Seeing and Being Seen

Emerging from a Psychic Retreat

SAMPLE CHAPTER

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Foreword by Roy Schafer

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Introduction

In this book I continue to explore the themes developed in *Psychic Retreats* (1993), especially those that appear from a consideration of clinical situations where patients feel stuck and where a failure to develop impedes the progress of the analysis. As in my previous works, my starting point is the recognition that we all need defences to protect us from anxiety and pain. The aim of analysis is not to remove the patient’s defences but to understand them and through such understanding gradually to help the patient recognise new possibilities and potentials.

Progress is often marred when defences that are no longer necessary continue to be deployed because the patient is afraid of losing the protection they provide and is uncertain about alternative ways of coping with anxiety and pain. Looking at the anxieties that arise as the patient begins to let go of defences can help us to understand his\(^1\) dependence on them. However, it is also important to understand that defences are sometimes held on to with great tenacity and are most resistant to change when they form an organised and coordinated structure. Our understanding of the basic form and function of these organisations has been greatly enhanced by recent analytic work, some of which is reviewed in my earlier book (Steiner, 1993), where I describe these systems of defences as pathological organisations of the personality and the structures they give rise to as *psychic retreats*.

The present volume comprises a selection of more recent papers that seem to me to share a common theme. In Part One, I discuss the importance of the experiences of embarrassment, shame, and

\(^1\) Throughout this book I have tried to avoid sexist language, however sometimes I use ‘he’ or ‘his’ to refer to an analyst or patient of either sex for the sake of simplicity and clarity.
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humiliation that confront the individual who begins to relinquish a narcissistic organisation and to emerge from a psychic retreat. In Part Two I describe a hierarchy of dominance ordered by the ability to humiliate. The fear of being seen as inferior may then create a threatening situation that makes it difficult for the patient to risk letting go of his defences and emerging from the protection of his retreat. I suggest that a power struggle arises when helplessness exposes both patient and analyst to the threat of losing familiar ways of coping. Finally, Part Three examines some of the obstacles to change. This leads to a discussion of resistance and an examination of the factors that prevent or facilitate psychic change. Many of these factors centre around mourning and obstacles to mourning.

Part One: Embarrassment, shame, and humiliation

Emerging from defensive organisations

Much recent analytic work has clarified the organisation of defences into complex systems. These can be looked at in three complementary ways. Sometimes we can examine the individual defences, sometimes it is helpful to recognise the complex system of object relations that the defences involve, and finally it is possible to conceive of the defensive structures as psychic retreats — that is, as places where the patient can withdraw to seek relief from anxiety and pain. Each of these approaches adds something to the understanding of the total situation. If we consider the defences themselves, then their mechanisms can be described, in most cases involving splitting and projective and introjective identifications. When we consider defensive systems, we recognise that object relations do not exist in isolation but are invariably formed into organisations. The structure and the dynamics of the organisations vary, but they are commonly held together in powerful ways. I have referred to these as pathological organisations and have described their high degree of resistance to change. Sometimes power relations play a critical role, as in Rosenfeld’s example of a narcissistic mafia-like gang in his inner world in which the patient becomes embedded and trapped. Third, using the notion of psychic retreats enables us to recognise that pathological organisations are also represented spatially as hiding places to which patients may withdraw. Within the retreat they feel sheltered from view, and from within...
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these hiding places their objects are also not clearly visible. These retreats may appear as phantasies that are sometimes visualised in dreams and other material as houses, castles, or fortresses but usually turn out to involve groups of people. Safety is then conferred by membership of a group or the protection of a powerful individual.

The patient who has hidden himself in the retreat often dreads emerging from it because it exposes him to anxieties and suffering – which is often precisely what had led him to deploy the defences in the first place. However, the first and most immediate consequence of emerging from a psychic retreat is a feeling of being exposed and observed. It is here that feelings of embarrassment, shame, and humiliation commonly arise. The situation is often represented in myth and fairy tale. For example the story of the Emperor’s new clothes shows the collapse of a narcissistic phantasy and the emergence from a psychic retreat that served as clothing in which the Emperor could hide. Of course, the biblical account of the expulsion from Eden offers a more detailed and instructive description of the shame that arises when a paradise is relinquished.

Once these emotions are recognised, one cannot fail to be impressed with the impact they have when the patient feels exposed to view. And yet shame and its related feelings have only recently been given prominence by psychoanalysts and tend to be ignored by Kleinian analysts. Indeed, Lansky (2005a) is surely right when he says that “Klein and the original pioneers of her school have shown … a striking theoretical insensitivity to the dynamics of hidden shame, even in the very important discoveries they have put forward” (p. 875).

