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Receiving the invitation to open up

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In this contribution, theoretical insights from object relations theory that underlie my therapeutic approach will be introduced. These can be seen to fit in well with an experiential dynamic therapy approach. In particular, I will discuss and illustrate the development of an interpersonal transitional space (cf. Winnicott, 1971) in which corrective emotional experiences can take place, that is, the therapist becoming an object to the patient thereby offering the patient a relationship working model that was missing or lost in childhood. In particular, the therapy can offer a new interpersonal space, from which the patient can develop a new or an enhanced Ego position. That is to say, the deep affects cannot be conceived just to “exist” somewhere inside the patient, if the subject who is to experience them has not yet arrived, or has sought shelter elsewhere.¹

Object relations and relatedness

The core of object relations theory, as I understand it, entails quite a revolutionary shift, or inversion, of emphasis from the primacy of the individual to the primacy of the relation. If we take relatedness as primary, and prior to individuality, then this inversion has some implications for the idea of a subject, for then relatedness is conceived to be the substrate of individual subjectivity, rather than the subject being conceived as the primordial carrier of relationships. The latter view is the more traditional way of conceiving, but it may be useful not to stick to it in all circumstances.

One reason to consider the primacy of relations, at least in some situations, has to do with the simple fact that subjectivity, the quality of a person to make up his own mind and to have access to his own experiences, desires, and thoughts, is a capacity that has to be developed while growing up. Though the raw experiences may be present, the person will have to learn how to deal with them, to recognise and process them. Individual subjectivity, therefore, can be understood as the outcome, rather than as the point of departure, of relations with other persons, especially parents. Psychodynamic therapies, those of the experiential dynamic therapies (EDT) family included, are usually assuming a suffering subject inside the patient. This, of course, is not flatly wrong, but it may also be helpful for the psychotherapeutic practice to do the inversion of concepts as described in object relations theory.

In particular, when very early traumas are being dealt with in a therapy, it is not so evident that the infant did have the subjectivity to experience the variety of affects that an adult person would have available. Generally, parents contain their infant’s deep affect in an act of protection (usually without too much reflection) before the infant becomes capable of tolerating a particular frustration and of “digesting” the facts that

¹ The “subject” is the epistemic carrier of the affects, where the “individual” is the physical person.

gave rise to it (cf. Bion, e.g., 1962). This protecting containment is missing when aggression, also mental abuse, comes from the parents themselves. It is here that trauma can be inflicted easily, as the infant does not have the capacities, cognitive and bodily, to act as a subject and to contain its own affects and digest them, let alone to defend itself adequately.

Although it is clearly important to offer patients a relationship wherein these therapeutic ingredients can be delivered, accepted, and made use of, a therapy that departs from individual subjectivity might overlook the aforementioned infantile incapacity.

Bowlby's (e.g., 1969) work extensively demonstrated the importance of attachment bonds between parents and infants. He focused not so much on the child's functional needs, on a set of metapsychological assumptions about unconscious destructive and other phantasies in the child, as did Klein (e.g., 1975), but rather on the empirical observation of attachment patterns. This was a basic issue in infant psychology and attachment theory: should parent-infant interactions be understood in terms of the existing social context or in terms of the child's functional needs? Neborsky (2010, p. 121) makes an interesting point in suggesting that Davanloo (1990) made a kind of "re-union" between Klein's and Bowlby's divergent stances, in that he considered guilt and Superego problems in a person to stem from a *continuum* between both positions, that is, between the relationships and the functional needs of the infant.

This is of major interest to the practice of Davanloo's original technique and of those therapeutic techniques derived from or inspired by it, such as the EDT family. For it entails that within the therapeutic interaction a pattern of transference resistances or other transferential behaviours and affects can occur, in which not only early relational issues between infant and parent are being re-enacted, but in which the therapist also has a major opportunity to encounter and counter these issues. This is to say that a major part of the therapeutic process takes place on the continuum between metapsychological constructs, such as unconscious phantasies, and real interactions, and that, through the latter, the psychotherapist can address the former and deal with them. Thus, deep affects can not only be observed within the actual therapeutic interaction, but through these observations they can also be encountered within the originating phantasies that gave rise to them or that were meant to handle them. Especially when this handling is immature the patient cannot "digest" the facts experienced, and as a result relies on very early defence mechanisms, such as projective identification and splitting. It is here that the subjectivity of the patient cannot be assumed to exist as a container of the various deep affects. Rather, this subjectivity is to be understood in terms of relatedness towards others, both in the past (parents) and in the present (therapist). It is here that, as ten Have-de Labije (2010, p. 247) puts it, a conscious or unconscious working alliance with the patient is often mistakenly assumed by the therapist to have been established, where in fact the patient is so much dominated by destructive Superego forces, to the extent of not being able to act from the position of an adaptive Ego and accordingly to accept the working alliance.

