Psychoanalysis and Analytic Psychotherapy in Japan

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ON DISORDERS

CHAPTER 1

STUDIES ON NARCISSISM IN THE UNITED KINGDOM: ESPECIALLY ON KLEINIAN STUDIES

I would like to present my studies on narcissism in the United Kingdom.

In the United Kingdom, there are few patients who fall into the classification of patients with the American narcissistic personality, and there are many patients with a schizoid personality or borderline personality. The study of narcissism in the United Kingdom developed as a study of the narcissistic organization seen in these patients or psychotic patients. It was the Kleinians, especially H. Rosenfeld, who mainly studied it. I would like to summarize the representative papers by Rosenfeld and then present an actual clinical case of mine.

As for the studies by the British Independent Group in London, there is the study of D. W. Winnicott on the development of normal narcissism under the "holding" situation, and the study of "false self" as its pathology. There are also the studies of M. Balint, that is, criticism on Freud's primary narcissism and the study on basic fault. However, it was Rosenfeld and other Kleinian analysts who most systematically addressed the issue of narcissism. Therefore, this paper will focus on Rosenfeld's research and describe the development of studies on narcissism in the United Kingdom.

Rosenfeld addressed the issue of narcissism in his paper in 1964, "On the Psychopathology of Narcissism: A Clinical Approach". What he focused on was narcissistic transference in therapy and he discussed its dynamics. He examined patients with dispositions of narcissism in general but some of them were considered to be patients with a schizoid personality and some were patients diagnosed with schizophrenia. Probably, within that broad spectrum, patients with narcissistic personality who are studied in the United States were included. In his paper, Rosenfeld considers as follows:

Freud classified his patients, in his paper in 1914, into patients with transference neurosis and patients with narcissistic neurosis, and he included patients with dementia praecox in the latter, which is a group of patients who do not develop transference. They show resistance like a stone wall, do not show interest in the therapist, and are considered incurable.

However, therapists of such severe patients, especially patients with schizophrenia, ignore Freud's distinction between transference neurosis and narcissistic neurosis, and consider that narcissistic neurosis does cause transference and that the transference is primitive. They also state that transference of narcissistic neurosis is truly narcissistic and the analyst and patient's self fuse, or features such as primitive destructiveness and extreme idealization of analysis can be seen.

Rosenfeld points out that such pioneers do not distinguish primary narcissism and secondary narcissism, as Freud distinguished, in narcissistic transference. He also considers that their clinical descriptions on narcissistic transference are satisfactory.

Rosenfeld's own achievement was that he clarified the functioning of the defence mechanism, especially the relation to narcissism in negative therapeutic responses, by scrutinizing the object relationship in such narcissistic transferences. In addition, in contrast to previous researchers who studied narcissism mainly in schizophrenia ―they were British researchers, and some American researchers―, Rosenfeld also studied much milder narcissistic patients including those who were socially successful.

He based his approaches on the Kleinian theory and was critical of Freud's view that primary narcissism was an objectless world and considered that it was in fact a primitive object relationship. He also stated that in such narcissistic object relationship, mainly two defence mechanisms, that is, omnipotence and identification with the object, are active.

Through omnipotence, the mother's breast or the care of the mother, as a part object, is omnipotently incorporated and becomes the babies' own property. Babies omnipotently project a part of their undesired self into the object. Furthermore, through projection/incorporation, the incorporated object and the self identifies and the boundary with the object disappears. Projective identification also causes a highly active movement in which a part of the self enters the object and acquires the good parts of the object.

Rosenfeld believed that such a narcissistic object relationship was in fact a defence against separation from the object. If you become aware of the separation from the object, a sense of dependence on the object occurs, and anxiety is aroused, therefore, a narcissistic object relationship is a defence method to deny the separation itself. To acknowledge that you are dependent on the object means that you recognize your love for the object or the value of the object. If you recognize such things, it means you will accept the separation. Thus, frustration will occur in the end and emotions such as anxiety, pain and aggression arise. Rosenfeld proposed that we adopt such a narcissistic defence mechanism to defend such emotions.

In addition, when a good thing in the object is recognized, envy occurs, which the patient considers unbearable. An omnipotent narcissistic object relationship is a means of eliminating them. If objects are omnipotently possessed, neither envy nor frustration will occur.

Rosenfeld considered that the intensity of persistence of such omnipotent narcissistic object relationship was associated with the intensity of the patient's envy. Envy is a keyword for the Kleinians, and Rosenfeld uses it often —the meaning of envy is the impulse to destroy what is good for oneself. He also focuses on the point where patients immediately exclude their undesirable things from the therapist, depreciate the therapist and use the object like a toilet without showing any compassion at all.

The above basic narcissistic object relationships are clinically expressed in various ways depending on the pathological condition. In extremely severe cases, the defence is obstinate and strongly defends the psychic reality. The patients lock themselves in a narcissistic world and try to exclude all conflicts. The defended anxiety in such cases is paranoic. An amazingly ideal conflict-free object relationship is developed there. Objects used like toilets are also idealized, and patients consider themselves as ideal beings, being loved by everything, and possessing all the good things. All therapeutic interventions that interfere with such state are strongly defended. Rosenfeld described a case patient who developed a typical narcissistic transference without becoming exceedingly psychotic.

