

ASSIMILATION IN ART AND IN PSYCHOTHERAPY

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Bion (1962) depicts the problem of the borderline or psychotic patient as involving an inability to learn from experience. By that Bion means that the psychotic either "swallows" experiences whole without digesting or assimilating them or spews them out via projective identification. Assimilation links an experience to memory and is reflected in the ability to think. The inability to think manifests as a lack of curiosity and Bion seems to imply that the only course open to the analyst is to interpret this lack of curiosity. What I propose to do in this paper is to re-examine assimilation and offer a therapeutic alternative. My interest in the issue stems from my attempt to understand "thinking" and the creative process of the artist, especially as it relates to creative blocks (Safán-Gerard 1978).

What is assimilation? What is the difference between an experience that is not assimilated and one that is? For assimilation to occur, we need to experience full contact with the matter at hand, one in which we open up to the possibility of being in some way transformed by such contact. In instances where assimilation is not occurring, the experience is one of impasse, dead-end, block. Patients declare themselves con-

fused, unable to see, hear, understand, think straight, think at all. Artists declare themselves lost, drained, stuck, blocked. Usually the therapist notices that his interventions do not lead anywhere and he feels the impasse. The question immediately arises, who is blocked, the patient or the therapist?

I will first present Bion's view of how we learn from experience. I will then illustrate his ideas with an imagery sequence of one of my patients. Following this, I will be comparing the experience of the artist at work with that of the therapist when the patient fails to learn from experience. Lastly, I will recount excerpts of three therapy sessions which suggest alternative ways of helping the patient to assimilate an experience.

Alpha and Beta Elements

In his book, Learning From Experience, Bion developed a model to explain the inability to develop thoughts out of experience. According to him, the translation of sensory input into a thought requires a function that is not developed in the psychotic or borderline patient. "Alpha" elements are those sensations, impressions, emotions, that the patient becomes aware of through what Bion calls "alpha function."

If, for some reason, the alpha function is not present or is disturbed, the sense impressions that the person experiences remain whole and unchanged. They are not experienced as phenomena but as things in themselves that the person needs to get rid of. Bion calls these undigested elements, "beta." They are suited for projective identification, for acting-out, and cannot become part of dreams or thoughts. Through the alpha function, alpha elements become suitable for storage, to be used in dreams, as well as in conscious thinking and creating.

How is alpha function developed in the child? According to Klein (1921) experiences and emotions are first perceived as though whole or part objects were inside of us. The absence of a good object may be incorporated and perceived as the presence of a bad object. For Bion (1962), beta elements become alpha elements through successive projection and introjection carried out through a mother in a state of reverie. This receptive, non-anxious mother allows the infant to display negative emotions and responses without attributing a personal meaning to them. An anxious mother is unable to see the infant as a separate entity with feelings of his own. When the infant's emotions are interpreted by the mother as a statement about her, the emotions are not taken in and transformed by her. The infant cries and the mother reads: "I am not a good mother," or "My baby doesn't love me." On the

other hand, through the existence of the "good enough mother" (Winnicott, 1965), the objects or beta elements are projected by the infant onto her and brought back inside transformed, which creates in the infant a sense of development and growth. The mother, either directly or indirectly, conveys to the infant the message that his feelings are not so bad and, better yet, that she is not being destroyed by his feelings. The introjected elements become alpha elements, ready for storage and suitable now for building an accumulated experience from which the infant can learn.

In working with psychotic patients, Bion (1957) discovered that they engage in projective identification with a vengeance as a way of making up for an experience they had been cheated of as infants. As with the mother, the patient uses the analyst in a state of reverie to project and introject beta elements, transform them and assimilate them. What is the role of the therapist doing psychoanalytic psychotherapy with borderline patients? Is there another way, short of a complete analysis, to help the patient restore alpha function than by having the therapist accept and transform the projections of the patient? I will attempt to answer this question later in the paper. We need to explore further the meaning of Bion's alpha function.