Anger and indignation towards maltreating parents cannot be supposed to exist in a child, if the parents are defining (and confining) the child's identity and if the child does not have the opportunity to escape easily to other persons who do offer the

containment and the opportunity for the child to develop its own subjectivity into an adaptive and adequately functioning Ego. Accordingly, I am suggesting that object relations theory offers some valuable insights which can be integrated into our EDT concepts, without devaluing any of the available techniques. The present contribution aims to illustrate some aspects of this, in that it presents some episodes of an approach to early trauma in a woman who did not manage to contain or digest the concomitant affects.

A note on video recording therapy sessions

At EDT Maastricht, we record therapy sessions, as mpg files, onto a memory stick that the patient can take home with them immediately after the session. If the patient gives their permission, the therapist will make a copy of the file. At home, the patient can review the session recording, enabling them to retain a better memory of the session, so that the next session can profit from that. Furthermore, study of the session recording offers new opportunities for the patient to understand what has been said in the session, as well as for recognising their own (non-verbal) behaviours and emotional expressions. Finally, watching the video often activates the patient's regular Superego responses, and thus helps us *within the session* to unravel Ego and Superego positions; the Superego and its criticisms can often be situated at the "other" side of the camera - the unfriendly spectator that is going to watch and judge the patient. The patient's anticipatory fears concerning these judgements can be explored, which also helps to make the Superego's disapprovals less ego-syntonic. It is then particularly useful to join the patient in finding a stance towards this anticipated "evil eye".

Case study

The patient, a woman in her fifties, had been suffering from long-term depressions and compulsive disorders. In particular, she had a particularly strong disapproval of herself, which can be understood as a hostile introject, stemming from her parents' long-term disapproving attitude towards her. As a child, she had felt utterly unwelcome with her parents, with no escape from their harsh and derogatory regime. She can remember often having been sent to her room and left to her own fantasies. As a result, she found ways to attain her parents' approval, and identified with their opinions about her. It is with the same harshness that she imposed upon herself a variety of demands, most of them in the domain of behaviours considered by her to be "decent" and "appropriate". Depressed mood, sadness, stress, and other unpleasant feelings were deemed undesirable behaviours and were criticised relentlessly, leading to vicious cycles in which her subsequent fears of disapproval were sufficient to heighten stress, lower her moods, etc. During the preceding fifteen years, several therapies had failed to bring much relief, or had even contributed to her conviction that, due to their failures, she was not a "good patient".

After the ninth session the patient gave permission to video record her subsequent sessions. The transcript presented below includes the major part of the eleventh session. The patient had mentioned her fear of watching the video recording of the previous session. She suggested that she might first practise and watch some old holiday videos, in order to get accustomed to how she looks on video. She mentioned that she was usually not bothered when other people had critical opinions of her, but

rather, was afraid of her own self-criticism. We join the session at 6 minutes 58 seconds, and the therapist is enquiring about the patient's self-criticism:

Session 11

0:06:58

Th: So it happens especially when you are doing it [the criticism] yourself?

(HP)

Pt: (Nods)

Th: And what is it, when you are doing that; how does it get into you? What is so offending, so grim?

Pt: Well, then I get stuck internally.

Th: Yes, is that what happens?

Pt: Yes, I get stuck. I withdraw entirely into myself (moves her head between her shoulders).

Th: And you move with your shoulders. Do you withdraw like that? (MI)

Pt: Yes.

Th: As if you are being beaten up ...

Pt: Yes.