Based on his experience with such cases, he found that clinically omnipotent and superior attitudes acted as rigid resistance and described the type of patients called intelligent narcissists who completely refuse to accept the value of the analyst. They take all the interpretations given to them by the therapist as if they were their own understanding and extract the meaning of the interpretations or develop the theory themselves. By doing so, patients maintain their ideal self-image and impede the analysis to develop.

Rosenfeld said that the prognosis of such patients depended on to what degree the patients could acknowledge their relationship with the analyst and that some patients whose degree of narcissism was not so strong and who had a part of self which was oriented to more normal objects could integrate with it.

The following paper was written in 1971 and describes "A Clinical Approach to the Psychoanalytic Theory of the Life and Death Instincts: An Investigation into the Aggressive Aspects of Narcissism", and additionally considers the characteristics of narcissism, especially the destructive aspect. A person of narcissism is a type of person who develops a negative treatment reaction in treatment and causes various problems such as

interrupting the treatment in the middle or showing suicidal behaviour. Rosenfeld gives a deeper consideration on the destructive aspects of such narcissism by referring to Freud's idea of death instinct and Klein's idea of envy.

Rosenfeld believed that Freud did not give a consideration on the relationship between narcissistic withdrawal and "death instinct" even though he had clearly noticed it, and that Freud did not think that the negative treatment responses had anything to do with the narcissistic state although he had considered that it had a relationship with the death instinct. Rosenfeld considered that Klein's study on the "paranoid-schizoid position" contributed most to the study of narcissism. Klein's "paranoid-schizoid position" is well known in Japan, too. Rosenfeld referred to Klein's idea that life and death instincts are distributed in the process where individuals split off the self and the object.

Kleinians often use the words "life and death instinct", or envy, however, this has caused controversy. I, the author, also cannot agree with the idea that it is endogenous. However, what is clinically important is that the Kleinians proposed that envy was a conflict of the two dispositions, aggression and "life instinct" ―a good disposition such as love for the object.

Rosenfeld considered that the sexual aspect of narcissism is related to overestimating and idealizing the self. By doing so, individuals omnipotently incorporate the good objects of the outside world and can feel that everything belongs to themselves and is under their control. On the other hand, in the destructive aspect of narcissism, where self-idealization plays an important role, the omnipotent and destructive part of self is idealized there. As a result, it destroys such things as the dependent good object relationship and the self's desire for the object. It is considered that this is related to the fact that narcissistic individuals are indifferent to the outside world.

Rosenfeld thought that the narcissism of most patients exhibits these two characteristics although the degree varies. In clinical practice, when the sexual aspect of narcissism is dominant, the patient assumes that the good aspect of the external object is his/hers, however, when the omnipotent self-idealization is threatened by transference interpretation, the underlying destructiveness is revealed, and the patient begins to notice his/her envy.

On the contrary, when the destructive aspect is dominant, the envy is more violent, and the patient thinks he/she wants to destroy the analyst and begins to possess a self-destructive impulse. In such cases, the patient feels that he/she would rather die than realize that he/she is dependent on the analyst or try to stop the treatment by disrupting the therapeutic progress or

insight. In addition, the patient ruins his/her own professional life, or develops suicide wishes, suicide attempts, death wishes, idealization of death, or a situation where the patient forgets everything. At this time, the patient's entire self appears to be completely identified with the destructive part of self which is filled with envy. The patient destroys his/her own sexual self and demolishes his/her ability to care for others and his/her love. When this problem is treated well in treatment, behaviours such as compassion for the therapist appears.

However, in some patients, such destructive impulse is permanently ingrained into their entire personality and begins to affect the object relation. The sexual self of such patients is almost inactive, and they remove most of their power to love and care for others. They come to devote themselves to depreciating and becoming disinterested in or punishing the therapist and they become exultantly triumphant about losing objects.

In this way, when the whole self is identified with the part of the destructive narcissistic self, some often become organized. Rosenfeld says this can be compared to something like a gang led by a leader, just like a criminal organization. The purpose of such a systematic defence organization is to maintain the status quo and eliminate the benign self. Receiving help or undergoing change means his/her weakness and the patient cannot stand it. Therefore, the patient strongly resists the treatment. According to Rosenfeld, there is a perverted fusion of "life and death instinct" here, and the patient has turned the aggressive impulse into a kind of pleasure and has fallen into a perverted object relation.

Rosenfeld described the relationship between narcissism and negative treatment responses, the relationship between destructive narcissism and death instinct, and its relationship to treatment impasse, in the third chapter of the book "Impasse and Interpretation", which was published in 1987 after his death. The basic idea is presented in the two papers mentioned above. Another psychoanalyst called Leslie Sohn also studied narcissism, however, the details will be omitted here.

What I would like to add is that the idea that there exists a bad self which overwhelmingly dominates the other good parts of the self, such like a gang, is the core perspective of the present Kleinians. It is an idea called pathological organization which the self is distortedly identified with. Research is actively being conducted to make use of this to understand severe patients, including patients with perversion or addiction, borderline cases, narcissistic patients, and psychotic patients.

Next, I would like to briefly describe one of my own cases. It is a patient who very clearly expressed Rosenfeld's narcissistic defence.