Following his analogy with digestion, I read Bion to mean that alpha function involves a breaking up of the sensory

input into elements or single particles so that they can later be combined with each other in unusual ways, and attach themselves or link with earlier memories to constitute new thoughts, new ideas. His distinction is useful clinically. When a patient is able to free associate in a way such that he is not only "reporting," but thinking and being curious about the reasons for his associations, he is utilizing alpha elements and is exercising alpha function. When, on the other hand, the patient seems unable to understand what is happening when he is in despair and looks at the therapist for rescue or, through projective identification, sees his feelings coming at him from the therapist, we are in the presence of a beta element. The characteristics of what I would like to call "the beta experience" are very similar to the one the artist has when confronted with an accidental happening in the work: he fails to comprehend how it happened; there is a certain amount of distress as to how to deal with it; he would like to be rescued from the situation and may blame someone or something for it. The beta experience can be thought of as a case of mental indigestion: one has been invaded by a bad object that cannot be moved upward or downward and cannot be broken up into digestible parts.

A writer I have been seeing in therapy for a year recently described a situation that reveals some of the issues involved in assimilation as I understand them. He was com-

plaining that the recent successes he had had with his work and the praise he is now receiving, was only bathing him on the outside, rather than getting inside him and giving him security. He claimed that he still had some remnants of self-doubt and wished he could get rid of that doubt and internalize the praise. In object relation terms, the self-doubt seems to be the experience of the absence of a good object -- security, the good breast -- which had become a bad object inside of him. His description was too abstract and seemed to lack the emotional component of the wish for self-nourishment he was talking about. I asked him to close his eyes and try to visualize the self-doubt inside of him which he described as "an oversized deformed baseball, grey, polluted, with hairs. It is located behind the lungs and is attached to my back with some tissue. It is like an obstacle I cannot get rid of and it does not let me breathe freely." I asked him to imagine that he had a magic wand and could create anything to transform this object in some way. He then imagined an apple corer that he was putting through this object, cutting it in many pieces. "It feels good to have the cut up pieces, they are just floating there loose and air is coming in finally."

He reported feeling very good about the image, and no longer had the need to get rid of the object. I reminded him of what he had said earlier about his inability to bring the

praise inside and suggested he use the magic wand to do that. After a while, he said he saw the praise coming in as a thick yellow liquid and, smiling, added, "not quite like chicken soup." He then described how this liquid was coating each of the floating pieces and how nice it all looked, like a dance. Since we were at the end of the session, I asked him if he thought it possible to have this image and feeling remain with him. His answer was an emphatic, "no way!" He explained, "If I don't watch the parts, they'll get all stuck together in no time." To my suggestion that the magic wand could instruct the parts to remain free and separate, he also had a definite answer, "No way can I do that. They all speak a different language!"

This imagery sequence seems to illustrate how a beta element is perceived, the attempts to get rid of it and the need to break it up. Only when fragmented can these particles be mixed with a good object, the praise. He imagined the linkage of the good and bad objects that could lead to assimilating both the good and bad aspect of himself. But why was he unable to take this good image outside of the office? The issue turns out not to be that simple. My presence seemed to be a necessary ingredient for the temporary linkage to occur. The patient may have been trying to get rid of the bad object through this internal fragmentation instead of through projective identification. Furthermore, he was using the omnipotence

I had provided him -- the magic wand -- to do this. Also, the bad object may be the me he had taken in and could not make use of because he had taken me in as a complete object. He had not been able to introject my ideas and make them part of him -- he had swallowed me whole. The yellow liquid might represent his need to impregnate the particles of me to achieve this assimilation. The fact that he could not imagine being able to sustain the good feeling outside of the office is that while he had taken me in he did not really understand me (after all, we do speak different languages!¹)

I have so far reviewed Bion's ideas on assimilation and examined its vicissitudes with a patient's imagery sequence. How is this related to creativity? Creative people are not necessarily exposed to a richer world or to more experiences than less creative people. The difference lies rather in the way they take in these experiences. Only when we can exercise alpha function can we nourish our psyche from the world around us. Only when we have nourished our minds can we generate new ideas as new elements connect with each other, with memories, and so on. The capacity for alpha function is, therefore, not only a requirement for thinking, but for any form of creativity.

Bion also conceives of a "contact barrier" between the conscious and unconscious parts of the mind, that is made up of alpha elements. Like Freud's ego function, this contact

1. My native language is Spanish.

barrier insures that unconscious processes do not invade the conscious mind when it is concerned with reality and that reality does not interfere with the primary process that is characteristic of the unconscious. One could conceive of the creative act as happening somewhere in the contact barrier where the alpha elements reside, and where they make contact with elements of reality, with memory, or with what is truly unconscious. The same applies in therapy. While the focus may be on the moment to moment relationship between patient and therapist, there is also an attempt to connect with the past and to make the unconscious conscious.

