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***'Where shall the word be found, where will the word resound?'* Absence of resonance and the struggle to find the right register.** [website version]

In April 1831, a brigade of soldiers marching in step across Broughton Suspension Bridge, felt it vibrate in time with their footsteps. Enjoying the sensation, they whistled a marching tune, stepping ever more in time with the movement of the bridge. According to accounts, "a sound resembling a discharge of firearms" was heard as the bridge broke apart beneath them, throwing dozens of men into the water. Following this, the British Army sent orders that soldiers crossing a long bridge must "break stride," or not march in unison. This tendency of an object to vibrate dramatically when driven at certain frequencies is *resonance.* Its potential for destructiveness is also exemplified by the way a sound vibrating can shatter a glass.

In the metaphorical sense, we think of resonance as the power to evoke emotions and memories; the overtones and undertones that accompany communication. Something resonates when it can be amplified – and that of course depends on qualities in the receiver too. Not much has been written by psychoanalysts on resonance, perhaps because it has tended to get subsumed under the more central concept of projective identification. The latter has hugely enriched our understanding of the unconscious communication *beyond words* – even if words remain the primary vehicle. To quote O'Shaughnessy, the patient's *'psychic predicament unfolds in a dual way, divided between words and communications beyond words'*. In her paper 'Words and Working Through' she describes how by using diverse modes of communication – verbal and more primitive – a patient can bring 'his unevenly developed personality into analysis'. He can use words not as words to express meaning, but along with other non-verbal aspects 'to engender projections into the analyst'.

So is resonance just a part of projective identification? Bion seemed to be describing resonance when he said *'I was listening to the silence; I was listening to the*

interference; I was listening to what came between him and me' (Bion 1975). He obviously had in mind the transference here – but I think he was also talking about a conscious use of his body and mind as a tuning fork to amplify those moments when he was resonating with the patient and to be aware when this was being impeded.

My brief quotation in the title from TS Eliot's *Ash Wednesday* conveys something of the subject matter for this paper, and is also a demonstration of what good poetry possesses – and what the patient at the centre of this paper lacks – the capacity to resonate deeply and meaningfully with the listener; to spontaneously evoke feelings and rich associations. *'Genuine poetry can communicate before it is understood*' wrote Eliot – the words touch something in us without us necessarily knowing what or why. Moreover, there is something transcending in the experience: *'The abstract conception of private experience, at its greatest intensity becoming universal'*. Being moved in this way implies being aware of a physical disturbance – a departure from a position of stillness; the amplification of a vibration. As analysts, we know that to be aware of such movement, we must make ourselves receptive, setting aside preconceived ideas about what is coming our way.

So to come to the focus of this paper: What is going on when instead of feeling *something* in response to a patient, one finds oneself feeling *nothing*? I describe how I was alerted to what was happening between the patient and myself by a lack of resonance in my conscious counter transference and how this was the first indication I had of her split and fragmented functioning. I describe how her rapidly shifting identifications arising through the operation of an omnipotent phantasy, made it difficult for me to keep up with where or who or even with whom the patient was. As someone who finds 'safety' from a world that terrifies her by getting inside and 'becoming' her analyst, her comments often seemed to emanate from the position of 'being' me. But this state of affairs would change rapidly, as she moved in and out of different identifications with different internal objects and parts of herself.

Patient J appears to associate freely to her thoughts and feelings without apparent censorship, giving an impression of normality and the appearance of wanting to understand her self through words. But her functioning is highly abnormal in certain ways. Dominated by a paranoid relationship with a hostile world, ordinary observations, scenarios and words are imbued with bizarre idiosyncratic meanings. Because J's disturbance is not grossly evident, there is a risk of treating her communications conventionally, as though they belong to a more constant underlying state. Whilst the delusional nature can sometimes be seen in the concreteness of her associations, more often, it is the pervasive *absence of resonance* to her words that can alert me.

