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## **On the Dialectical Structure of Experience—Some Clinical and Theoretical Implications**

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*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' 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 with which to think about the components of the dialectical process generating human experience. I will explore 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<sup>1</sup> while 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

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<sup>1</sup>*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. Neither concept has been integrated into the main body of the American psychoanalytic dialogue.*

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of **symbolization**, mode 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 sequentially in this paper. 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 paper. In the end, the reader must become the juggler **holding** in generative tension the multiplicity of modes constituting human experience.

## **I. Experience in a Depressive Mode**

The concept of the depressive position was introduced by **Melanie Klein** (1935), (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.<sup>2</sup> 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 paper, I will focus 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

<sup>2</sup>*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.*

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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 represents the symbolized and is experienced as different from it. Symbolic meaning is 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 one 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 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

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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 essential objects like food or air. Objects can be damaged or used up, only subjects can be hurt. Therefore, it is only in the context of the experience of subjective others, that the experience of guilt becomes 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 has acknowledged 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

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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 the knowledge 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 the 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 in relationships with new objects transferentially and will form an important core of her mature, adult love relationships (cf. Loewald, 1979) ; (Ogden, 1987).

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 which the subject finds too frightening or unacceptable to put into words. I am thinking here not only about frightening and unacceptable sexual

and aggressive wishes, but also about other sorts of fears such as [the unconscious](#) anxiety that aspects of oneself are so private and so central to an

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endangered sense of being alive that the 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, etc. have to do with overdetermined unconscious phantasies 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 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, a patient, Mr. M., early in analysis, 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 noted a passing thought of my own that was as ephemeral as a dream as it recedes on waking. 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 wherein only the "dirty laundry" of the patient is "aired." My thoughts then went to the question of what "dirty laundry" I thought 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 [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 their sexual intercourse 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 after intercourse.

This use of the intersubjective resonance of unconscious [processes](#) of 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; an 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 pure form.

## II. Experience in a Paranoid-Schizoid Mode

The [paranoid-schizoid position](#) is Melanie Klein's (1946), (1952), (1957), (1958) conception of a psychological organization more primitive than the [depressive position](#) which she conceived of as having its origins in the first quarter of the first year of life. Again, the emphasis in this paper 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](#) that 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 (e.g. the relationship of a loving self to a loving object) discontinuous from object-related experience of other valences (e.g. the relationship of a hating self to a hating object). Each time a good object is disappointing, it is no longer experienced as a disappointing good object, but as the discovery of the bad object in what had been masquerading as a good object. Instead of the experience of [ambivalence](#), there is the experience of unmasking the truth. This results in 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, etc., 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 relationship between patient and analyst 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 is perpetually in uncharted territory in the presence of unpredictable strangers. Analytic theory need not appeal to the concept of the [deathinstinct](#) to account for anxiety experienced in 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 like 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 his patient, A., was discussing. The patient experienced this as an anxious, intrusive, over-reaction on the part of the therapist that led her to experience him as having become her mother (not simply similar to 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 over-anxiousness 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. Predominantly, the self is 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 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 the patient's feeling that he is infatuated with a woman, one talks with him about what the patient 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 must think the patient's thoughts and feel the patient's feelings if he is to be of any value at all to the patient.

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. (This is the psychological meaning of splitting.) All defenses in a paranoid-schizoid mode are derived from this principle, e.g. 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," 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 the more primitive mode. Since one's objects, like oneself, are objects as opposed to subjects, one cannot care about them or have concern

for them.<sup>3</sup> There is little to empathize with since one's objects are not experienced as people with thoughts and feelings so much as they are felt to be 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 even the most important of one's possessions. 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, for example through the use of omnipotent reparative phantasies. The injury to the **object** is denied through the use of a magical remedy that is intended to expunge from history the harm that one has done. History is rewritten and the need for guilt is 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

<sup>3</sup>*Since 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 meaningless phenomenologically. 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**.*

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similarly can be used to dissipate feelings that threaten to become an experience of guilt. In self-punishment, one uses an omnipotent **phantasy** that the punishment eradicates the present and past **existence** of the crime and there is therefore 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. For example, a patient explained that my vacation turned out to be a "blessing in disguise" since he had learned 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 work with this patient, my absences were regularly followed by an enactment of manic defenses in the form of a threatened disruption of treatment (which he "no longer needed") or a grudging agreement to continue analysis "if that's what you think is best" or "for the sake of the completeness of the analysis" which he was convinced was in its [termination](#) phase.