Attacks on Linking

In his paper, Attacks on Linking, Bion (1959) deals with one of the main obstacles to thinking. The patient will not only attack the links between his own alpha elements but will also attack links in the thought process of the analyst. We could say that in the psychotic part of the patient's personality -- and each one of us has that psychotic part within us -- the link between the patient and the analyst is the mechanism of projective identification. In the early months of post-partum life, an unreceptive mother can destroy the link with the infant as much as primary aggression and envy in the infant can destroy the link with the breast. In both

instances the person will become unable to develop thoughts out of experience. In the analytic situation the capacity of the analyst to introject the patient's projective identification while maintaining his composure produces hatred of the analyst. For Bion, "attacks on the link are synonymous with attacks on the analyst, and originally on the mother's peace of mind." (p. 106) The destruction of the link between infant and breast leads also to "a severe disorder of the impulse to be curious, on which all learning depends." (p. 107)

Because of this lack of curiosity in the psychotic or in the psychotic part of the personality, the question "why" is never raised by such patients. "The patient appears to have no appreciation of causation and will complain of painful states of mind while persisting in courses of action calculated to produce them. . . .Therefore, when the appropriate material presents itself, the patient must be shown that he has no interest in why he feels as he does." (p. 108) It was the seeming incongruity of this anti-climatic statement that originally prompted me to write this paper. It reminded me of that joke of the psychiatrist that claimed to have cured a patient's compulsive behavior by saying "don't do that." An analyst can make an interpretation that focuses on the obstacle to curiosity but this has to be done in such a way that the patient experiences the analyst's willingness to stay with the patient's experience. Often, however, he will seem to be blaming the patient for something the patient cannot

do, even though what the analyst may be saying is accurate. If the purpose of the analysis is to help the patient formulate the "why" of his experience, it is clearly a Catch 22 situation: the patient would have to be curious which he presumably is not, about why he is not curious.

Comparing the situation of a patient unable to link with the situation of the artist who is blocked suggests an alternative route to development. In the creative process there is a tendency of the artist to work out the parts, not knowing until later how they will be connected and what the finished product will look like. There is resistance to connecting before the parts have developed. The parts operate as beta elements that need to be digested and transformed into alpha elements before they can be connected. As beta elements they are threatening; connecting them would induce too much anxiety. Segments of the painting or a work in progress do act as beta elements. The artist may try at times to eliminate them as he perceives them as something foreign to the work like an unwelcome, annoying accident.

When the artist is unable to deal with a beta element in the work he will leave it alone and continue to work on another area of the painting that is more familiar. He is lowering his anxiety level and will return to the problem area later. If an art teacher were to insist that his student connect the disparate elements of a painting in progress, or

even consider the totality of it when the artist is working out or solving the problem presented in one area of it, there would be trouble in the relationship with the teacher manifesting as resistance and anger -- the artist would be caught in the middle of an undigested meal. The process of transforming a beta element into an alpha element would be disrupted. Inability to link at this point or even see the whole, could be, and often is, interpreted by the student in self-referenced negative terms, concluding that he is not talented. This points up the necessity of the teacher being sensitive to these processes since, in a sense, the teacher here is unwittingly the artist's therapist.

Attacks on linking, characteristic of the borderline or psychotic patient, may reflect his fear of connecting beta elements that he wants to get rid of. Perhaps his fantasy is that if these elements were connected, he would be overwhelmed by them. In this sense, attacks on linking occur concurrently with projective identification and splitting, since alpha function is not yet developed. The only link possible for the patient is one of fusion with the therapist so that projective identification can take place. In light of this, to interpret attacks on linking as a defense against a real connection with the analyst is tantamount to blaming the patient for a response that is, of course, defensive but developmentally speaking, the only response the patient has available.

Case Illustration

I would like now to turn to the three therapy excerpts. In each the patient is having a beta experience and is either overwhelmed with feelings or is trying to get rid of the experience through projective identification. In either case, the patient is unable to establish links and thus develop thoughts.