An example of this lack of resonance occurred one day when the patient described an extreme sense of danger. I felt quite unaffected as I listened to her telling me about an encounter with a man. As she spoke of her terror of all men, I was aware only of feeling very little – mildly perplexed and detached. Her words were not touching me at any level to which I could meaningfully respond. Some weeks later,

she recalled this vignette again, mentioning the man's words from before. He had said 'you're worried that I'll hold it against you if it ever comes up'. At this point it became clear that she had taken this quite concretely to mean that he believed she felt threatened by him getting aroused and then assaulting her. I came to see that I too had been responding concretely to her account; too preoccupied by the reality of the material and thus oblivious to the underlying anxiety of a paranoid nature. Until we could start to understand some of the elements of her phantasy (the highly condensed sexual and paranoid meanings this contained) her associations about the encounter were perplexing and dull – whilst these phantasy elements remained split off somewhere and lost to us both. Patient J is not psychotic in psychiatric terms, but she reverts to primitive mechanisms that we are familiar with seeing in more psychotic patients. I don't think that her concreteness and its impact on me was fundamentally different to that of another patient – a schizophrenic man – and the striking impact he had on the staff caring for him. This deluded patient expressed great relief that he no longer had anything to fear, because *'help is on hand'*. With this, he lifted his sleeve to show the words 'HELP' scratched onto his hand. The ward staff, responding concretely themselves, saw what he had done as a sign that the patient was now asking for help, rather than recognising that this was not a symbolic communication but had arisen out of his omnipotent belief that he could concretely conjure up the help he needed for himself. In interpreting the patient's behaviour as a 'sign' they were forgetting that they were dealing with a schizophrenic.

In her discussion of my earlier paper on this subject, Priscilla Roth suggested that what is experienced as an *absence* of resonance, a negative, is in fact the potent projection of something present. What J mostly projects, is her experience of confusion and doubt; doubt about what things mean, about what is real and what is not. Faced with such a patient, instead of recognizing that one's mind has been taken over, there is a wish to make things make sense - for our own defensive reasons. The trouble is that this puts us in danger of *creating* rather than analysing the patient; supporting defences and nourishing a false ego. When Bion tells us to *'put down our precocious comprehension'* he is warning us against false knowledge. In the face of relentless projection of uncertainty and doubt, patient and analyst can defensively become *possessed by* an idea rather than *possessing* an idea or knowledge. Unless we are vigilant as to how we can be affected in ways that interfere with our own symbolic functioning, we can end up in a collusion with the patient in which both patient and analyst become dominated by concrete thinking. If we take the patient too literally, we respond at the wrong level and the patient's deeper predicament is missed. In this way, communication through projective identification comes to dominate both patient and analyst.

When I last presented her, there were many interesting but also contradictory responses to this patient. Why, if she was so concrete, could she produce dreams rich in symbolism? Was the psychotic disturbance really hers or did it belong to her object? I have come to see that this way in which she evades capture and definition is one of her defining characteristics; her rapid movements from one register to another reflecting both the fluidity of her identifications as well as the operation of

an omnipotent phantasy, leading the analyst to struggle constantly to remain tuned in to the right register. More recently, it has become clear that she moves between parts of herself that could be variously described as psychotic, neurotic or even hysterical; so that gauging the level of psychopathology at any given time, is very difficult.

I focus in this paper on the challenges posed by the patient's pervasive use of omnipotent functioning and the impact this has on the analyst's mind. In the analysis, she is unable to allow for an amplification of meaning between us, fearing the shattering impact of a deeply resonant contact if the multiple levels of her experience are registered. Instead, she 'breaks step' with me, leaving us with a thin verbal connection. I suggest that the origins of this functioning lies in the overwhelming nature of both persecutory and depressive anxieties associated with her premature exposure to experiences in her environment that could not be made sense of or psychically bound.