Object relatedness in a paranoid-schizoid mode is predominantly in the form of [projective identification](#) (Klein, 1946) ; (Grotstein, 1981) ; (Ogden, 1979), (1982). 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

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recipient of the projective identification can sometimes retrospectively become aware that he is "playing a part ... in somebody else's phantasy" (Bion, 1959p. 149). Projective identification is a "direct communication" (Winnicott, 1971p. 54) in that it is unmediated by interpreting subjects; instead, it is predominantly 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 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 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, 1911). 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

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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 about whom I am afraid of having sexual feelings and fantasies. 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 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 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." The patient had developed compulsive study habits in an effort to become a perfect student and 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. There would be no power or poignancy to the Oedipal dilemma if it were not the problem of a subject (for example, the boy) who hates, and 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 the unconscious **conflict** and resultant symptomatology (e.g. anxiety attacks) 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

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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 resulting 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, 1985). In the "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, it is a process directed at helping the patient shift the balance of the dialectical interplay between 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, re-establishment, 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 man develops the capacity for abstract **symbolization**, subjectivity and self-reflection, concern for others, guilt, and reparative wishes that lead to cultural productions. 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. 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 and depressive modes serve as essential negating and preserving contexts for one

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another. The depressive mode is a mode 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.

### **III. 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 in so far 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) ; Tustin (1972), (1980), (1981), (1984),

(1986) ; and Meltzer (1975), (1986) ; (Meltzer et al., 1975). Each of these authors was strongly influenced by Bion's (1962), (1963) conception of the container and the contained as well as his theory of thinking. (A very incomplete list of other important contributors to this line of analytic thought include J. Anthony [1958], Anzieu [1970], Brazelton [1981], Eimas [1975], Fordham [1977], E. Gaddini [1969], R. Gaddini [1978], S. Klein [1980], Mahler [1952], Milner [1969], D. Rosenfeld [1984], Sander [1964], Spitz [1965], Stern [1977], [1985], Trevarthan [1979] and Winnicott [1960].) In this paper, space allows for only a brief introduction to a discussion of this mode of experience.

The autistic-contiguous position is a primitive psychological organization operative from the beginning that generates the most elemental form of human experience.<sup>4</sup> It is a sensory-dominated

<sup>4</sup>*The autistic-contiguous position is conceptualized in this paper not as a pre-psychological (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 psychological organization can occur only within the unfolding relationship with the mother as environment and the mother as object (cf. Winnicott, 1963).*

<sup>5</sup>*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 the form of psychological organization and defense associated with it. In the autistic-contiguous mode, psychic organization is derived in large part from sensory contiguity i.e. connections are established through the experience of sensory surfaces "touching" one another. Breakdown of this organization leads to the implementation of autistic defenses that will be described.*

*It must be borne in mind that throughout this paper 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 suffering from pathological autism while relying heavily on an autistic-contiguous mode of generating experience as it would be to think of infants or adults as paranoid-schizophrenics while*

*organizing experience in a paranoid-schizoid mode, and depressed when operating in a predominantly depressive mode.*

<sup>6</sup>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 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.

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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<sup>5</sup> of 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 the earliest relations with objects: the nursing experience and the experience of being held, rocked, spoken to and sung to in the arms of the mother. 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 edginess. 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 non-reflective state of sensory "going on being" (Winnicott, 1956p. 303) derived

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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).<sup>6</sup>

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, etc.

*A twenty-nine year old patient, Mrs. L., came to an analytic hour just after having 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 in 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-countertransference 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 that 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*

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*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, 1960) 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 non-symbolic, bodily terms. Although the 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 reflex may to an observer have periodicity, but periodicity is different from the feeling of rhythm; the reflex may have a temporal and spacial beginning and end, but that is not the same as a feeling of boundedness. The rudiments of 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, etc. is the end of the infant.