The therapist tries to focus upon the underlying feelings of helplessness and despair. The idea is that, before any anger can be felt by this patient towards her parents and other caregivers, this despair is the only affect that she is capable of experiencing as owned by herself and situated in herself as an individual, separate from the parents. This despair is the outcome of the various kinds of violence and punishment suffered by the patient, augmented by her own self-disqualifying and self-annulling gestures and acts. As soon as the latter (coded DA in the transcript) can be made recognisable to her, a more authentic Ego position can be helped to come into existence and express itself.

Th: ... and no way for you to defend yourself any more at such a moment?

(XA)

Pt: No.

Th: You cannot avoid the beating.

Pt: Yes ... I cannot disconnect from that.

Th: What would be a way for you to defend, when being beaten up? Is there something you might need, a thing you could use?

Pt: I don't know ...

Th: You're defenceless. (MI)

Pt: Yes ... yes ... it happens to me in many respects, this kind of cramp.

Here the therapist makes an implicit connection to the childhood experiences:

Th: Yes, defenceless, huh, without anything to defend you with. There is no

tablecloth that you could get, no protecting blanket, no protecting wooden shield, nothing to find shelter, nothing.

Pt: No.

Again the therapist addresses the despair:

Th: Nothing, there's nothing you can crawl under? So unprotected? (XA)

Pt: Yes.

Th: Like a child that is being beaten up, without a chance to withdraw, that's how I imagine this.

Pt: Hm hm.

Th: You are watching yourself on the video recording, and you punish yourself, you cower, with no options to reciprocate. (SE)

Pt: Hm hm (nods).

Th: I would wish you to learn to reciprocate. It is very hard, you didn't learn it ... And it is there that you could learn to do more than you do now. You do not have it readily available, you should discover how to do it. (RE; DA; SO)

Pt: Hm hm.

Th: At least you might say something in return: keep your hands off me, don't mess with me, look at someone else, get lost, I don't need your judgement, I don't need your criticisms, I don't want your shit, I can do without you ... I'm just trying something ... (SO)

Pt: Well, yes, I do try even those things at times ... or rather, quite often, but they don't work.

Th: So you do try them.

Pt: Yes, I try.

Th: OK, so they don't work, but at least you do try them. That's very important. These things are not sufficient ...

Pt: No.

Th: ... but you do perform them. (SO)

Pt: Yes.

Th: What kind of things are they? What is it you are doing then? (HP)

Pt: Well, inside, I try ... to get out of something ... telling myself, "What are you involved in?" or "So what!"

Th: "So what"? How do you mean?

Pt: Something inside myself...

Th: How do you mean?

Pt: When something happens to me, "So what?"

Th: That's what you're telling yourself, "So what? What does it matter?" (DA)

Pt: Yes! But it doesn't work!

Th: Aha, so you're saying "What does it matter", but in fact things do matter very badly ... (MI)

Pt: Yes.

Th: ... and you start reproaching yourself. (SE)

Pt: Yes.

Th: But fortunately there's at least something you are doing; you're not entirely quiet. (SO)

Pt: No, I'm not fully passive, I don't think so. No, I'm sure of it.

The therapist continues to reinforce the adaptive Ego functions rather than focusing on their self-punishing effects (SO):

Th: So there is a real kind of resistance, even though it is not good enough.

Pt: Yes, and that resistance just should stop! I oppress it! (patient demonstrates, with fists, her own self-oppression).

The therapist takes the patient's anger about her self-oppression as a signal that the self-oppression has become more ego-dystonic, and continues to support and reinforce the patient's adaptive expressions (SO):

Th: Yes, that's what it looks like.

Pt: I always oppress it, put it away.

Th: Yes.

Pt: And that's why I trivialise them I can often hear myself say, "Let it go, it's not that bad, it's not that bad!" But I've been telling this myself for all my life! (yelling) "It's not that bad! It's not that bad!"

Th: But about what are we talking? What is not that bad? (DA)

Pt: Eh, eh ... I don't know ... anything.

Notice that what is being called "resistance" here is considered by the therapist as a very authentic, though failing, attempt by the patient to protect herself.

Th: You're saying, "I trivialise the resistance, telling myself, 'It isn't that bad'". You are resisting something, and then ...

Pt: And then I nevertheless put it off ...