The patient, Ms. A was an unmarried woman in her forties who came to see the therapist twice a week for about two and a half years and her chief complaint was sexual frigidity. She had been dating her boyfriend for about 5 years, but she came to see me with a chief complaint that she did not have any sexual pleasure at all. She was a clerk and the eldest of three siblings.

Her father did not have a regular job and had several part-time jobs such as a parttime teacher. He had a slightly eccentric personality, was selfish, and exploded his emotions with trifle things and her mother was always obedient. Only the patient confronted her father, and the other siblings immediately locked themselves up in their rooms when he had a tantrum. When she was 12 years old, she finally had a huge fight with her father. She said that she thought she won and had not talked with him properly ever since.

According to the patient, her mother was a truly kind passive person who worked and was often not at home for night shifts when the patient was small.

Patient Ms. A was dating Mr. B who was a divorced man some years older than her, when treatment started. Mr. B was very keen on her, but the patient had been dating him for about five years saying she did not know if she really loved him.

There is a characteristic in Ms. A's relationship with Mr. B. She set a condition on him that they will not interfere with each other's lives. Ms. A has several boyfriends and had dates with them every day alternately. She got sexual satisfaction when she sometimes had sexual intercourses with them. However, it just did not work with Mr. B. Even when Mr. B met another woman or his ex-wife, she pretended that she did not care. I only took up episodes, but when I pointed out in the therapeutic situation that Ms. A was actually feeling jealous or lonely about such things, she strongly denied it. After the sessions ended, she would say things like "I have a date with another boyfriend," or allude that she might have a sexual relationship.

When I, the therapist, pointed out that Ms. A was trying to consider that I was just one of those male followers and deny that she was in need of treatment, she would just laugh and refuse to deal with my interpretation. She also said that she had so many boyfriends and that even though she did not have any feelings for them, they desired her, and even if one or two of them left her, it was okay because there would be a next.

When Ms. A told me such things, I gave interpretations such as that, by doing so, she could quickly switch to the next boyfriend no matter whom she broke up with and was trying to avoid the pain of breaking up. I continued that she was denying all her parts which want to rely on people and desire people, and instead projecting those feelings into these boyfriends

and despising them, trying to control her feelings, and have control over her boyfriends. However, Ms. A just listened silently.

In the meantime, Mr. B could not stand it anymore and began to say that he would work in another city as a seasonal worker for a while. Ms. A came to me and lied that Mr. B could go if he wanted to, and that she had plenty more alternative boyfriends. The therapist repeatedly interpreted that the patient actually did not want to lose him and did not want him to go but the feelings of separation were so painful that she was denying them all.

As I repeatedly gave interpretations, Ms. A gradually became aware of her feelings, and at the farewell party, she got dead drunk and clung to Mr. B in tears saying, "Don't go," and made a show of herself. Thereafter, Ms. A came to treatment and blamed the therapist in extreme vexation saying that it was not her intention to play such a blunder, and she was just influenced by the suggestion of the therapist.

When Mr. B actually went to another city, Ms. A started dating another boyfriend from the very day. When she came to the treatment, she said that Mr. B, who had gone away, became a past person in a few days, and that she had forgotten him. Even when the therapist once and again pointed out that that was the way to somehow manage her pain of abandonment anxiety, she gave no clear answer.

Two weeks later, Mr. B contacted Ms. A and told her that he had become ill and was hospitalized in another city and that he wanted to come back to her home town after he got well. Ms. A said to me, "I've forgotten Mr. B and have started a new free life, so it's such a nuisance." When the therapist interpreted that, by doing so, Ms. A was trying to get her revenge on Mr. B, who abandoned her, she just kept silent and listened.

Mr. B came back and took a rest for a while in Ms. A's apartment, but she looked down on him, saying that she was disappointed with him because he was leaning on her and looked weak. However, Mr. B became well aware that he needed her after going to another and asked her to marry him. At that moment, Ms. A thought that she had won, and her spirits lifted. She despised the pitiful Mr. B, and replied, "I don't know if I will." However, she would not break up with him.

The therapist pointed out that the patient was disdainful of her own feeling that desires people, so when she saw it in a person, she despised that person. However, the patient did not answer anything and just listened. The patient showed various different attitudes; she sometimes listened with a serious look, and sometimes with an incredibly scornful look.

What was notable during this period was that Ms. A began to call her mother and return home on weekends. Ms. A never did so until then. She would not go home even on Christmas Eve, but she began to return every

week. She would go home and talk with her mother and siblings. Furthermore, she and her sibling who was in the same city as her started to stay at each other's place. I thought this indicated that although the patient had a narcissistic defence mechanism, on the other hand, her sexual desire to the object was growing.

What I also focused on was that Ms. A, who was from a place far away from the city she lived in, accepted her father to stay at her apartment when he came to her city and asked her if she would let him stay. She had obstinately refused until then. She started talking with her father, too, little by little.

In the meantime, Ms. A began to realize that she could not separate with Mr. B and accepted his proposal. However, she did not make clear when they would get married. She promised that she would marry him after they had found a place to live, and they started looking for a house. This was an incredibly symbolic event which indicated that the patient expressed her intention to share a common world with the object. However, this house-hunting took an awful lot of time. She did not like any of the houses she went and saw. She viewed dozens of houses for more than half a year, however, there was always some point she did not like, so they were having a hard time to get settled.