I hope the present book will go some way towards integrating the experience of shame with other concepts important in a Kleinian approach, but I am concerned with the broad range of experiences that confront the patient upon emerging from a psychic retreat and not simply with shame. A brief review of recent papers in this field appears in Chapter 1.

The situation I am examining is that of patients who feel exposed to view when they lose the protection of a pathological organisation. This may arise if the organisation shielding the patient is weakened, sometimes as a result of progress in the analysis. In these cases the patient has often begun to make moves of his own to emerge from its protection. More commonly, the patient continues to feel dependent on the organisation, and its loss signals the danger of collapse or breakdown. Patients may then complain that they are
being forced out of a psychic retreat before they are ready to manage without it. Without the protective clothing of the retreat, they feel naked and exposed and that they are being observed in a critical, condemning, and often terrifying way. The severity of the discomfort varies; it has led me to think of a spectrum of emotional states, with embarrassment lying at the milder end and humiliation at the more severe end. The existence of a large number of words for feelings in this area seems to me to suggest that individuals find them significant and are able to make subtle distinctions between them. In a rough order of increasing severity the patient could describe himself as embarrassed, thin-skinned, self-conscious, sensitive, vulnerable, disconcerted, awkward, blushing, ignominious, improper, indecent, unchaste, demeaned, ashamed, belittled, slandered, debased, defiled, disfigured, demoted, disgraced, dishonoured, degraded, contemptible, mortified, scorned, worthless, and humiliated.

A striking feature of these states is that, although they vary in severity, they are all felt to demand immediate relief. They all have to do with feelings of inferiority and are commonly associated with fantasies of being viewed with contempt, and often ridiculed and looked down on.

**Seeing the object and the depressive position**

I have found it useful to divide the anxieties that have to be confronted on emerging from a psychic retreat into those to do with *seeing* and those to do with *being seen*. Previously, like most Kleinian analysts, I had not paid much attention to the problems of being seen and concentrated instead on feelings associated with what I thought of as the deeper and more significant issues connected with seeing the object. Rosenfeld had described how narcissistic organisations protected the patient from experiences of separateness. When it was not properly separate, the object could not be properly seen. Its appearance was distorted, with some aspects split off and denied while others were altered because of the patient’s projections. Coming out of the psychic retreat enabled the patient to see the object more realistically, and this forced a confrontation with unwanted elements that had previously been hidden. These new recognitions meant that the patient had to deal with envy, jealousy, frustration, rage, guilt, and remorse.

The anxieties of *seeing* arise when the patient observes the object from a sufficient distance to enable it to be seen as a whole, so that
both good and bad qualities can be recognised. Good qualities stimulate love and gratitude but also give rise to envious hatred. Attacks on the good object are unavoidable, and it is these that give rise to anxiety and guilt as the patient recognises that the good object has been damaged or lost. When the patient emerges from a psychic retreat, this opens the possibility of integration based on a more realistic view of the object, but the painful experiences that necessarily result are difficult to bear. The patient now finds himself or herself in what Klein termed the depressive position, and further development critically depends on the capacity to suffer, endure, and recover from the experiences that result. The confluence of love and hatred is the basis of some of the deepest conflicts we have to face and has been extensively described by a variety of writers – most vividly, for me, by Klein (1935, 1940), Riviere (1936), Segal (1964), and Rosenfeld (1964, 1971a). Klein made an understanding of ambivalence and its consequences central to her descriptions of the depressive position, and I find her accounts of this theme to be clear and moving. Here is an example from 1936, from one of her unpublished papers on technique in the Melanie Klein Archives (housed in the Wellcome Library for the History and Understanding of Medicine):

All feelings of love begin with the libidinal impulses, especially the libidinal attachment to the mother (her breast) and from the very beginning of development, hate and aggression are active, as well as the powerful libidinal urges. When the infant is able to perceive and to take in his mother as a whole being, and the libidinal attachment to her breast has grown into feelings of love towards her as a person, he becomes prey to the most conflicting feelings. I hold the view that feelings of sorrow, guilt and anxiety are experienced by the infant when he comes to realize to a certain extent – that his loved object is the same as the one he hates and has attacked and is going on attacking in his uncontrollable sadism and greed – and that sorrow, guilt and anxiety are part and parcel of the complex relation to objects which we call love. It is from these conflicts that the drive to reparation springs, which is not only a powerful motive for sublimations, but also is inherent in feelings of love, which it influences both in quality and quantity.