Th: So you're telling me that you oppress the resistance?

Pt: Yes ... and then I put it off ... and ... eh ...

Th: Then what are you opposing?

Pt: First I start with resisting, and then I tell myself, "Oh, leave it, oh, it isn't that bad, it doesn't matter."

Th: "Don't resist," that's what you're telling yourself. (DA)

Pt: Yes, actually I'm saying, "Don't resist."

Th: And "It doesn't matter" is about what? Being beaten? (DA)

Pt: Anything! Nothing matters any more!

Th: OK, so you just have to give up your resistance.

Pt: Yes! I just used to give it up!

Th: So the resistance is being attacked from behind, so to say, and then you drop it ...

Pt: Yes, then I drop it.

Th: OK, so this is a very healthy resistance, but you do not keep it up. (SO; XA)

Pt: Indeed. And whenever it is there, it is there only for a moment!

Th: So it is already there. (XA)

Pt: Yes, but it does not go on.

The therapist perceives the patient as attempting to continue her anger towards herself for failing to maintain her resistance, and continues to support the adaptive Ego (SO):

Th: It does not go on, and it is not sufficient, not strong enough, not convincing enough.

Pt: Indeed.

Th: But it does exist, in fact, fortunately! (XA; SO)

Pt: Yes, but I cannot display it ...

Th: ... utilise it.

Pt: ... go on with it, give it more expression ... pfew!

Th: Yes ... you cannot really unfold it. (MI)

Pt: No.

Th: Elaborate it, so that it can serve you. (MI)

Pt: Yes.

Th: And then again you are left behind, defenceless against all criticisms.

Pt: Yes, and then I get angry again, at myself, and so it goes and goes ...

Th: Angry for having done what?

Pt: ... then I get angry again, thinking things like, "Why didn't I resist, why didn't I do this or that?"

Th: So then you also get angry at yourself for not opposing? (HP)

Pt: Yes.

The therapist introduces the notion of a choice for her to defend or not defend herself. The anger at herself is restructured as intended by her for the activation of her own self-defence.

Th: Aha, so then in fact you have let yourself down, which you can become angry about, and so you can go on ... (DA)

Pt: Yes, it goes on and on, I always keep going on in this circle.

Th: So ... quickly ... your anger is always your first response to yourself. (HP)

Here the patient has accepted and acquired the idea of self-defence as a desirable option. Hence, anger towards others can now become a topic of exploration, whereas it used to be only possible as a punishing anger towards herself, introjected from the parents. First this latter anger is kept in focus, and only after the independent Ego position has become more solid, can the former be explored more fully.

Pt: Yes, and that's so strange ... when I'm angry and want to express it ... I just put it aside ...

Th: Hm.

Pt: ... and then nothing has happened.

Th: Yes, you're good at that, huh, putting it aside ... and then afterwards you get angry again for having done that. (DA)

Pt: Yes.

Th: So it is one boiling mass. (MI)

Pt: Yes.

Th: And what is missing is good protection, protection against your anger, protection against all nasty criticisms, of yourself against yourself, like criticisms that you do not hold your teacup as you should, or that you do not protect yourself well enough, or that you give up your resistance, or that there's something else that you're doing not well enough ... Each time there's a new attack. (SE)

Pt: Hm hm.

Th: And you don't protect yourself well enough against all those attacks, huh? And from there new anger comes ... And so you keep reproaching yourself for not defending yourself well enough against the reproaches ...

Pt: Yes.

Th: And so the circle is closed. Right?

Pt: Yes, right. Yes.

00:17:25

Th: And what you need is a much better protection against all this anger. (DA)

Pt: (Nods)

Th: For it is not a pleasure to always be immersed in all that anger. (XA)

Pt: (Silent and non-responsive)

This may be correct, but nevertheless it may have been hard for the patient to deal with at this moment. The therapist therefore tries to re-establish contact with her, after he notices her withdrawal:

Th: I feel I have spoken too much and that I lost contact with you. (RE)

Pt: No, it's correct.

Th: And where are you ... (RE)

Pt: I'm here.

Th: ... and what are you feeling right now? (XA)

Pt: Restlessness! (sighs).

Th: Please describe it to me.

Pt: Restlessness, emptiness ...