Ms. A's relationship with Mr. B was still unsteady, and she sometimes dated other boyfriends. In such a situation, Mr. B suggested going on a trip, but at the destination, Ms. A obstinately refused to have sex. Mr. B got angry and did things such as introduce another girlfriend to her. The patient insisted to the therapist, "I don't care about that, I have many other boyfriends." Even when the therapist pointed out that Ms. A was actually angry at Mr. B and was jealous of the woman, she refused to accept.

Then, Ms. A suddenly decided to change her workplace to a small town which took two hours from the city she used to live in. The therapist said it was apparent that she did so to run away from her feelings and protest against Mr. B because she was angry with him and suffered from jealousy, but she would not listen. She thus decided to drive two hours each way, twice a week, to come to me for treatment.

However, once she began to work at her new workplace, Ms. A felt that it did not suit her on the very first day and returned to her former workplace in the previous city she lived in even though she had to pay compensation for the breach of contract. The therapist repeatedly pointed out to her that it was apparent that she did so because she felt that she needed Mr. B but did not want to notice, and would feel jealousy and have a painful experience of being abandoned if she acknowledged her feelings. This made the patient extremely angry with the therapist, and she left the room in the middle of

the session saying that the therapist's words were no help for her, and they were incomprehensible.

Here is another episode: The patient was 45 minutes late because of snow for the first session after the discontinuation of treatment because the therapist took a winter vacation for two weeks. She rushed into the interview room breathlessly. There were only 5 minutes left because the next patient was waiting then. As soon as Ms. A entered the room and met the therapist, she suddenly noticed that she had bothered to endure the traffic jam and come all the way to meet the therapist and made a downright vexatious look. Consciously for her, the therapist was just one of her many men followers, and had been an object that could be replaced any time, however, now that she had come to realize that she needed the therapist, she thought it was extremely vexing.

In such way, Ms. A lived in an omnipotent narcissistic world where she completely denied that she needed the objects and projected her dependency onto the objects. She thought she was loved by all the men around her and they were under her control. Although she would not clearly affirm with words that she directly accepted the importance of the relationship with the therapist, as the therapist interpreted her narcissistic defence mechanism at every opportunity, she began to meet her mother and family.

As I mentioned earlier, this patient came to treatment about twice a week for two years and three months with almost no cancellations. In the meantime, she got another boyfriend —a person who listened especially to her and understood everything— and had long talks with him regularly every week. The therapist interpreted this as a clear representation of a part of a positive transference. Although the patient would just nod and not affirm clearly, I felt she understood. It is considered that the sadomasochistic relationship with her father is clearly related to the formation of such an object relation, and that the fact that the mother who should have satisfied her desire was often absent is also related to it.

In addition, her other various episodes tell that Ms. A was a person who often had traumatic experiences. The defence mechanism she took at that time was probably identification with her father's awfully aggressive attitude to try to deal with her painful experience.

Technically, I concentrated on interpreting the patient's separation experience caused by narcissistic defence consisting of what Rosenfeld described, e.g., omnipotence, projection, introjection, and projective identification, and interpreting the defence against traumatic experiences. Practically, when I felt that the patient was denying things such as the patient's desire for the object, her dependency or her experience when losing the object, I tried to use confrontation.

While I attended her with such an approach, the patient's sexual feeling, in other words, her desire for the object, gradually became stronger, and eventually Ms. A said that she would finally marry her original boyfriend, Mr. B. Around that time, my treatment came to an end.

Note: This paper is a revised version of the presentation record of an Educational Seminar.

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CHAPTER 2

THE MOURNING WORK AND ITS PATHOLOGICAL STATE

1. Introduction

The concept of mourning work was clarified by Freud in a paper entitled "Mourning and Melancholia" (1917) [(2)], and since then it has been considered as the most important developmental emotional experience in the studies of psychoanalysis and developmental psychology. Basic research on it also has greatly progressed as a study of the infant's separation experience from the mother, owing to analysts including Bowlby [(1)] in the United Kingdom and Mahler [(6)] et al. in the United States. Furthermore, along with the development of psychosomatic medicine, the issue of object loss has attracted attention in the study of stress and psychosomatic correlation. In other words, in stress evaluation questionnaires, it has become clear that the experience of object loss, such as loss of a spouse, is one of the items that show the largest stress coefficient. Moreover, object loss and mourning work have come to gain attention from researchers in a wide range of fields [(7), (8)].

Mourning work refers to the entire psychological process in which an individual gradually recovers from the grief associated with the experience of object loss. Loss experience includes many experience worlds in daily life as follows: 1) separation from or bereavement of a close person such as a family member, 2) experience of losing material things such as property, 3) loss of social self-image such as failure of promotion or work, 4) developmentally inevitable loss as a person grows (e.g., independence from parents in adolescence, retirement, death of spouse or oneself due to aging), and 5) loss of physical function or physical self-image, and loss of social self-image, etc. due to illness or handicap. A healthy person can successfully carry out mourning work, and can gradually accept the real world in which he/she has lost his/her object, and eventually start a new life. However, some people are unable to carry out a healthy mourning work, and develop

pathological symptoms such as depression, psychotic conditions, and neurosis as a result of the loss experience [3], [7], [8].