(p. 1)
Klein speaks about the “ability of the infant to perceive and take in his mother, as a whole being”, and it is this integration of aspects of the mother that seems to be so difficult to bear. Damaged aspects of the good object create guilt, while good elements provoke envy and are defended against by attempts to undo the separateness and to return to the protection of the psychic retreat. We have learned that the most widespread and important type of retreat takes the form of a narcissistic type of object relationship in which good qualities belonging to the object are appropriated and bad qualities are disowned. While they are prominent in narcissistic patients, these defences are universal and have been extensively studied. They interfere with the experience of separateness between self and object and prevent the object from being perceived and related to as a whole.

**Being seen and embarrassment, shame, and humiliation**

The other significant consequence of separateness arises when the patient feels that he is exposed to being seen. This aspect of separateness became more apparent to me when I recognised that psychic retreats served as hiding places. Of course narcissism involves a degree of self-idealisation that is reflected in the idea of being admired; when this collapses, the patient has to face the experience of being seen with his narcissistic self-admiration exposed. With the collapse of admiration, narcissistic pride is replaced by feelings of embarrassment, shame, and humiliation that demand to be dealt with. The patient may be exposed to a persecutory state in which pathological splitting and paranoia predominate. Alternatively, he may try to retreat to the protection of the pathological organisation. In either case progress towards the depressive position is reversed or delayed.

The intensely uncomfortable experiences of embarrassment, shame, and humiliation are the most immediate problems facing the patient as he begins to emerge from the psychic retreat. They have an unbearable quality that demands urgent relief. This urgent need for relief may prevent the patient from facing deeper problems, such as guilt, which have to be tolerated if movement towards the depressive position is to proceed. Embarrassment, shame, and humiliation are commonly experienced by patients in analysis where exposure to being observed is a prominent feature inherent in the setting. If they
Embarrassment, shame, and humiliation give the experience of being observed a particular cruelty and pain. The observing figure is felt to be hostile, attacking the superiority of the narcissistic state and trying to reverse it so that the patient feels inferior. These attacks are often imagined to be a prelude to more severe assaults, and the patient feels that they are intended to weaken and demoralise him so that he can be destroyed and eliminated. A vivid description of the way humiliation can give an unbearable quality to persecution is given by Senatspresident Schreber, whose memoirs and Freud’s paper based on them offer such a striking portrayal of depression and paranoia. Schreber writes as follows:

In this way a plot was laid against me, the purpose of which was to hand me over to another human being after my nervous illness had been recognised as, or assumed to be, incurable, in such a way that my soul was handed to him, but my body – transformed into a female body – … was then left to that human being for sexual misuse and simply forsaken, in other words left to rot. … Always the main idea was to forsake me, that is to say, abandon me; … to allow my body to be prostituted like a female harlot, sometimes by killing me and later by destroying my reason.

(Schreber, 1903, p. 63)

Schreber refers to the worst suffering as “soul murder”. This is never precisely defined, but it seems to involve the deepest humiliation and misuse that a person can undergo, in which an attempt is made to undermine his sense of worth and to destroy the very essence of his identity for someone else’s benefit. This illustrates a feature of humiliation, which always involves a personal agency wanting to inflict punishment. While this may also be true of embarrassment and shame, it is not invariably so. When pain does not arise accidentally but is inflicted as a punishment, the resulting persecution is much more difficult to bear. Suffering then is not simply a confrontation with pain or danger but something imposed with the intention to hurt and ultimately to destroy. Sometimes the persecution is more feared than the physical attack, as for example in the account given by the twelfth-century French teacher, Abelard, who was
castrated as a punishment for his indiscretions with Heloise and who complained that:

the whole city gathered before my house, and the scene of horror and amazement, mingled with lamentations, cries and groans which exasperated and distressed me, is difficult, no, impossible, to describe. In particular, the clerks and, most of all, my pupils tormented me with their unbearable weeping and wailing until I suffered more from their sympathy than from the pain of my wound, and felt the misery of my mutilation less than my shame and humiliation.

(Fenton, 2006)

Lansky (2005a) has made a similar point when he argued that “The paranoia of the Kleinian paranoid-schizoid position is not always entirely rooted in the fear of physical attack or destruction; it often includes the fear of deliberate humiliation (paranoid shame, i.e., shame coming from the express intent of the other to shame one)” (p. 876). Such extreme cases can sensitize us to notice the less intense versions, which can nevertheless feel agonizing. It was such observations that led me to become interested in embarrassment, shame, and humiliation, which seemed to be so ubiquitous and particularly prone to be provoked by aspects of the analytic situation. Of course it has long been recognized that patients need to have their dignity respected and are very sensitive to slights and signs of disrespect, but I was not fully aware of how often they felt looked down on and humiliated. Many features of the analytic setting, such as the timing of sessions, the fees, lying on the couch, and determining holiday dates, may be experienced as the analyst unfairly exercising power and placing the patient in a position in which he feels inferior and looked down upon. Narcissistic defences are mounted to deal with these feelings, and these are often able to reverse the situation of dominance, allowing the patient to feel superior. However, since the feeling of superiority is based on omnipotent phantasy, it is fragile, and when the narcissistic defences collapse, the patient once more feels looked down on and the cycle is resumed.