The therapist does not believe this:

Th: Emptiness?

Pt: Also sadness, I presume ... a feeling of myself as ... as just nothing.

Th: Aha, this is what you also said last time; I am just nothing at all!

Pt: Yes, and I'm feeling it again.

Th: And "nothing" is another word for "hopeless". (XA)

Pt: Hopeless, yes, you took the right word ... hopeless.

Th: So very sad indeed.

Pt: Yes (angry voice), nasty, that's how I just feel, dismal, nasty.

The patient takes a position that is ambiguous, between active and passive. The therapist emphasises the suffering and passive position (**MI, DA**):

Th: So very much unprotected.

Pt: Y-yes.

Th: I think that is what it amounts to, that you are very vulnerable, and very much hurt ...

Pt: Yes.

Th: ... without being capable to do something against it, without having been able to withstand it ...

Pt: Yes (whispering).

Again the therapist emphasises the passive experiences, hoping to trigger a more active Ego position:

Th: And nobody notices the sadness, because you are hiding yourself completely. (MI)

Pt: Yes, correct (whispering).

Th: Can you feel this hopelessness?

Pt: Yes (whispering) ... yes (sighing).

The therapist does not want the patient to withdraw:

Th: Yes. Please describe it to me. (RE)

Pt: The shame also.

Th: Also that ...

Pt: It flashed through my mind (swings her left hand horizontally, from left to right, along her face, as if to apologise and to illustrate the strength of the impulse).

00:21:04

Th: Yes.

Pt: You looked at me ...

Th: I look at you?

Pt: Yes, and then ... (repeats the hand movement several times) ... I just feel ashamed.

Th: You also feel ashamed ... because I am looking at you. (RE)

Pt: Yes.

Th: Because of everything that is being shown to my eyes.

Pt: Yes.

Th: And what are those things that are being shown? What is it that makes you feel ashamed so much?

Pt: Well, perhaps it is because I am vulnerable.

Th: Yes, might be ... yes, that is what is shown to my eyes, that you are vulnerable ...

Pt: (Nods)

Th: ... and in fact this should not become visible to me.

Pt: (Nods) Indeed.

The therapist probes for projections (DA):

Th: And then you feel my mockery, my contempt?

Pt: It does flash through my mind, yes.

Th: Does it? And do you also notice it on me, do you see it on me? (RE)

Pt: No, I don't think so.

Th: But that's what you think.

Pt: But your gaze is so penetrating.

Th: Do you notice any mockery or contempt in my attitude or manners?

Pt: No, but just this penetrating thing already makes me nervous.

Th: Makes you already afraid that I may feel this, feel the contempt, so that you will feel compelled to be ashamed for me looking at you ...

Pt: Yes.

Th: ... for then I can see something that I am not entitled to see, huh? That cannot be good, or so ...

Pt: Well, another flash goes ... "stupid", "stupidness".

Th: That I find you stupid? (DA)

Pt: Yes.

Th: Aha. ... Is that also what you can see on me, that I find you stupid? Or just a thought? (RE)

Pt: It just flashed through my mind.

Th: Aha. It must be very unrealistic to you that I come to see so much of you, whereas actually I do not behave in the way that you're so afraid of. You're afraid that I feel contempt, that I find you stupid, ridiculous ... that you will have to be ashamed towards me. All this flashes through your mind, but actually in my behaviour there is not so much that would indicate any such thought in me. (RE)

Pt: Yes, but it is because of that penetrating way of looking at me ...

Th: Yes, but this very look of me is not yet the same as any opinion of mine that you are stupid, or is it?

Pt: No, it isn't.

Th: I look at you, yes, I have been looking at you, yes, indeed, that's what I have been doing, that's right, but it is a way for me to stay concentrated.

Pt: Yes, I know, but I can't help it, but actually I then feel like hiding there in the corner of the room.

The therapist senses that the patient is feeling guilty, following the therapist's explanation for his penetrating gaze that sounded like an apology. The therapist offers a mirroring intervention (**MI**), in order to continue ego-enhancement and in order to offer an alternative to her own explanation of the gaze.