There are many possible factors that determine the course of this mourning work, but generally they include the followings [3]: (1) The value and symbolic meaning of the loss for the individual: The loss can be many things, such as parents, property, or physical function, and there are many kinds of variations in loss experiences. Especially in the case of individuals who have lost their parents, ambivalent relationships with them while they were alive are considered to have a significant impact on mourning work. (2) The age of the individual when he/she had the loss experience: For example, even in the experience of losing a mother, it is natural that the ego's processing ability, semantic experience and other matters are different in the case of infants, adolescents, and adults. In the former two cases, it may leave a significant influence on personality formation and formation of predispositions such as mental illness. (3) Individual personality before the loss experience: This also has a great relation to the individual ego's coping ability for mourning work. (4) Supporting and coping ability of close relatives such as family members. (5) Supporting and accepting ability of medical personnel and society: Various factors are involved, particularly, the issue of social acceptance and rejection of handicaps. Each individual will follow a unique process of mourning work.

2. Case

Here, I would like to report a patient who failed to go through such mourning work and presented pathological conditions, and describe the influence on her mental health. This case patient presented chronic neurotic symptoms triggered by the death of a family member (her father), which is the most typical loss experience.

Patient

The patient was a 28-year-old unmarried woman. She was an aspiring actor and made her living while working as a secretary.

Current medical history and life history

She had continued to have chronic compulsive behaviour since her father died when the patient was 8 years old. For example, the patient had fear that her mother would die if the patient did not blink 8 times at the

moment a car passed by, and had a magical thinking that her father would come back to life if she hit a nearby object multiple times. Furthermore, when she became an adult, she had to make sure that all the bar lock handles in the room were turned up and that they were locked properly. Since she repeated this no matter what kind of sociable situation she went to, social life became difficult and it had an injurious influence on her relationships with people around her.

She had had chronic depression and suicidal ideation since her junior high school days, but said she could not commit suicide when she thought of her mother. The patient hated herself and suffered from inferiority complex, and tended to feel guilty about everything. Since the death of her father, the patient had never felt happy. She suffered from a sense of isolation, and felt that she was wasting her life without anything to live for. The degree of these chronic depressive states changed slightly as the patient grew, however, they did not improve.

Physically, she also had continued to have symptoms including headaches, haemorrhoid, chronic gastritis, and enlarged tonsils for a long time since her father died when she was 8 years old.

At the diagnostic interview, the patient was very particular about death. She described that many people around her had died. The first death was the death of her father when she was 8 years old. After her father died, the patient and her family began to live with her grandparents, who died when the patient was 16 and 20 years old, respectively. When the patient was 24 years old, her paternal aunt, whom she admired, died. This aunt lived in the patient's neighbourhood and she took good care of the patient. In addition, when the patient was 12 years old, her neighbour classmate friend was killed in a plane accident. The patient said those many deaths had devastated her.

The patient has kept on studying although she has been suffering from compulsive behaviour and depression since she was 8 years old. She visited a child psychiatrist at the age of 9 and received outpatient treatment for 3 months. At that time, although she did not get completely better, the degree of obsessive-compulsive symptoms was slightly reduced, so she stopped going to the hospital. In her junior high school days, compulsive behaviour and the depressive state became stronger, but she managed to continue going to school without seeing a psychiatrist. Although she suffered from symptoms and continued to have a lonely high school life, she kept on studying diligently and her school grades were good. She proceeded to the department of English language and literature of a university and achieved excellent grades. She then entered an acting school with the aim of becoming an actor and graduated in three years. In this manner, obsessive-compulsive symptoms and depressive states did not completely suppress the

patient's basic social life, despite they prolonged for a long time and imposed considerable restrictions on her life. However, before she came to my clinic, the above symptoms worsened due to troubles with her boyfriend and isolation among her peer actors, thus the patient herself decided to receive psychoanalytic psychotherapy and came for consultation.

Family members

- Father

He was a company worker and was healthy. He died of acute heart failure during sleep (35 years old) when the patient was 8 years old. The patient said that she was his favourite and she liked him more than she liked her mother. The night before her father suddenly died, the patient did something wrong and was scolded by her mother, and she did not listen to her father even when he told her to, so he did not give her his usual good-night kiss. Her father suddenly died without reconciling with her so it has become a strong guilty feeling for the patient.

- Mother

She was 52 years old. According to the patient, her mother was dominant and self-centred. After her husband's death, she worked as a hairdresser to sustain the household, but she remarried two years later. The mother was dependent on the patient, but on the other hand, she tried to control everything about the patient. The patient also established a dependent relationship with her mother after her father's death and tried to follow her mother's opinion in everything. However, she had hatred and anger against her self-centred and dominant mother. Nevertheless, the patient needed experience of self-exploration with psychotherapy to be clearly aware of this. In other words, before the death of her father, the patient hated her dominant mother and had a strong attachment to her father. However, after the death of her father, the only person the patient could rely on was her mother. According to the patient, the patient cried to and leant on her mother like a baby. At the diagnostic interview, the patient's mind was so preoccupied with the thought that her mother would also die if the patient did not perform a compulsive ritual, she could not realize her hostility against her mother.