**The significance of gaze and of being observed**

The recognition that being observed can lead to embarrassment, shame, and humiliation allows us to focus on the importance of gaze.
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This has led to a helpful distinction between the primary object and the observing object in the transference, put forward by Ron Britton (1989). His discussion of the Oedipal situation allows us to appreciate that the child finds it difficult to tolerate being excluded when the parents are in an intimate relationship with each other, and that he prefers to make a link with either parent separately. This means that one parent is excluded and may then be experienced in the position of a superego figure who observes and judges the child’s relationship with the primary object. Sometimes the observer offers praise, admiration, and encouragement, but when he has been excluded he often acquires persecuting qualities in which he is felt to be exercising power through threats and humiliations. In these cases the observing object, usually the father in the classical version of the Oedipus complex, interferes with the patient’s relationship with the primary object on whom feelings of love and hate are focused.

Despite considerable research, there is still no clear understanding of the course of development of feelings of shame and embarrassment in infancy (Nathanson, 1987). It is interesting that early in life the child is insensitive to embarrassment and shame, for example in relation to nudity and toilet functions. Then, at some stage, usually in subtle ways from the beginning of the second year, embarrassment begins to emerge, and a touching loss of freedom develops, as if the child, too, has emerged from paradise. If embarrassment fails to develop, the child may lack an important restraining factor and grow up to be shameless, while if the inhibition is too severe, he may develop an oversensitivity to shame.

Freud himself commented that,

Small children are essentially without shame, and at some periods of their earliest years show an unmistakable satisfaction in exposing their bodies, with especial emphasis on the sexual parts. The counterpart of this supposedly perverse inclination, curiosity to see other people’s genitals, probably does not become manifest until somewhat later in childhood, when the obstacle set up by a sense of shame has already reached a certain degree of development.

(1905, p. 192)

However, if the observing relationship is too persecuting, feelings of embarrassment, shame, and humiliation can interfere with the working though of the primary ambivalence towards the good object.
and arrest development towards the depressive position. It is therefore technically important to analyse the problems of being observed in order to enable deeper feelings to be addressed.

Vision plays an increasing role as development proceeds, both in the maturation of the individual and in evolution as species develop. In both cases, vision is increasingly made use of where formerly the senses of taste, smell, touch, and balance were dominant. These proximity senses are phylogenetically older, and it is initially through them that primitive mental mechanisms are expressed. Separateness, which is so important in establishing mature object relations, depends on vision, while the more primitive senses function when physical closeness to the object prevents it from being seen properly. Although vision provides more precise and detailed information, the relatively crude proximity senses remain important, especially in our relationship with basic elements of life such as food, faeces, illness, death, and sex. Later in development the eye takes over some of the functions that had previously relied on the proximity senses. In particular, projection and introjection now come to be mediated by the eyes, as for example when gaze becomes capable of penetrating and can be used to enter the object and identify with it.

Part Two: Helplessness, power, and dominance

Depressive and paranoid outcomes of the Oedipus complex

An interest in embarrassment, shame, and humiliation naturally leads to the question of relative status and power. A hierarchy of dominance is often indicated by the direction of gaze and the ability to humiliate. Narcissistic patients are particularly sensitive to status. They expect to have their phantasies of superiority challenged and fear to find themselves looked down on. They may feel they have been humiliated by figures of superior power and often harbour resentments that lead them to seek revenge by bringing about a reversal in which they regain a position of superiority.

Power relations exist whenever there are differences, and tensions often emerge around issues of relative status and power. In most families an acceptance of difference in capacities can be tolerated without too great a sense of unfairness, but when power is felt to be unjust or usurped, or when it is exercised in a cruel way, the child
may feel resentful and may resort to narcissistic identifications in an attempt to reverse humiliations. A good example seems to me to arise from Freud’s description of the resolution of Oedipal conflicts (1924), where the will of the father imposes a structure on the family through an authority based on power, wielding the threat of castration to intimidate the child. In my view (Steiner, 1990b, 1996b, 1999), this solution leads not to a resolution of the Oedipus complex but to a stand-off in which the child harbours resentments and plots revenge.