Th: But actually that's also what I stay looking at ... while looking at you, I have been imagining a child hiding itself in a corner, perhaps that's why my looks are like that ... I have been watching that child, imagining you hiding yourself somewhere ... And apparently this feels very unpleasant to you, when I look at you that way.

Pt: (Nods)

Th: As if I find you stupid ... Imagine that I do not find you stupid, imagine that I do not feel contempt for what you have been telling me and for what you have been showing me. Can you imagine that, or is it too far-fetched, too hard? (SO)

Pt: (Sighs) Yes, but only rationally so.

Th: Only rationally, for your feelings are telling you the opposite.

Pt: (Nods)

Th: So now you are projecting upon me all mean judgements about you; I have become the angry eye, watching you like you might watch yourself when seeing today's video recording ... It is with such a meanness that I am looking at you right now. (DA; RE)

Pt: (Nods)

Th: So now it is between us, huh? (RE)

Pt: Yes.

The therapist aims at inducing a further rise of transference:

Th: And can you still find a way to protect yourself against me, against my looks, my mean looks, my mean judgements about you? (DA)

Pt: (Makes the "flashing" hand movement) At times by rationalising.

The therapist senses a deepening of the patient's affect, in particular, of her sadness.

Th: That's what you're capable of; to realise that it is not like that.

Pt: And in the meantime, there was a dreary ... (makes the hand movement) and I felt. You're looking at me in such a way, I will be beaten.

Th: Beaten by me?

Pt: Yes!

Th: Is that how I am looking at you? (RE)

Pt: Yes!

Th: To that extent! So you are not only seeing how angry I am looking at you, but also that I am abusing you. (DA)

Pt: I do know that that's not the case, but it does flash through me! (flashing hand movements, now with both hands, desperate voice).

Th: It's good that you are aware that that is not how it is, but it also shows how very vulnerable you are feeling. When you feel so vulnerable, someone may promptly start to beat you, abuse you ... Very grim, painful. And you can protect yourself by thinking "Oh no, that is not what he is doing; oh no, that is what I am myself making out of it; this is not what is really happening here." (SO; MI; DA)

Pt: (Nods)

Th: But you do feel as if I can start doing so right now. I would not even dare to think of doing so, of course.

Pt: Indeed (whispering).

Th: But you nevertheless do have the fantasy that I would be willing to do so ... It reveals how vulnerable you are feeling, undefended ... that if you are feeling so undefended, someone just might beat you ... without any chance for you to strike back. I would be happy if you would learn in fact to strike back, to do more, though I don't want you to beat me, but to defend yourself better. (DA; MI; XA; RE; SO)

Pt: (Sigh, whispering) Yes, so would I.

Th: And what you have learned is that it never works and that it is never good enough, so that you'd better not try it. (XA)

Pt: (Nods)

Th: "Resistance is futile" is the expression, huh?

Pt: Yes.

Th: Utterly fruitless.

Pt: That's the point ... ehm ... ehm ... I don't have control of myself ... I would like to ... but I do not manage ... Like what happened right now ... I feel that myself becoming hard and stiff ...

Th: And then you become very anxious ... you responded with a lot of fear.
(AA)

Pt: And then ... I am no longer capable of responding.

Th: Yes.

Pt: And ...

Th: Then you are so much afraid, that you tense up entirely. **(AA; MI)**

Pt: Yes.

Th: Yes, and you need to discover that I will not do you any harm; that I do not feel the contempt that you are projecting; that I do not find you stupid, as you are projecting; that I am not going to abuse you, as you are projecting. All these things seem to be impending at the moment, and it is so hard to relax and get out of the cramp. **(RE; DA)**

Pt: Hm hm.

The therapist notices that the patient is less tense and mirrors to the patient that she is more relaxed **(MI)**:

Th: There seems to be some relaxation right now, as if you discover that things are not that bad.

Pt: (Nods)

Th: Do you see me right now as a person involved in treating you aggressively? **(RE)**

Pt: No.

Th: With contempt in my eyes, mockery, and the like ... **(RE)**

Pt: No.

Th: Not.

Pt: Not now, but just a while ago it all came to the surface and flashed around.