For Bion, it is not thinking that gives rise to thoughts, but thoughts (or rather *unthought* thoughts) that require an apparatus for thinking them. Raw experiences need to be transformed into meaningful experience – or *alpha elements*. Dreaming, in this sense, is an equivalent of unconscious phantasy and is central to this process of making meaning. It is a product of alpha function - a continuous activity that we are aware of only at certain times. The dream enables us to 'continue uninterruptedly to be awake', that is, awake to what we are doing in the external world but asleep to elements which if they could penetrate the barrier of the dream, would lead to domination of the mind by ideas and emotions that should remain unconscious. The dream makes a *barrier* against mental phenomena that might otherwise overwhelm our awareness of what we are *actually* doing and also makes it impossible for our awareness of what we are actually doing to overwhelm our unconscious phantasies. According to Bion, 'The psychotic's attempt to discriminate one from the other leads to rational thought characterized by a particular lack of *resonance*'. As with my patient J, there are to quote Bion, 'no overtones or undertones', leading the listener to feel 'so what?' In analysis, such patients have little or no capacity to evoke a train of thoughts in the listener – in other words, *we find we cannot free associate to what the patient tells us*.

There were other aspects of J's communications that, when I could notice them, alerted me to her disturbance. She often spoke loudly and with great speed, jumping from one vignette to another, ostensibly to make an emphatic point; demanding little but my physical presence. At times, I felt nothing much, but on other occasions the absence of resonance in me would be replaced by something more obviously troubling: a maddening sensation of movement and a giddiness in me as she lodged herself first in one encounter then another. At these times, my stance was more one of 'attending in suspense' than Freud's 'evenly suspended attention'. Moreover, her associations and my responses rarely deepened my knowledge of her.

Gradually, I came to see that J's unconscious aim was to maintain an illusion – one in which she never need feel separate from her object. This would be exposed in bitter

moments of painful disillusionment: 'I thought by now we would be much closer than this' she said after a year – 'best friends *at least'*. The closeness she described was no ordinary closeness, but belonged to a phantasy of being able to move rapidly in or out of her object's mind and spoke to her frustration when in more sane moments, she found she could not. More commonly, becoming me and speaking as I might, she could sometimes convince me of her therapeutic insights – even her apparent awareness of her wish to be in an exclusive relationship. Her comments might then stimulate spontaneous associations in my mind, providing fuel for interpretations that could make us both feel that we are on the right wavelength and in touch. The trouble is that I'm under the illusion at these times that the patient can think symbolically. She on the other hand is where she feels she needs to be - of 'one mind' and 'on the same level'. But we are on *different* levels - and in the end, such interactions lead to a feeling in the countertransference of unreality.

The significance in J's history of a psychotically depressed mother to whom she was denied access emotionally and physically, raises questions about the origins of this omnipotent phantasy of being able to gain entry to her object's mind at any time. J's early experiences may have reinforced a mechanism that she felt was necessary for survival and that came to dominate her functioning. J and her brothers lived in their Scandinavian ancestral mansion with their parents and several nannies. Her mother, deluded and frankly psychotic for months at a time, remained un-medicated in the remote community in which the family lived. These crises were managed by the father incarcerating the mother in a locked room in the house, out of sight. She's been told that during these times she was *'well looked after, always in someone's arms'* and *'never put down'* but passed around constantly from nanny to nanny. Early on in the analysis, J (where J stands for Jump) behaved as if there were no locked doors between our minds allowing her to jump or move seamlessly from one association to another *'always in someone's arms'*. This omnipotent phantasy defended her from her anxiety that she might be unable to get through to me. But her rapid jumping from one object to another left me unable to get through to her. In this way, it was me who became the giddy confused child, constantly moved around and locked out of reach from her mother. I think that J's omnipotent strategies became an attempt to hold herself together as well as to triumph over her dependent self that felt so kept out of her mother's mind. Nothing is ever still for J – in her words, she has to *'try to stay ahead'*: ahead of the unrelentingly unreliable quality that is reality for her and that pervades everything.