- Brother

He was 32 years old. Like the patient, the sudden death of their father had become a major traumatic experience for him. The relationship with his mother had not worked well and he tended to be a rebellious, domestically violent, self-destructive man.

- Father-in-law

He was 54 years old. When the patient was 10 years old, he remarried her mother. His ex-wife died when she gave birth to their younger daughter. When he remarried, the child was 10 months old. The patient was hardly attached to him and their relationship was tenuous.

- Sisters-in-law

They were 28 and 19 years old, respectively. Their relationships with the patient were shallow. As a child, the patient had a stormy relationship with her two sisters-in-law. Her older sister-in-law also suffered from depressive neurotic symptoms.

As described above, the case patient was a patient who had a traumatic loss experience, and had hardly overcome that experience through mourning work. Therefore, she was chronically suffering from pathological obsessive-compulsive symptoms, depressive states, and physical symptoms. In addition, her mother had also failed to achieve mourning work for that loss experience, and had become dependent on the patient. The mother had continued to have an interdependent and integrated relationship with the patient. As a result, the mother could not sympathize with the desperate world of the patient's loss experience. Instead, the patient was forced to take mental care of her mother.

The man whom the mother remarried had just lost his wife. This entire stepfamily tried to use each other to fill in their experiences of object loss, leaving each one unable to carry out mourning work successfully. The patient's brother and older sister-in-law also had neurotic problems.

3. Therapeutic course

In the early stages of treatment, the patient's pathology was clearly manifested in the transference relation and free associations that the patient developed. They clearly indicated that the mourning work for the death of her father had failed. The patient was treated by psychoanalytic therapy 3 times a week, and after 2 years of treatment, the symptoms disappeared and interpersonal relationships improved, so the treatment was terminated.

At the start of treatment, the patient was in an extremely anxious and desperate state. She talked rapidly on and on about the details of the many deaths in addition to her father's death. She often asked if the male therapist would understand and help her with them.

In addition, the patient reported many dreams from the beginning of therapy, most of which were about death. For example, "I became very jealous when my boyfriend was with another woman. The boyfriend died.

My mother was by my side and he came back to life.", "My father-in-law and mother got divorced. My dead father appears and becomes arrogant and takes my mother away. And I am left alone.", and "My birth father is hospitalized for a serious illness, and his whole body is dirty with stool and urine. I sang a song and washed them off with shampoo." In those dreams, there was a world of magical desires where her father was not yet dead in her mind or where she tried to bring him back to life. They expressed that she was still suffering from ambivalent feelings towards her dead father.

She also said that the men she dated kept on leaving her, and repeatedly said that she needed them even though she did not love them. Such object relations with men were repeatedly seen with 2 or 3 men. This also was considered to represent the influence of the ambivalent relationship with the inner representation of her father, who suddenly left her behind. This disposition was clearly demonstrated in the transference to the therapist. That is, once she met the therapist, she became dependent on him, although he was supposed to be an unimportant man for the patient. She worried that the therapist might leave her someday, or the therapist would die during the vacation, and she would be hurt again.

Regarding her mother, the patient kept on crying showing her strong anxiety: "My father and men have left me, but only my mother does not leave me. I hate my mother because she suffocates me, but I absolutely need such a mother." and "I had vaguely realized that I hated my mother because she was dominant, but if I'm not a good girl, I would hurt her and she also might die." At one point, the patient asked her mother on the phone, "What will you do if I marry a non-Jewish man or kill a person?" (The patient was Jewish.) The patient said in tears, "My mother said she would still accept me, so I'm sorry for my mother." This expressed her separation anxiety and how strong her sense of guilt was when she did not follow her mother's intension. In addition, the patient said, "I'm like being connected to my mother by an umbilical cord, and only my mother accepts me. I want to see her. I want to be a baby and disappear in her arms. But I want to be independent, I want to be a person who doesn't need her." She poured out an extremely ambivalent disposition against her mother, which was originally related to her father's death.

Such stories were also linked to the transference relationship with the therapist. For example, when separation with the therapist became a problem because there were no treatment sessions for a while due to vacation, the patient would cry intensely remembering the scene where she saw her mother off at the station when her mother had to go to another city for hair dressing training 2 weeks after her father's death. She said, "I need my mother. I want to be a baby and go back into her womb. But I don't want

to rely on my completely controlling mother. I have to be independent." The patient also developed this ambivalent relationship with the therapist. The patient did not bring a watch. She hated being told the treatment time, and disliked leaving the room. Then again, the patient came to complain that the therapist's room was like a prison, and that if she was locked in once, she would not be able to leave the room. There was something common to the relationship with her mother. In regard to this, the therapist pointed out to the patient that, in the back of her mind, she was experiencing the ambivalence of the same quality as the feelings for her mother in the separation from the therapist during the vacation. The patient denied, but it seemed she did so because she would recall her painful emotions if she became aware of the ambivalence. The patient disliked hearing the therapist's interpretations and sometimes rejected them angrily, but her subsequent associations showed that such interventions were correct.

The patient could not share her loss experience with her mother, but instead took care of her mother. She became a good girl, and sacrificed herself to repair her mother's apparently unsuccessful loss experience. Instead, she continued long to be in a state where she relieved her anxiety of isolation by clinging on to her mother. This was a form of "false self". Mourning work on the death of the patient's father seemed to have never been completed between the two of them.