The therapist tries to make the unconscious alliance more explicit and to reinforce the patient's openness towards him, both by recognising the patient's emotional qualities and by pointing out that the communicative acts performed by the patient are steps in which her Ego acted less inadequately than before:

00:32:16

Th: Yes, yes I can believe that ... And at least you can tell me all these things.
(RE; SO)

Pt: Yes, yes (smiles).

Th: So to that extent there is still some confidence [in me, as a therapist], huh? (RE)

Pt: Yes, that is a true word.

Th: Actually it's a beautiful thing, this also being the case.

Pt: Yes.

Th: We've been together into a horrible abyss, where tremendous fear and hopelessness exist, hopeless, helpless ..., where only evil is to be expected ... but you managed to show it to me. It was a kind of guided trip for tourists; not so nice a one ... but perhaps it is a tasteless metaphor ... I came as a kind of outsider and I was introduced by you, in order to explore this area. (RE)

Pt: Yes.

Th: If I were to do this every day on my vacation, I would not have nice holidays, so I would not recommend this for tourists. It is hard work, and it has been hard work for you to show me, but very important for you to do so.

Pt: (Nods) Yes.

The therapist recognises, more explicitly, the isolation in which the burden has been carried:

Th: For I think you have been lonely here for a very long time. (XA)

Pt: Funny, isn't it.

Th: What?

Patient happily receives the recognition about her own communicative steps:

Pt: As you put it, "You have shown it to me", it relieves me, actually.

Th: I am happy to hear so. At least it decreases your isolation, huh, when you can show it, even though it is ghastly what you show ... It comes from very far ... It has been there for a long time. It is not over, but it is less hidden now. (XA)

00:35:55

The patient recognises her own communicative steps and her enhanced Ego position:

Pt: Yes ... I think, the way you put it, is very beautiful (voice breaking with sadness).

Th: What is it you heard me saying?

Pt: This idea that you're a tourist and I am guiding you.

The therapist begins to conclude the session. We rejoin the session three minutes later:

00:38:22

Pt: Strange! ... there is kind of gladness in me now, due to all this.

Th: Great!

Pt: Glad and sad.

Th: Yeah, how different from angry. (XA)

Pt: Therefore I think it I should watch the video!

Th: Be careful, small fragments may be sufficient.

Pt: Yes but I feel it as "today's video, I want to watch it!"

Th: Yes.

Subsequent developments

The therapy unfolded as follows. There was an ongoing growth of self-respect and awareness of her capacities to protect herself against her family and others, and, more basically, against her own self-criticisms. Depressive and compulsive phenomena diminished and openness towards the therapist increased. The patient shared and elaborated with the therapist a variety of additional traumatic experiences. Although the therapy was not yet finished at the time of writing, the developments described herein turned out to have been crucial for the course of her recovery during the half year that was to come.

Conclusions

In the therapy described above, the patient accepted the therapist's invitation to introduce him into her fantasies of being dismissed, and her subsequent mixed sense of joy and gladness can be understood as a confirmation that she did receive the therapist's presence as an *amendment* to her fantasy of being dismissed, thereby experiencing an interaction that opposed and countered the long-term traumatic neglect perpetrated by her parents. What mattered was that the patient introduced the therapist into her realm of isolation, where an adequate differentiation between self and other had been missing and where the patient's sense of identity was predominantly defined by hostile introjections. Though this can be understood in terms of therapeutic maieutics, that is, helping the deep affects be excavated towards their full expression (Osimo, 2003), it is, I think, not only the expression of the deep affect that was of importance here, but also the origination of a kind of relationship that was new to the patient - one in which she was allowed to export her intolerable feelings and project them onto and into the therapist, who was willing to contain them. As a result, she opened up and made her hostile issues accessible as topics of conversation. The therapist's job was to create a safe environment in which the patient was enabled to distinguish her own Ego position as the locus of her own identity, as distinct from her self-dismissing Superego. It is the creation of this space and the patient's experience of it that, I think, comes before the deep affects can be worked through. Interpersonal transitional space was created as transference rose.

