively reconstitute a rudimentary sense of the cohesiveness of one's surface. The surface of the other is utilized as a substitute for an incompletely developed or deteriorating sense of one's own surface. Examples of the means by which the surface of the object is defensively "adhered to" in adhesive identification include imitation, mimicry, and clinging forms of sensory connectedness to an object that "can hold [one's] attention and thereby be experienced, momentarily at least, as holding the parts of the [sensory-dominated] personality together" (Bick, 1968, p. 49).

Tustin (1986) prefers the term *adhesive equation* to the term *adhesive identification* since, in this defensive process, the individual's body is equated with the object in the most concrete, sensory way.

formation is the development of infantile eczema that Spitz (1965) understood as a psychosomatic disorder resulting from insufficiency or inadequacy of parental holding in the first weeks and months of life. The continual scratching (often leading to the necessity of wrapping the infant's hands in gauze to prevent severe skin damage and infection) is understood from this perspective as the infant's desperate attempt to restore (through heightened skin sensation) a surface by means of which the terror of leakage and of falling into shapeless space is allayed.

Wrapping a hospitalized patient snugly in sheets (while he is continually accompanied and related to by an empathic staff member) is an effective and humane way of treating someone who is experiencing the terror of impending annihilation in the form of the dispersal of the self into unbounded space. This form of intervention represents an attempt to almost literally supply the patient with a second skin by means of the provision of a firm, palpable, containing sensory and interpersonal surface.

Common forms of second skin formation encountered clinically with adult patients in psychotherapy and analysis include unremitting eye contact that begins in the waiting room and is only painfully terminated by the

closing of the consulting room door at the end of the hour; constant chatter on the part of the patient filling every moment of the session leaving hardly a moment of silence; continual holding of one object or another that is either brought to the session or picked up from the analyst's office (e.g., a tissue); perpetual humming or repeating of sentences or phrases, particularly when a silence might otherwise ensue.

Tustin (1980, 1981, 1984, 1986) has explored the defensive use of autistic objects and shapes in the face of threatened disruption of the sensory continuity of self. Autistic shapes and objects offer a form of self-soothing that is "perfect" in a way that no human being can possibly be. The self-soothing activity, whether it be hair twirling, stroking the lobe of the ear, thumb sucking, sucking on the inner surface of the check, rocking, tapping one's foot, humming, imagining symmetrical geometric designs or series of numbers, is absolutely and reliably present. Such activities always have precisely the same sensory qualities and rhythms; they never evidence shifts in mood, and are never a fraction of a second late when they are needed. No human being can provide such machinelike reliability. The individual has absolute control over the autistic activity; however, at the same time, the autistic activity can tyrannize the individual (Tustin, 1984). The tyrannical power of the activity derives from the fact that an individual relying on an autistic mode of defense is absolutely dependent on the ability of the perfect recreation of the sensory[10] experience to protect him against unbearable terror ("formless dread"). I have been impressed by the way in which both aspects of this tyranny—the individual's control of the autistic activity, and the activity's control over him—play important roles even in the psychoanalysis of adult patients who have achieved the capacity for stably generating experience in a predominantly depressive mode.

> A 42-year-old patient, Dr. E., a psychotherapist, became enraged if I was a minute late in beginning his analytic hour. (He wore a digital watch.) Dr. E. said that he knew I understood the importance of "the frame," and that if I violated it in this egregious way, I must not care about him or the analysis in the least. The "frame" was not just an idea for this patient, but a palpable feeling as tangible, hard, and enclosing as the metal frame around a picture. This man had indeed become addicted to the analytic frame as an autistic object. Dr. E. made it clear that he needed not simply reliability in our "relationship," but absolute certainty. As a result, he attempted to control everything including my thoughts and feelings. He would continually tell me what I was thinking and feeling; in that way he could attempt to ensure that he would never be surprised or disappointed by me. Interpretations of mine that incorporated an idea or perspective that Dr. E. had not yet thought of were extremely distressing to him because they reflected the fact that I had thoughts that he had not created and therefore did not control in an absolute way. This set of feelings and this form of

[10] Boyer's (1986) version of the "fundamental rule" incorporates a full appreciation of the sensory dimension of the analytic experience. He at times directly and at times indirectly (e.g., through the questions he poses) asks his patients to attempt to notice and put into words the thoughts, feelings, and *physical sensations* that they experience in the sessions. He also asks the same of himself in his efforts to utilize his countertransference experience (Boyer, 1983, 1987).

relatedness are usually understood in terms of anal-erotic obsession, omnipotence, and projective identification. These are no doubt accurate descriptions of this symptomatology and form of relatedness, but they need to be supplemented by an understanding of the way in which the experience also involves tyrannizing relatedness to an autistic object.