Through detailed clinical material that cannot be published here, I describe the pervasive way in which this functioning dominates the sessions and my own struggle to register and understand the primitive object relationship that the patient is projecting. At times, this seems to involve a phantasy that she and I never need feel separate, but this changes constantly as she struggles to maintain her equilibrium. Whilst at times this process is more obvious, at others, it is difficult to recognise except by its impact on my mind - impeding my capacity to function more normally and freely. Sometimes this functioning can even masquerade as progress, patient

and analyst caught in the illusion, but later this gives way, and then we see more clearly the confusion she has been defending herself against.

Michael Feldman has described the way in which a patient's projection may fail to be noticed by the analyst if it is congruent with a version with which the analyst is reasonably comfortable. He suggests there might be an unconscious convergence of the patient's and the analyst's defensive needs that serves to reassure both. I provide an example of how at times, I can feel comfortable enough with a particular version of myself being projected – but more importantly, how I am resisting being in touch with the disturbing nature of my patient's projection and her deeper predicament – the doubt and confusion she feels about everything – her incomprehension and fear. Michael goes on to describe *'a complex relation between the projection into an object in phantasy…and what happens as soon as the patient and analyst encounter one another… quite subtle, non-omnipotent interactions begin to take place…'* I found this helpful in understanding why at times my patient can't look at me; something in her that can appreciate reality, anticipates that this will disturb her; confronting her with the discrepancy between her phantasised archaic object relationship with me and who we actually are to one another. Who we *actually are* of course, is not some realistic version of our relationship, but one that is instantly transformed into a disturbing relationship with a bad absent object, a persecutor; some version of her disturbed and disturbing relationship with her mother who she has to shut out with her eyes and her ears.

This is how J deals with experiences that feel unmanageable to her. If it's real, it's attacked. Her ego isn't strong enough yet to bear her depressive anxieties and restore things realistically. Instead, her fragmented reality is put together in bizarre ways. Bion observed that the psychotic has two problems to solve: the neurotic problem of resolution of conflicts, and the psychotic one - repair of the ego. My patient behaves as if her primary problem is neurotic. In going along with this, I become 'numb' to her reality and fail to resonate responsively. My difficulty in facing my own depressive reality - that J can leave me feeling helpless and inadequate - is also why I can't know this in the moment.

Through the clinical material, I try to show how overwhelmed J becomes when she is unable to stop the unconscious contents of her mind from permeating everything around her. Everything becomes saturated with meaning. In this state, nothing can be discarded because everything is attached to everything else; associations that her ego can't hold - all connected to her disturbing primary object. She can no longer differentiate between her waking conscious activity of being with me, her analyst, and the inexhaustible resonances this activity holds for her: It's all a sign of something – my will, my intention and nothing stays in its place. All those elements that should remain unconscious and on the other side of the 'dream barrier' in Bion's terms, are now overwhelming her awareness of what she is *actually doing*. Bion suggested that it was 'the psychotic's attempt to discriminate one from the other [that] leads to rational thought characterized by a particular lack of *resonance*'.

I think that it is the fragility of J's 'dream barrier' that demands in its place an omnipotent solution.

It is precisely these unconscious elements that, when operating from the other side of the dream barrier, ordinarily lend depth to our communications; the stuff to which we resonate. Recently, Cathy Bronstein has suggested that it is the projection of what she calls 'early embodied phantasies' that give rise to emotionally evocative contact. I would say, words *'resound'* when they are imbued with this richness. These phantasies are intimately connected to the body and to unprocessed emotion and often impact upon us in a physical way. Cathy suggests that even if early unconscious phantasies get modified in a symbolic way they don't disappear as symbolic development occurs, but continue to operate alongside and independently of words – contributing to the duality in communication, as well as being responsible for pathological developments.