The patient's self-disapproving, self-demanding, self-dismissing, self-devaluing, self-rejecting, self-neglecting, and self-ignoring attitudes were manifestations of her Superego pathology, but the patient could not recognise them as alien to her as she had a strong identification with her parents who had disapproved of her so strongly. The therapist therefore offered special support to the part of the patient that suffered from all these criticisms, approaching it as the abandoned child, or the unsupported Ego, that had sought refuge in her room all those years ago. First, the therapist drew the patient's

attention to the abandoned child part of her that deserved their attention. Second, it was highlighted as a position in serious need of a better defence against the Superego reproaches and criticisms. Third, new ways for it to defend itself were identified, and previous authentic (though failing) attempts at its own defence that had already been ventured were recognised, affirmed, and validated. This task was dominant throughout the entire session. Connections between the patient's current self-criticism, and the past criticisms of the parents, were pointed out to the patient, to render the self-criticisms less ego-syntonic. Therapeutic interventions were primarily concerned with clarifying these links to the patient and helping her to turn against the self-dismissing part of her Superego, thereby helping her move towards relinquishing the self-harming defences and demands, and to better make use of her new experience and knowledge of her emotional life in order to develop more self-valuing and self-compassionate internal representations. More specifically, the therapeutic job was to deal with the punishing Superego, and to undo the patient's identification with it. Hence, many interventions are coded as SE. However, the therapist's attempts to approach and support the hidden child brought the patient into a state of alarm, as if they constituted for her a new type of attack. Nevertheless, an unconscious alliance was established between us, becoming manifest in her various explicit reports of hostile projections towards the therapist that "flash" through her mind, that she was willing, and even eager, to mention. When, by the end, the therapist mentions this alliance (in terms of her confidence in him, due to which she could take him on the "guided tour") she could recognise it and feel both joy and sadness. This can be taken as a more open position, in which her ego-adaptive capacities had become enhanced so that self-criticisms were less dominant, and less damaging. The invitation to open up had been accepted.

In helping the patient to shift into a more open position, the therapist worked on their real relationship. First, as previously stated, the patient's Ego was vulnerable and in need of support, and the therapist directed the patient's attention to that vulnerability, and the necessity for her to regain powers in order to defend herself. Then he created the opportunity for the patient to experience and express her paranoid fears. This permissive role not only confirmed the existence of those feelings, but also situated them within an ongoing conversation with the therapist, thus contributing to the definition of their real relationship as one in which feelings can be expressed and investigated safely - without undermining the relationship. At the same time, the therapist repeatedly brought the patient to relate her fears to his actual behaviours. Thus the real relationship was confirmed simultaneously to the exploration of the fears. As a result, a safe space was built in which the patient could both explore her feelings, and experience the stability of the contact with the therapist.

A final remark: naïve objects

It is clear in the above vignette that the patient's self-reproaches had a self-referential character. They pertain to her lack of ego-power and her subsequent self-negation. Accordingly, she reproaches herself for being too submissive towards her own reproaches. It is of interest, both practically and theoretically, that this vicious circle breaks down as soon as the identification of her Ego with a harshly judgemental Super-ego position starts to weaken.

The practical interest, of course, is that it helps a patient escape from self-directed

impairments. Theoretically, however, the issue is of interest as it illustrates the absence of a critical distance for this patient, whereby she does not distinguish (the positions of) her two parts - her Ego and Superego - that she sees as identical. It is the impossibility for the patient to make this distinction that is most difficult to imagine for the critical observer, the therapist. I have called this type of non-distinction a naïve way of perceiving, and the objects thus perceived “naïve objects” (Goudsmit, 1998, 2009). Naïve objects are experiential entities, defined in terms of an absence of differentiation between what is perceived and how it is being perceived. Hence, a naïve object is experienced as an immediate given, and by definition its way of being experienced is not reflected upon. This is a more general formulation of the idea, as presented in object relations theory, that individual subjectivity has to develop within social relationships. In the case presented here, the patient does not differentiate between her angry self-reproaches and the incapacitated Ego. Her upcoming distinction between these two is not an abstract intellectual accomplishment. Instead, it happens through the creation, within (and due to!) the shared space, of a new naïve object. In the case presented here this new naïve object pertains to the patient herself, as suffering from her own vulnerability. This is what she comes to experience as a really existing identity of herself. Thus, the new naïve object comes to replace the old one. Experiential dynamic psychotherapy explicitly deals with such new naïve objects, and the interpersonal therapeutic space can be made available as their locus of origination.

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