4. Consideration

In this way, the pathology caused by the failure of mourning work for the sudden death of the patient's father was clearly demonstrated in the early treatment associations and transference relationship. The patient still possessed a living father in her mind; the father was not dead in the patient's unconsciousness. The patient had tried to deny the reality of her father's death for nearly 20 years. The mother also had hardly completed mourning work, and she had not been able to assist the patient's mourning work. The patient had made efforts to somehow cope with the experience of her father's sudden death by having a symbiotic relationship with such mother. There was no sympathy that promoted each other's mourning work, and they had been supporting each other in a way that rejected it. The mother's remarriage to a man who had just lost his wife may have further strengthened this.

As can be clearly seen in the transference, for the patient, men were existences that abandoned her and disappeared, and existences that died when she depended on them. On the other hand, although women did not resolve the patient's suffering of death separation, they were objects who survived, whom the patient could depend on. Especially, her mother was the

only object of dependency who protected the patient from isolation. Such patient tried to avoid separating from her mother even by sacrificing her self. However, when she was near by her mother, the patient felt suffocated and her hatred being dominated by her mother enhanced. Nevertheless, if the patient departed from her mother, the patient was unable to deal with the problem of her father's death and her lonely world where she was isolated from her mother. One of the methods the patient adopted was to throw herself, who sought for an object that would heal her, into her mother through the mechanism of projective identification, and handle herself by taking care of her mother.

Freud [(2)] studied the disposition where individuals tried to solve such psychology of object loss by introjecting the lost parents (external objects) into their minds, identifying with them, and becoming like the lost persons. Klein [(4), (5)] established a theory that focused on the object relation between the internal "good object" and "bad object" based on the concept of the "depressive position". When individuals lose a family member or the like, they lose not only an external object but also an internal object. For example, if a father dies suddenly, the individual loses not only the external father but also the internal father. At this point, when the ambivalence between hatred and affection in the previous relation with the lost object was strong, the negative feelings of being left behind are intense and it will take time to restore the lost object as a good object. Furthermore, the individual cannot utilize external assistance well, and he/she will not be able to carry out mourning work successfully.

Furthermore, in a case where the experience is too traumatic, even if the relationship with the lost object had been relatively good, if external assistance is not appropriate, the ego cannot complete mourning work, thus, cannot recover the lost good internal object. Especially when the individual is a child, such as the case patient, appropriate support and understanding from the surrounding people such as the mother are important factors for successful mourning work. In that respect, the coping ability of the subject, such as the age of the individual when he/she had the experience of object loss, and the environmental conditions are also major factors for mourning work to succeed.

In the case of this patient, the relationship with her lost father was relatively favourable, but the child's ego did not have enough capability to complete mourning work. In addition, it must have been difficult for the mother to assist the patient's mourning work in situations where the patient-mother relationship was ambivalent and the mother herself had not successfully overcome mourning work for the loss experience of her husband's death.

5. Conclusion

As a specific case of mourning work pathology, I introduced and added consideration on a case patient who continued to have compulsive behaviour, depression, and physical symptoms for a long period of 20 years because her father died of heart failure during sleep when the patient was 8 years old. I also showed that the symbiotic relationship with the remaining mother further prevented the mourning work, and that the pathology of object loss was clearly expressed in the therapeutic relationship. I further introduced the studies of Freud and Klein on object loss and the mourning work.

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CHAPTER 3

ON THE FORMATION OF THE BODY IMAGES IN PSYCHOSIS: IN KLEINIAN THOUGHTS

1. Introduction

When we recognize others, we cannot capture them without their body images, especially their facial expressions which are a special part of the body. The existence of the body is the basis of an individual, however, on the other hand, we intuitively understand and face that other people have a mind inside their body. Moreover, we cannot think about our self without our physical presence, and we also intuitively grasp that our mind exists somewhere inside that body. Although it is considered that this is already functioning in infants and children, there are still many unknown parts about the generation process.

Some psychotic patients exhibit phenomena where they feel that their mind exists outside the body, or feel that there are souls which do not have a body, and there are a group of patients whose body images themselves are considered mentally ill such as patients with hypochondria and psychosomatic disorders. In order to understand such people, it is important to understand how the body self-image and the object image are generated. However, at the present stage, it is difficult to say that this theme is sufficiently studied.

Originally in psychoanalysis, body-centred drive theory, anxiety generation theory and object relation theory have been developed and the body plays an important role, however, it is difficult to say that its mental function and the problem of the body self have been clarified. S. Freud developed the instinct theory which aims to satisfy the instinctive pleasures of the maturity of the body and openings of the body in a developmental theory based on drive theory.

Some researchers such as P. Schilder and E. Bick consider that physical contact when the mother takes care of the baby greatly influences the formation of the baby's body self, and pay attention to the existence of skin as the boundary between the inside and outside of self. Furthermore, the

Kleinian concept of phantasy activities related to the inside of the body has a potential to make an important contribution in the study of body image formation. Although psychoanalysts including M. Klein do not actively take up the problem of the body image of self, they consider that part object phantasies and the whole object image in the integration of them as something that can be grasped physically, and have made many highly suggestive references.