Roth and Sodre vividly describe the state of imminent catastrophe that can take patients over when they are faced by a premature confrontation with both overwhelming depressive anxieties as well as persecutory ones. They refer to Klein's patient Dick, who was unable to invest his objects with symbolic significance, but who like the patients they describe, was struggling with 'too much meaning'. I believe that J too, was prematurely exposed to things she could see and hear, but not yet comprehend: perceptions involving psychotic unhappy parents, conflicts and separations. J, 'breaks step' with me in an attempt to evade contact with these unmanageable depressive anxieties. Much of the time, I fail to register the extent of her predicament. I fail because she can't allow things to resonate with me for fear of cracking the bridge – but also because my mind has been taken over. We are in a collusive claustrum together, one that shields her from the projected impact of what she can't bear – the symbolic implications of what have been projected: what it is to be confused, uncertain of anything and dangerously outside, alone on the street with everything meaning everything.

Bion was the first to suggest in his 'Experiences in Groups', (1961) that we might become aware of when we have been taken over by a patient's unconscious communications through 'the distinct quality' to the countertransference which he believed should enable us to differentiate when we are at the receiving end of a projective identification from when we are not. He said 'the analyst feels he is being manipulated so as to be playing a part, no matter how difficult to recognize, in somebody else's phantasy'. However he also refers to how we can easily lose this insight; we are aware of strong feelings, but these seem 'justified by the objective situation' without needing to look for a hidden meaning. What is essential he says is *'the ability to shake oneself out of the numbing feeling of reality'* (1961) that accompanies this state – to avoid becoming numb to the psychic reality of the transference. I found this account of Bion's profoundly helpful in accounting for my great difficulty with J, where there is something like a pull to take her words far too much at face value and neglect the pervasive way in which her omnipotent phantasies dominate our interactions.

John Steiner has suggested that for potent projective identification to occur, abstract symbolic elements must first be transformed back into a concrete form. Without such conversion, they can't be evacuated as they remain attached in the mind to memories, thoughts and other resonances. I think this is helpful in shedding light on the contradictory impressions one can have about J, who clearly is capable at times of symbolic thought but who also spectacularly loses this capacity. John suggests that a reversal of symbolic capacity might also go on in the analyst especially if he finds himself unable to tolerate the symbolic implications of what has been projected into him. This helps us to understand why it is so difficult *'to shake oneself out of the numbing feeling of reality'* (Bion). Something of the patient's communication is hard for us to bear too. I think this might be particularly the case when the patient is less obviously disturbed. The utterances of the floridly psychotic are strewn with obvious idiosyncrasies. J however, is not so disturbed that she can't mostly conceal the concreteness of her thinking, even if her sentences are peppered with oddities. It is only when we can recover our own symbolic functioning that we stand a chance of being alert to the whole of the patient's communication, verbal, non-verbal, symbolic and concrete, and can start to resonate responsively. We can see in the clinical material that I found myself going along with the patient's phantasy that she and I were gainfully employed in analytic work. I was unable to recognise that my mind had been taken over. My struggle must have included an unwillingness to face my own depressive anxieties – my inability to repair my severely ill patient.

But as I become more able to recognise and tolerate this sort of experience, reality also starts to intervene for J. Occasionally I become someone who can 'see her and hear her' – a real me who, takes in both her words and her projections – the contradictory dual communication. Registering this with her becomes too much for her. When for example, I tell her she has thrown doubt on the previous day's session, I think she hears this as me showing her the damage she does with her projections - the horrible, scrambling doubt that harms my mind and leaves her with a damaged analyst (the mother who *didn't know what to do with her*). She sees me finally but briefly, as separate from her, and the ensuing loneliness and depressive concern about what she has done to us both, overwhelms her, mobilizing more persecution.

We know from Bion that the ego is never wholly withdrawn from reality. *'Its contact with reality is masked by the dominance of an omnipotent phantasy…'* J, I think, is mostly aware that her withdrawal from reality is an illusion, but she behaves as if her perceptions can be destroyed. In this slow and painful analysis, the hope is that she and I may gradually learn to tolerate the full symbolic import of what we have to bear, rather than defensively becoming possessed by ideas and hopes.

END

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