I think of Freud’s model as a paranoid solution of the Oedipal dilemma. To some extent this is always present, but in narcissistic patients it may dominate. However, it co-exists with a depressive solution that can arise if the child is able to express his hatred in action rather than nursing it internally as a grievance. When this happens within a pathological organisation, the familiar omnipotent solution is based on the phantasy that the child defeats the authoritarian father and usurps his position with the collusion of his mother. By contrast, if he is able to enact this phantasy and to emerge from his omnipotence, he realises that he has attacked not just his father but the structure of the family. Far from being able to function as a father, his infantile weakness and dependence become apparent. Then instead of the phantasised triumph he has to face his regret, remorse, and often despair, which have to be painfully worked through. If he can tolerate the initial sense of humiliation, the child is able to work through these depressive feelings, and a new family structure can sometimes emerge in which an authority based on earned respect rather than on omnipotence has a place.

Most discussions of the Oedipus complex centre on the relationship between father and son, perhaps because the issues of rivalry are more dramatic and hence easier to identify. The situation is significantly different when the rivalry is between mother and daughter, or mother and son, or father and daughter, and different again when the rivalry is between siblings or between husband and wife. At a fundamental level, however, many of the elements remain the same, despite differences in age and gender. In all cases, difference – whether in age, size, gender, or any quality whatever – is sometimes not felt as a painful and natural aspect of reality, but gives rise to feelings of exploitation and injustice. It is in fact very difficult to make this judgement, since exploitation and abuse are very real experiences, both in life and in psychoanalysis, but they are not integral to the
existence of difference. A tolerance of difference is necessary for development and for creativity, but difference can also provoke envy, and it is often when this is attached to injustice that the destructiveness becomes so magnified.

These two solutions to the Oedipus complex alternate with each other. The paranoid situation that is available inside the psychic retreat gives way to the depressive contact with reality that the patient has to face as he emerges from it. The patient’s capacity to deal with resentment is a vital factor in determining which solution will predominate. Many psychic retreats are based on feelings of resentment, which are nursed and held on to because the patient does not have the confidence to emerge from the retreat and express them as hatred and a wish for revenge.

These issues of power, dominance, and helplessness are rooted in the reality of the infant’s relative smallness and weakness, but they may be felt as particularly acute if the child has to contend with a mother who cannot open herself to receive the child’s projections. This may be felt to rub in the feeling of helplessness, and the child may feel that he is obliged to turn to narcissistic mechanisms to compensate. Normally, even the newborn baby is able to exercise power over his objects and can make his presence felt through reactions evoked by his inborn repertoire of smiling and crying. By these means the child can normally force even a reluctant mother to attend to his needs, but if his ability to project is deficient or the mother is emotionally unavailable, omnipotent measures may be brought into play. Smiling and crying can develop into seductive and coercive means of exercising power in the family and lead to a narcissistic organisation structuring the family relationships.

In a family with more effective checks and balances, either of the two parents can intervene to moderate the narcissistic tyranny of the dominant figure – that is, the other parent, or the child. In this triangular configuration, the child exists in a structure that protects him from excessive exploitation by the parents but also protects the parents from being taken over and controlled by him. These power relations in the family are, of course, relevant to any consideration of power relations between individuals, groups, and nations in the wider sphere. They are also internalised and re-evoked in the transference, where confrontations over power are ubiquitous.

In order to emerge from the psychic retreat and work through the more depressive version of the Oedipus complex, the patient has to
be able to tolerate the indignities of the paranoid version and find sufficient support from his analysis to live through them. When it is his analyst who is felt to impose the paranoid structure, this can be very difficult to negotiate. However, the depressive position can only begin to be faced when the patient feels that it is worth enduring the slights and indignities involved in being helped to recognise his narcissistic self-aggrandisement. If this becomes possible, the aftermath of vengeful attacks on the objects by whom the patient feels slighted can be worked through, and the subsequent regret and guilt can be faced.

The paranoid and depressive solutions to the Oedipus complex seem to me to represent the fundamental choice that faces the individual as he tries to negotiate the conflicts he is confronted with. Of course, the patient rarely feels that he has a choice, since unconscious pressures drive him in one direction or the other. Loewald (1979), who seems to me to be discussing the same issue, puts it in stark terms when he suggests that the patient must choose between castration or parricide. In an unpublished paper Dana Birksted-Breen came to a very similar conclusion, as reported by Astor (1998):

her paper gave a vivid clinical description of the two main resolutions of the Oedipus complex, the paranoid resolution, in which the threat of castration looms large intra-psychically; and the depressive resolution, in which the parent’s sexual intimacy is allowed to exist, and envy, exclusion and jealousy minimally distort the acceptance of it as a fact of life.