The first patient -- I will call her Sally -- is a young woman of 22. I have been seeing her for two and a half years. In the two years previous to my therapy with her, she was hospitalized four times. Seven months after initiating treatment with me, she went through what could be considered a near psychotic break: intense anxiety, depersonalization, paranoid delusions. We had extra sessions, some of them quite difficult, and there was no need for hospitalization. She has made uncommon progress since then.

In a recent session, Sally begins talking about her sprained knee not getting better in spite of the physical therapy. (She had injured her knee while exercising.) She is quite distressed and talks about feeling confused and overwhelmed. She wonders if the physical therapist is really helping her -- she is very angry with him. In treatment he asks her to report to him when the leg starts hurting as he applies different weights to a pulley.

Sally: I think he is hurting me. It is hard for me to know what I feel with the leg, it seems to hurt all the time and I don't know if I am misguiding him... but he ought to know. I don't know if I want to go back there. I don't know if he is really helping me.

Ther.: You would want him to know what is going on with your leg. You get angry with him for not knowing and with yourself for not guiding him.

Sally: I am making it worse by not following his advice and staying off my feet. I went shopping yesterday because I was feeling better but I am overdoing it. I shopped for seven hours (starts crying) I don't know... I am so confused. Everything goes wrong!...

Ther.: (After a while) Tell me about the shopping.

Sally: Seven hours! Of course I cannot expect to get better. I am always overdoing it (continues to cry).

Ther.: There must be something good about the shopping. You would not do it just to spoil your treatment.

Sally: I really enjoy finding the right things for my apartment, left a lamp on hold which will be perfect. And with clothes too. Remember when I started therapy how I talked about hating to make decisions? And the problems with what

my mother likes and what I like? Now I feel very confident about my taste and how I put things together. I don't get overwhelmed in a department store anymore, I know how to find what I want.

Ther.: The contrast is very clear: in bed, unable to move with your leg up and helpless; in a store feeling in charge, competent, creating something new...

Sally: I hate being stuck in bed and needing help and no one there to bring me a cup of tea... I guess when I go shopping I forget everything about being in need or getting angry that no one is there. I can do what I want to do by myself and it makes me feel good... to the point where I forget about taking care of myself... (After a silence) ...I have two exams coming up this week. I will stay in bed all during the week studying... at least I'll have a sense of purpose and that'll help me not to focus so much on my feeling needy. I still have a lot of problems with that and that's why I can't afford to get sick... (pause) ...I'll continue with the physical therapist. It's not his fault really if I can't tell him what I

feel. (smiles) Poor guy! I was so angry with him.

As you can see, I have her talk about her shopping experience at the time of impasse. Talking about the shopping breaks up the situation and helps Sally focus on that experience only -- supposedly a good experience -- rather than being overwhelmed by the whole picture. It also distances her enough from the distress so that she can begin to look at what she does. She discovers that in the shopping she has a sense of mastery she misses when she's helpless in bed, with no one there. She finds out why she shops with a vengeance -- to avoid the painful feelings of need and anger if she were at home and resting. Now that her anxiety is lower she can begin to talk about what she's going to do. Projective identification in which the physical therapist is perceived as harming her is also resolved as she comes to understand at the end that this is not so, and that she was projecting her anger onto him. That understanding means that she has been able to assimilate her own anger at her helplessness. In other words, she takes in her projection.

The next excerpt is with the same patient. I had gone to a conference in Berkeley and when I returned, she had to cancel a session due to car problems, so I did not see her for over a week. She was clearly distressed and, as she sat

down, she began to question the value of therapy. She has been coming for two and a half years and she is feeling so desperate. When are things going to change? She is not getting what she wants from anyone. I agreed with her that it was hard to have it take so long. It is also difficult for her, I said, to realize she does need me and she wishes she didn't. I can well understand her impatience.

She then began to talk about the exams she took the previous week in school. She has gone back to school and is taking two classes. She did not do well on one of the tests. Even though she was very upset and was tempted to go home for the day, she stayed for the other class and soon began to feel better. At this point, she started getting tearful. The interaction continued as follows:

Sally: I don't know if I want to continue with school or get a job.

Ther.: You do not feel you are getting enough out of the classes and wonder again about doing something that is more immediately satisfying. It is hard for you to have to wait for the results of your efforts.