The topic of countertransference responses to analytic experience in an autistic-contiguous mode can only briefly be touched upon here. The analyst's feelings often include feelings of being tyrannized by an automaton (as in the case of Dr. E.), feelings of inadequacy for having no compassion with the patient or for being unable to make any connection whatever with him or her, and intense feelings of protectiveness for the patient. This relatively familiar range of feelings is not unlike the group of responses one has to patients operating in predominantly paranoid-schizoid and depressive modes. More specific to the autistic-contiguous mode of experience is countertransference experience in which bodily sensations dominate. Somatic experiences like twitching of one's hand and arm, stomach pain, feelings of bloatedness and so on are not uncommon. Very frequently the countertransference experience is associated with skin sensations such as feelings of warmth and coldness (see earlier discussion of Mrs. L. in this chapter) as well as tingling, numbness, and an exaggerated sensitivity to skin impressions like the tightness of one's tie or one's shoes. At times, the space between the patient and myself has felt as if it were filled with a warm soothing substance. Frequently, this is associated with a drowsy countertransference state that has nothing to do with boredom. It is a rather pleasant feeling of being sus-

pended between sleep and wakefulness. (Perhaps this is the sensory dimension of Bion's [1962] idea of "reverie," a concept referring to the analyst's state of receptivity to the patient's unconscious experience and the mother's receptivity to her infant's symbolic and asymbolic [or presymbolic] experience.)

From the perspective developed in this chapter, the autistic-contiguous mode, under normal circumstances, can be seen to provide the bounded sensory "floor" (Grotstein, 1987) of experience. It offers sensory enclosure that exists in dialectical tension with the fragmenting potential of the paranoid-schizoid mode. The danger of psychosis posed by the fragmenting and evacuative processes of the paranoid-schizoid mode are contained in two ways: (1) "From above" by the binding capacity of symbolic linkages, historicity, and subjectivity of the depressive mode; and (2) "from below" by the sensory continuity, rhythmicity, and boundedness of the autistic-contiguous mode.

Summary

In this chapter, human experience is conceived of as the outcome of a dialectical relationship between three modes of experience. The autistic-contiguous mode provides a good measure of the sensory continuity and integrity of experience (the sensory "floor"); the paranoid-schizoid mode is a principal source of the immediacy of concretely symbolized experience; and the depressive mode is a principal medium through which historical subjectivity and the richness of symbolically mediated human experience is generated. Experience is always generated be-

tween the poles represented by the ideal of the pure form of each of these modes.

These modes of generating experience are analogous to empty sets each filled in their relationship with the others. Psychopathology can be thought of as forms of collapse of the richness of experience generated between these poles. Collapse may be in the direction of the autistic-contiguous pole, the paranoid-schizoid pole, or the depressive pole. Collapse toward the autistic-contiguous pole generates imprisonment in the machine-like tyranny of attempted sensory-based escape from the terror of formless dread, by means of reliance on rigid autistic defenses. Collapse into the paranoid-schizoid pole is characterized by imprisonment in a nonsubjective world of thoughts and feelings experienced in terms of frightening and protective things that simply happen, and that cannot be thought about or interpreted. Collapse in the direction of the depressive pole involves a form of isolation of oneself from one's bodily sensations, and from the immediacy of one's lived experience, leaving one devoid of spontaneity and aliveness.

3

The Autistic-Contiguous Position

The exchange of ideas constituting the British psychoanalytic discourse of the 1930s to the early 1970s revolved in large part around the work of Klein, Winnicott, Fairbairn, and Bion. Each of these analysts provided the context for—as well as a counterpoint to—the ideas generated by the others. The history of the development of British object relations theory in the last twenty years can be viewed as containing the beginnings of an exploration of an area of experience lying outside of the experiential states addressed by Klein's (1958) concepts of the paranoid-schizoid and depressive positions; by Fairbairn's (1944) conception of the internal object world; by Bion's (1962) conception of projective identification as a primitive form of defense, communication, and containment; or by Winnicott's (1971a) conception of the evolution of the mother–infant relationship and the elaboration of transitional phenomena.

The clinical and theoretical work of Esther Bick (1968, 1986), Donald Meltzer (Meltzer, 1975; Meltzer et