(p. 707)

The central importance of the Oedipus complex and the critical issue of its resolution are discussed in several of the chapters in this book. It is described in detail in Chapter 5, where the struggle over dominance is explored, but it is also central to Chapter 6, in which the outcome is linked to a basic sense of helplessness. Finally, it is important in Chapter 7, which shows how the depressive route allows for the possibility of reconciliation and forgiveness while the paranoid route makes this impossible. The topic seems to me to be so important that it is worth emphasising.

The potential shift between depressive and paranoid outcomes of the Oedipus complex is a particular example of the more general and inevitable shifts between progress towards the depressive position
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and regression to the paranoid-schizoid position that take place in the course of development. Often the choice seems to be between persecution and guilt, and in this respect it is interesting that Melanie Klein once suggested that her most important single idea was the paranoid defence against guilt. Neither the paranoid-schizoid position nor the depressive position is an end-point, however, and periods of integration may have to break down to enable further developments to take place (Britton, 1998b).

Part Three: Mourning, melancholia, and the repetition compulsion

In the final section of the book I continue to explore dichotomies or divergent paths that appear to give the patient a degree of choice about whether to move forward or regress. Sometimes the anxiety may be so great that no real choice exists and the patient feels driven to take defensive action by forces beyond his control. At other times the balance is more even, and here the analyst may make a difference and support the patient through difficult periods to enable development to be sustained despite the ensuing anxiety and pain. Even in the most intractable patients some movement is nearly always discernible. This movement has usually been understood in terms of a shift between the paranoid-schizoid and depressive positions, which can be thought of as being in equilibrium with each other. However, if psychic retreats are included in the model, the alternations are more often seen to be between staying in the retreat and emerging from it. Here, too, resistance is not so much a static position (although it may appear to be so); rather, any moves to emerge from the retreat can result in a rapid return if the anxiety cannot be borne.

Resolution of many conflicts depends on the individual’s ability to tolerate loss. At the root of the dilemma facing the individual when change seems to become a possibility is the choice between facing loss, on the one hand, and denying it through a defensive organisation, on the other. Giving up omnipotence involves facing loss, and the mental processes involved have much in common with those that arise from bereavement. Freud’s (1917) differentiation between mourning and melancholia enables us to trace the stages that the patient has to go through when passing from one to the other. Melancholia can be thought of as failed mourning. It occurs when
the cost of accepting loss – both the loss of the object and the loss of the omnipotence which is simultaneously involved – is felt to be too great. One can think of melancholia as a psychic retreat in which the depressive position is approached but shied away from in favour of omnipotence. If the patient can shift from melancholic denial towards facing reality, then it is mourning that he has to confront and work through. Usually this involves an initial identification with the lost object in order to deny the loss and then a second and painful reversal of this denial. Freud (1917) described how “each single one of the memories and situations of expectancy which demonstrate the libido’s attachment to the lost object is met by the verdict of reality that the object no longer exists” (p. 255). It is this verdict of reality that makes the work of mourning so painful. In order to consolidate psychic change, this process has to be worked through repeatedly. While the process is clearest when mourning follows an actual loss, Freud understood that an essentially similar process is gone through whenever there are slights or disappointments that are felt to imply the loss of the object’s love. Here the loss of the external object leads to a loss of omnipotence, which had previously been felt to guarantee that the object could not be lost.

When this process is examined in its fine grain, we can see that every meaningful analytic contact that takes place when the patient understands an interpretation has a quantum of loss and hence a quantum of depression associated with it. In such moments of insight the verdict of reality is applied, and this enables projections to be reversed. The patient is able to give back to the object what belongs to him and, equally importantly, to regain the parts of himself that he had disowned by projection. I suggest that mourning the loss of omnipotent control over the object, and then mourning the loss of the object itself, is what leads to meaningful change in analysis.