Sally: (Annoyed) This is not what I want to talk about. You don't understand me, nobody does.

Ther.: (After a silence) You seem to want something from me very badly. What do you think it is?

Sally: I don't know! I can't think. I am confused!
(and crying) You should know! You used to figure out what's wrong with me. Today you seem so distant! You are looking at me as a specimen or something.

Ther.: (Taking a long time to examine my own feelings) I do not feel distant. I am very much in contact with you today (at other times when she has expressed similar complaints, I have revealed to her at which point I was distant and what I was thinking about). You are probably angry with me for my going away (I had just returned from a short vacation) -- and now you see me as angry and distant.

Sally: (She nods and looks at me in despair)

Ther.: (Thinking aloud) It is so hard to know what one really wants. Yesterday, during a group therapy session one of the participants, a young woman complained that she felt left out or marginal and that it probably had to do with the fact that her chair was somewhat outside of the circle. Someone in the group offered to exchange chairs with her. She thought for a minute, thanked him and said she didn't think that that is where she wanted to sit. Then she

pointed to the center of the couch and said that she would rather sit there, right in the middle of the group. She smiled widely when she finally sat there. She talked from there for a while and then moved back to her chair. She had had enough and now she wanted to also look at the people who had been sitting on either side of her. This was no minor achievement for her; to take the invitation to change seats as an opportunity to find out what she really wanted and have the courage to say so.

Sally: (After a long silence) Actually, when I was on my way over here, I had a fantasy that you would hold me and I could cry in your arms and for a while neither of us would talk.

Ther.: What happened to that wish?

Sally: I thought that I haven't done that for a while and if I did it again, it would mean that I was going backwards. So, I guess I didn't want to.

Ther.: You were upset at your having needed me when I left and now you were stopping yourself from needing me even in my presence. Then you thought it was I who was distancing.

Sally: ...When it was I who did not want to feel close

(long silence)... To think that this is what I wanted and what I did instead was to push you away.

Ther.: Yes. You started by challenging the therapy and then criticized everything I was doing. You are lucky I did understand. Someone outside of the therapy situation could have gotten really angry.

Sally: (Laughing) I know. Now that I think of it, I do this all the time. No wonder my friends don't want to call me... and then I think no one cares for me. (After a long silence, she smiles and then starts laughing) I never thought what it would be for Randy (an ex-boyfriend). We would start making love and all of a sudden, when he was inside me, I'd say, "It doesn't feel good, this is not what I wanted." He would stop and never pushed me to say what I wanted like you do. He must have been devastated. And I did not know what to do either.

Ther.: What a scene!

Sally: Yeah! (Laughing) Funny, I forgot what I had done. All I could think later was how I had been used and that he really didn't care about me. (Pause) And, ah! (Laughs) I told you what happened with Alan (another ex-boyfriend) that night. In the middle of our making love, I told

him his breath and beard smelled like salmon. After he went to the bathroom to brush his teeth and wash up, we started again and I could not help it. I told him, "You still smell like salmon!"

Ther.: Like you did with me today: this is not right and then I try again and you still tell me it's not right!

Sally: I guess I want people to read my mind as proof that they care or something.

Ther.: You split your wants from your capacity to think. You keep the raw wants and you give us your capacity to think. Then you feel overwhelmed with feelings and enraged if we don't do our job right.

Sally: I do this not only with boyfriends, but with everybody! Today, with Jim (a friend at school she is interested in), when he finally showed real interest in me I told him I had to go to an appointment. I was abrupt. I guess I am attracted to him physically. He is sweet... (smiles) and cute. The fact that he may not be intellectually stimulating bothers me. I only want to have a relationship with him if he has everything. (Pause) Although I was having a

wish to watch TV together and cuddle up. Do you think that would be wrong?

Ther.: You again want to have your wishes and for me to do the thinking for you.

Sally: I don't think it has to be all perfect. I would enjoy being close to him. He seems tender and I would like to cuddle up with him (smile). I will be nicer to him next time and invite him over.

Ther.: You are having a wish and doing the thinking too, and you can make your own decisions.

Sally: Oh boy! Why does it take me so long to get to it! (end of session)

My story about the patient in the therapy group was my way of distancing Sally from the impasse of not being able to develop thoughts out of her experience of need and action. I thought the story would resonate with her experience of not knowing what she wanted plus providing her with an example of someone able to think and take some action that was rewarding. Through this detour into somebody else's experience she was able to go back to her own wishes that she herself had denied.