2. Klein's study on body phantasy

Klein explained the early object relation with the concepts of paranoid-schizoid position and depressive position. In "Psychoanalysis of Children", all the states of activity of early object relation are described as exchanges between the object body and the self body. The overview is summarized in the abstract of the academic conference so it will be omitted here. The activities of early object relation, which occur in the pre-verbal world, are complex activities of the internal world, which are experienced as activities of phantasy. It is a world of concrete phantasy, and a world where object representation and abstract thinking are not fully developed yet. In infants and children, it is often difficult to distinguish phantasies from external reality. The babies' world of internal phantasy is also considered to be almost equivalent to the actual experience. In any case, it is exceedingly difficult to capture what the mental activity of this period is like. The activity of the children's phantasies differs from adults' fantasy and imagination activities and they are the basic materials which form the core of the self and the objects themselves. It is considered that sensory impressions such as visual sensory impression, auditory sensory impression and tactile sensory impression of the body play a big role in this. In the phantasy activity, the world of concrete exchanges between the partial body-others and body-self is active there. The worlds of others-body and self-body are gradually constructed, and the self fits into the body. Then a self which can examine the reality that others exist outside the skin and inside the others-body is established.

An integrated self-body image will come into existence at the time when the integrating stages develop after the depressive position, similarly to the formation of the others-body image.

In Klein's research, although the object's body phantasy is described in details, the infants' and children's own self-body phantasies and the phantasies inside their bodies are only mentioned briefly. From the subject side of infants and children, it seems relatively easy to grasp the mother's body object with senses such as visual, auditory, tactile, and gustatory

senses in early object relations. In addition, babies can see their mother's expressions and body. However, babies cannot see their own expression and it is difficult for them to directly see their entire body. Spontaneously, infants gradually discover a part of their body sensation through actions such as finger sucking. Experiences of hunger, satisfaction, pain, pleasure, discomfort of wet diapers, pleasure and pain of defecation become the grounds of the inner body sensation. Skin sensation will be important to distinguish the inside and the outside of their body. It is something that is experienced through physical contact including cuddling by the mother's hands and arms in the care by the mother. Compared to the object's body image, the self body image of infants and children is something quite ambiguous which is formed while being largely influenced by emotions and drives. Actually, even for us adults, it is quite difficult to call up the body image of our own. As for their own body phantasies, infants are strongly influenced by their experiences with the objects and the phantasies of them. Many are formed through the reflection experiences with the objects and will be influenced by extremely subjective and emotional experiences. The bias of cathexis for the self body parts are greater compared to that for the object body image. In any case, as the object body phantasies are integrated, the subjective self-body phantasies associated with them will also be integrated. In this process, as described by Bick, the skin of self is thought to play an important role in distinguishing the inside from the outside. On the other hand, Klein and other psychoanalysts assume that the inside and the outside in part object relation exist from immediately after birth, and consider that splitting, projective identification and introjective identification occur from the beginning.

3. Bion's semiotic ontology and Bick's skin boundary theory

While considering the development and the formation process of psychotic and non-psychotic parts of personality, Bion tried to explain sense impressions, alpha-function, beta-elements, bizarre object, fragmentation, projective identification, and splitting with symbols such as L, H, and K. All of these are something that symbolize and conceptualize the states of various activities, mainly the functional aspect, such as projection and introjection of physical phantasies, in the process where part objects are integrated into whole objects. However, he focused on the formation of their mental function part and made a consideration on the process where thoughts, concepts, symbolization, and memories developed. Although he has not made much consideration on the body-self, he considered their

actual mental activities as extremely physical part object or whole object phantasies.

Bick, who was strongly influenced by Bion, thought that the skin played an important role in differentiating the inside from the outside of self, as described above. Most of the care by the mother including lactation, cuddling, and dipper changing are conducted mainly through the skin sensation. This becomes the important sensation where the inside of the self and the inside of the body, and the outside of the body and what are not the self are distinguished around the border of the skin. Then, the babies introject the skin, which can be contained first, from the object. According to Bick, babies identify the firstly-introjected primary object with their skin, and thereby distinguish the outside from the inside. It is considered that babies then hold space within their body, keep what they introjected, and make it as the core of their self. This means the containing function of the primary object (the mother) is important. If this does not work well, it is considered that a defensive secondary skin is formed, and the problem of the world of autism which has no internal space is presented. The problem of psychogenic psychosomatic disorder may also lie in here.

As described above, Bick considered that the premise for conducting introjection from the object is established by the formation of an inner space in the self. Then, through the exchange where babies introject good objects into the skin self, and project and exclude the bad object world outside the skin body boundary, they form a steady world of self and objects.

4. Case Report — A male patient who expressed his body-self by drawing

I would like to present a case where a male patient who has suffered a psychotic breakdown depicted his self-image in his recovery process. Furthermore, I would like to show that the body-self is oddly distorted in the pathological condition of the paranoid/schizoid position. It is considered that the unresolved areas will be further elucidated by observing as many body images of patients with such psychotic problems as possible, and further accumulating early observation data of severe patients in infantile observation and psychoanalysis of children.

Case

The patient was a man in his 20s. His chief complaints were "My withdrawal has prolonged," "My soul will crush," "My words do not work," and "People's gazes make me feel uneasy."