The analyst plays a vital role in facilitating this process in the patient. He becomes a central figure, first as the observing object that inflicts such immediate humiliation on the patient and then as the primary object towards which love and hate are directed. If he can contain the anxieties of feeling like an excluded observer, the analyst may be able to help the patient cope with the intense feelings that arise in relation to the primary object. Equally, if he can cope with his position as a primary object, he is often able to moderate the persecutory effects of being observed.
In functioning as a facilitator, the analyst must be able to accept the patient’s projections, to refrain from too extreme a reaction to them, and to understand both the patient’s communication and his own reaction to it. Bion (1962) called this process containment. He suggested that when the patient is understood in this way, his projections become more acceptable to him, and he can then take them back in a modified form. In my view, however, this description is incomplete. Containment relieves anxiety and makes the patient feel understood, but in itself it does not allow a true separateness to be achieved. I believe that projections are not fully withdrawn until the second stage of mourning is worked through. In the first stage the patient internalises an object containing parts of the self that are still inextricably bound to it. At this stage the loss of the object during actual separations is denied by a phantasy of omnipotent possession. Relief from anxiety comes from a sense of being understood by the analyst, and it relies on the analyst’s authority. However, understanding has to arise from within. It depends on a capacity to think and judge for oneself, and to achieve it the patient must give up his dependence on the views and judgements of authority figures, including the analyst.

Relinquishing this dependence ushers in the second phase of mourning, which involves a move towards independence and towards facing the pain of the mourning process. In this phase the reality of dependence on the object must first be acknowledged and the reality of the loss of the object must then be faced in order that mourning is worked through. Both are often vehemently resisted.

**Resistance, the repudiation of femininity and the repetition compulsion**

The nature of resistance to change occupied Freud throughout his life, but it gained particular prominence in his classic late paper, “Analysis Terminable and Interminable” (1937), where he described patients who cling to their illness and defend it by every means possible. When this happens, the patient’s illness forms an essential part of the psychic retreat, and if the analyst is experienced as trying to help the patient, the pleasure of thwarting him may be more immediate than the satisfaction to be gained from change. While it is clear that Freud has the death instinct in mind when he
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examines the forces that obstruct development, he makes what seems to me to be a surprising and highly significant observation when he attributes the resistance to what he calls “the repudiation of femininity”. For the woman, he argues, a discontent with her femininity leads her to want masculine attributes, revealed by her desire for a penis. For the male, the adoption of a feminine attitude makes him feel inferior and leads to a masculine protest. Freud argues that

The decisive thing remains that the resistance prevents any change from taking place – that everything stays as it was. We often have the impression that with the wish for a penis and the masculine protest we have penetrated through all the psychological strata and have reached bedrock, and that thus our activities are at an end.

(Freud, 1937, pp. 252–253)

I touch on this point in several chapters – for example, in Chapters 3 and 5, and particularly in Chapter 9. Again, the point is so important that repetition is warranted. I argue that the “repudiation of femininity” is more appropriately thought of as an intolerance of a receptive dependence on good objects. This seems to present similar problems for both men and women. It is, in fact, the position that infants of both sexes have to adopt in their earliest relationship to the mother and her breast. Attacks on linking, as described by Bion (1959), are particularly prone to be directed against a receptive link to a good object, both to the good breast that is initially essential to development and to the creative penis, which represents new life, reparation, and the potency to provide a safe structure for growth to proceed.

Attacks on these creative links prevent the emergence of new developments and lead to repetition compulsions. Receptivity and dependence involve loving and valuing an object. This stirs up hatred and destructiveness, since it reactivates envy. At the same time the achievement of growth and development opens the patient up to envious attacks from others. Hence fear of envying and of being envied may co-exist, and both can have powerfully inhibitory effects on the possibility of change.

With these considerations concerning resistance, the book can be thought of as having come full circle. Embarrassment, shame, and humiliation were introduced to examine the more immediate consequences of being seen, and we can now recognise the close relationship between being seen and being envied. Both are connected with
vision and with the appreciation of something good. If the patient feels that he has stolen the good and usurped the power it confers, he fears to be observed as he really is because he is afraid that he will be seen as false and looked down on. However, even when he believes he has goodness that can bear examination, he continues to fear being observed because of the expectation of envious attacks. In both cases the “evil eye” is what is feared. Since no development is ever purely good, the two sources of resistance are always both present to varying degrees. It is the task of analysis to help the patient accurately to perceive both his own and others’ value, to accept the embarrassment of being found out when wanting, and to stand up to attacks when real achievements have been made.

Conclusions

The work presented here builds on my earlier understanding of psychic retreats by looking at what enables and what prevents the patient from letting go of his dependence on the pathological organisation and emerging from the retreat. The chief new idea that is presented here is that emerging from a psychic retreat leads to the feeling of being observed. This leads to shame and humiliation, particularly if narcissistic defences have created an illusion or delusion of superiority. My awareness of the anxieties that arise in relation to the observing object does not lessen my view of the importance of anxieties associated with the primary object. However, it is often the case that shame and humiliation are the initial experiences that confront the patient as he faces a new reality. These have to be endured if progress is to be made in relation to the anxieties of the depressive position.