The next example is of a couple whom we shall call Steve and Cathy. Originally Cathy was the patient and her boyfriend joined after about six months of therapy. Their relationship was loaded with primitive mechanisms of splitting and projective identification in which there was a great deal of

acting out. In this session they both describe their distress about a recent extended vacation after which they had planned to get married. Steve no longer feels he wants to marry her, questions his feelings and claims that after all, they were only compatible on the surface. They described the different situations on the trip in which they felt distance from each other. Their discrepant expectations were disclosed and there was some recognition on the part of each as to what determined the other's behavior.

In the process of arguing their points, they successively blamed each other, understood each other's point of view, recognized their projections. All of this was instructive to both of them and to me, but it did not affect his feeling of hopelessness; a mixture of sadness and a sense of defeat. I suggested that he think in more detail about the nature of his feelings at the time. He began to describe several situations where he felt his mind was being invaded. Cathy was taking pictures of him with some animals and would ask him to look in this or that direction. This infuriated him because, as he puts it, he wanted to get completely involved with the animals. By being concerned with taking a good picture, Cathy was interfering with his involvement by making him self-conscious.

In another situation, she had arranged a dinner date with another couple at 8:30; he wished she had made the reservations

at 7:30 since he wanted to eat early. Even though he told her it was not that critical, she kept making attempts to find the friends and change the reservations. He felt angry at her, "I had this stupid 7:30 or 8:30 issue inside of my head taking up the space of all my other thoughts." Cathy also wanted to move the beds together in the different hotel rooms, and even though at some level he agreed with her that this was a good idea, he kept having the thought that "nothing is enough for her," making him very angry. He kept saying that, after all, this was a vacation and it did not really matter.

The projecting nature of his complaints became evident in the discussion: it was clear that when she did not care about changing anything, he wanted to, and complained bitterly about things not being just right. Steve had found a good target onto which to project his "excessive" needs, his obsessing thoughts, his self-consciousness, that he wanted to rid himself of on this vacation. Cathy was experienced by him as planting in him self-consciousness, thoughts, demands, which he then experienced as poisoned objects inside of his head. Steve felt at the mercy of these objects. On and off during the trip, he fantasized getting rid of them and her, the cause of it all.

In the session, I asked Steve to describe in detail how these thoughts, demands, etc. felt inside of his head. I wanted him to more fully experience his own struggle. As he

stopped, unable to carry the experience further, I described to them a recurrent experience of mine with my husband. The patient had reached a dead end and I wanted to provide him with a new vantage point from which to look at his experience. My husband, I told Steve, would point out which trees needed to be fed, what part of the garden wall had to be rebuilt, or where the ants were coming from, at a time when I wanted to enjoy with him a nice breakfast I had just prepared. I told my husband how his comments were experienced by me as intrusions of a bad object inside of my brain and how this stopped my enjoyment of breakfast. I had found, I told the patient, that no matter how much I complained to him he had been unable to change his behavior, so eventually I had to change my interpretation of his behavior. He, my husband, no longer made me angry with those comments, but it made me laugh that he had to be straightening up the world when, instead, he could be enjoying himself.

In the next session with this couple, Steve told me he had thought many times about the incident with my husband, and he had wondered what made him (Steve) have such a "thin skin." I speculated in front of them that I did not think it was a matter of thick or thin skin, but one of thick or thin experience. My self-disclosure at the end of the session had presented Steve with a different circumstance, a similar experience, and an identical reaction, which peaked his

curiosity. "A thin experience," I said, "was copping out of dealing with all the feelings involved in these situations which protects us from worse experiences. This one we can fantasize about getting rid of, other ones, who knows? As if having been given a license to go ahead, he gave other instances of his irritation with her and described and felt again the anger of having some object planted inside. Something in his delivery changed as he realized that the object was actually his: his excessive need, his self-consciousness, his thoughts, that he now had to make his and assimilate. She had not been a mother or a therapist in a state of reverie but another person whose own needs were very much interfered with. By arguing and challenging him she had returned the beta elements projected onto her unaltered and his anger with her was understandable. In the detailing of other instances and his full emotional experience with them, he had been able to break up a beta experience and restore alpha function. His projective identification with her was possible because of his illusion of fusion with her. He would now give up this illusion, free her from these projections, and see her as separate from him. It was at this point in the session that Steve looked at Cathy very lovingly, as though seeing her for the first time. Then, smiling, turned toward me saying, "I do love this lady."