Tustin (1980) attempted to communicate the nature of experience

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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 constitute forms of definition of experiential 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 therefore 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" in himself (his inability to think or talk) and in the analytic relationship (which he experienced as non-existent) by focusing intently on a rectangular shape that he discerned in the pattern of lines and textures 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 post-partum depression for which she was briefly hospitalized. She told him during the course of the analysis*

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*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 thirty-five year old attorney, during an acute regressive phase of treatment, developed extreme muscular rigidity that led to cramping of her muscles, particularly in her neck. She would frequently massage her cramped muscles in 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 pin cushion. This was understood as a derivative of Mrs. M.'s (previously discussed) feeling 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 hardness in her body that would serve as a way of resisting my attempts to get inside of her in order to control her and turn her into what I needed her to be for me. Mrs. M.'s massaging of her muscles was viewed as a way of both creating a sensory surface on which to locate herself and a way of reassuring herself that the surface was a hard protective one. (During the regressed phase of analysis under discussion, the patient presented no phantasies or dreams of being invaded or 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*

<sup>7</sup>*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, e.g. by means of the creation of psychosomatic illness (McDougall, 1974), alexithymia (Nemiah, 1977) and forms of "non-experience" (Ogden, 1980).*

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*made at a time when the patient seemed incapable of operating in a depressive mode) that he or she has utilized the interpretation.<sup>7</sup>*

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 (1959) 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 fifty-two 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, etc. 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 for the first time in the treatment. 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 to go to the bathroom because she had had the 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 self experience. For example, the patient reported that her mother would tie her arms and legs to the bed posts of the patient's bed when she was six years old in order to prevent her from masturbating at night.*

The terror ensuing from disruption of 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

<sup>8</sup>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 *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, 1968p. 49).

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

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at resurrecting a feeling of the continuity and integrity of one's surface.<sup>8</sup> An example of pathological second skin formation is the development of infantile eczema that Spitz (1964) understood as a psychosomatic disorder resulting from insufficiency or inadequacy of **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 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 a patient 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 disrupted at 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

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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 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 cheek, rocking, tapping one's foot, humming, imagining symmetrical geometric designs or series of numbers, is absolutely reliably present. These activities always have precisely the same sensory qualities and rhythms, never evidencing shifts in mood, never once being a fraction of a second late when they are needed, etc. No human being can provide such machine-like reliability. The individual has absolute control over the autistic activity; 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 protection of the perfect recreation of the sensory<sup>9</sup> experience to protect him against unbearable terror ("formless dread"). I have been impressed by the way in which both aspects of this tyranny 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 forty-two year old patient, Dr. E., a psychotherapist, became enraged if I were a minute late in beginning his analytic hour. (He wore a digital watch.) Dr. E. said that he knew that I knew the importance of "the frame" and 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 a 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*

<sup>9</sup>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).

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*control everything including my thoughts and feelings. He would continually tell me what I was thinking and feeling and in that way could attempt never to be surprised or disappointed by me. Interpretations 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 form of relatedness are usually understood in terms of anal-erotic obsessiveness, omnipotence and projective identification. These are no doubt accurate descriptions of the symptomatology and form of relatedness, but 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 the patient, and intense feelings of protectiveness of 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 sensation dominates. Somatic experiences like twitching of one's hand and arm, stomach pain, feelings of bloatedness, etc. are not uncommon. Very frequently the countertransference experience is associated with skin sensations such as feelings of warmth and coldness (see discussion of Mrs. L.) as well as tingling, numbness, and an exaggerated sensitivity to skin impressions like the tightness of one's tie or of 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 which has nothing to do with boredom. It is a rather pleasant feeling of being suspended 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 paper, the **autistic**-contiguous mode, under normal circumstances, can be seen to provide

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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.

## Concluding Comments

In this paper, 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 between 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 non-subjective world of thoughts and feelings experienced in terms of frightening and protective things that simply happen and 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.

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