In bringing these papers together in this book, I attempt to understand the complex processes that arise when a patient makes moves to develop. The route I have taken includes issues of power and dominance as well as resentment and revenge. Finally, I have had to consider the role of mourning and the difficulties of adopting a feminine receptive position. All these complex interactions seem to be interrelated and linked to both the new themes presented here and the old which have been more firmly established over the years.
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Outline of the book

Part One

The main themes to do with embarrassment, shame, and humiliation are discussed in Chapter 1 (“The Anxiety of Being Seen: Narcissistic Pride and Narcissistic Humiliation”), where clinical material is presented from a patient whose defences were based on fantasies of superiority and admiration and who was particularly sensitive to being observed. The analytic setting made him feel exposed, and he was prone to feeling inferior and persecuted. His reactions to being observed played a central role in his pathology. I also describe his use of gaze to reverse the experience of humiliation. He felt that he could enter his objects through an excited looking which restored his narcissistic superiority.

Chapter 2 (“Gaze, Dominance, and Humiliation in the Schreber Case”) considers the famous Schreber case. I use both Schreber’s memoirs and Freud’s wonderful case study to highlight the role of humiliation in Schreber’s breakdown. I suggest here that Schreber’s failure to find anyone who could understand and contain his distress left him unable to face the humiliation and emerge from his paranoia.

Chapter 3 (“Improvement and the Embarrassment of Tenderness”) describes a patient who had been trapped in a resistant type of narcissism but who had made a great deal of progress and was beginning to want to emerge and face himself and his objects more realistically. I present material to illustrate the narcissistic organisation that he could turn to for protection and his fear that this would be seen through and exposed. However, he also allowed a contact with warmer, more tender feelings, which emerged as he was able to express love and gratitude. An interesting feature of this case was that the patient’s tender feelings also led to embarrassment and shame, since he thought of them as feminine and feared they would be seen as inferior.

Chapter 4 (“Transference to the Analyst as an Excluded Observer”) distinguishes between the primary object and the observing object in order to show how the analyst can be placed in the position of an excluded observer. This chapter reviews the history of transference and describes how the analyst can sometimes be provoked to make judgemental interpretations outside the transference in response to being excluded and looked down on.
Part Two

In Chapter 5 ("The Struggle for Dominance in the Oedipus Situation") I describe the conflicts over power and dominance that can arise in the Oedipal situation and distinguish between the paranoid and depressive solutions to the Oedipus complex. The clinical material illustrates the struggle of a patient who tried to reverse what he felt was a condescending dominance that my role as the analyst gave me over him.

In Chapter 6 ("Helplessness and the Exercise of Power in the Analytic Session") the importance of power in the patient’s relationship to the analyst is related to the development of a narcissistic superiority as a reaction to helplessness. At its root the helplessness is connected with an inability to find an available figure who is able to receive and cope with the patient’s true situation. The clinical material describes a situation where the patient seemed to me to be inaccessible until I recognised that he also found me to be inaccessible to his communications and projections.

In Chapter 7 ("Revenge and Resentment in the Oedipus Situation") the relationship between resentment and revenge is explored using an extract from Robert Louis Stevenson’s *Kidnapped*. I argue that if resentment can be expressed as hatred and a wish for revenge, this may bring about a shift to the depressive solution to the Oedipus complex. If this happens, resentment can in part be relinquished and replaced with forgiveness.

Part Three

In Chapter 8 ("The Conflict between Mourning and Melancholia") the importance of mourning is discussed in relation to the task of letting go of omnipotence and facing the reality of loss. The possibility of development and change leads in the direction of mourning, while resistance to change leads to melancholia. When the depressive position begins to be faced, there is a conflict between mourning and melancholia. In order to mourn, the patient must first emerge from his psychic retreat and face the anxieties of seeing and being seen. Indeed, the capacity to face both the loss of omnipotence and the loss of objects is presented as an essential factor in determining the possibility of psychic change.
Finally Chapter 9 ("Repetition Compulsion, Envy, and the Death Instinct") focuses on the repetition compulsion and discusses the place of envy and the role of the death instinct in creating obstacles to psychic change. In my view the repetition compulsion expresses a hatred of change which demands that nothing new is allowed to develop. It is related to the difficulty in both sexes of tolerating a receptive position, which is often viewed as feminine and inferior. Envying and being envied are related to the experience of seeing and being seen. Both present problems that the analyst needs to understand if he is to facilitate the possibility of growth and development in an analysis.