If we wanted a happy ending, this sequence should end

here since it also makes a clear, digestible point. Seeing his love after all his anger, Cathy was moved to tears, her chin trembling. Steve looked away and muttered to himself, "There goes that trembling of the chin again," and to me, "I hate that," and we began to work on this new sequence.

Distancing

What is the common feature of these three excerpts of therapy? In all three instances the patient has arrived at an impasse where he or she could not assimilate the experience. In the case of Sally, she was overwhelmed by her emotions, was confused and unable to think. In the case of the couple, Steve was unable to think and was avoiding a full experience. In both instances I helped them first focus attention on a manageable sequence of their experience rather than connecting the elements of their experience with an interpretation. In order for an interpretation to be meaningful, alpha elements must already exist. Secondly, I took them away from the impasse to relate an experience they could identify with. Let us deal with the feelings first.

In Steve's case, a fuller experience was needed for him to develop thoughts about it. There are times, however, when pressing for a full experience does not lead to anything but an impasse, which is what happened to Steve. One of the

reasons most of us fear the full contact with a negative feeling is an underlying assumption that change does not take place in and of itself but is either the result of an act of will or the outcome of a rescue effort by someone else. Having the patient experience change as a result of his own immersion is very critical, especially for those patients who engage in creative work. Incidentally, artists who have a good relationship with their work seem to have an assumption that involves change both in themselves and in the matter at hand. It is this assumption that enables them to withstand the many bad moments during the work.

Let us now try to understand again what the purpose was of having the patient focus his attention away from his experience. First, we need to make a distinction between the person who shows clear signs of distress with no clear thoughts -- the case of Sally -- and the person detached from his emotions who also cannot think clearly about what is happening to him -- Steve's case. Studying the phenomenology of emotion, Thomas Scheff (1981) distinguishes between emotional overdistance and emotional underdistance. He defines distance as the ratio of observation to participation in one's emotions. For Scheff, reliving the past is a case of overdistance. Neither of these states is conducive to learning from experience insofar as there seems to be a split between emoting and thinking. When the connection between emotion

and thinking is made we have a case of what Scheff calls aesthetic distance where one is both participant and observer. The participant relives certain emotions and the observer does the thinking. This corresponds to Sterba's classic (1932) distinction between an experiencing, subjective, irrational ego and a reasonable, observing, analyzing ego. In aesthetic distance the two states are present at the same time: "The patient moves so rapidly between participation and observation that the two states are experienced as simultaneous." (Scheff, (1981) p. 41.)

For Scheff, a good therapist moves the patient towards optimal emotional distance in a manner similar to the playwright's consideration of the audience's reactions to a drama. He suggests that "any therapy which insists on a single preferred direction of emotional distance might be improved by making modulation of distancing flexible, and so tailoring it to the patient's needs at any particular time." (p. 50) When I have provided patients with a new vantage point by distancing them from a beta experience, I have intuitively brought into the therapy situation what I do as an artist in coping with a similar experience. As I said earlier, removing oneself from the anxiety provoking situation to deal with a more familiar one reduces anxiety. This anxiety reduction may also be accomplished by an increase in ego strength which may then enable the person to return once again to the beta experience.

It has been interesting for me to begin to think that I may be unwittingly manipulating emotional distance. In a way, however, this is no more manipulative than what I was trying to do without manipulation. And here I stumble into my own prejudice against anything that implies a hidden agenda in the therapist. I am not talking here of the extreme of having a long term plan as to where we want the patient to go but the more short term plan as to what we want to have happen in the next five minutes.

If I think of therapy as a creative act, I have to come to terms with the fact that goals cannot be completely avoided. Sometimes we dream as we paint and sometimes we want to paint a dream. The danger is that when we do the latter we may forget about our relationship with the work; we may be using the canvas solely as a screen. If we do that we are really not connected with the work but with some goal inside of our heads -- the creative process goes stale since we are not learning or taking in anything new. The question is, how can we have a goal and still have a true connection with the work? We have to have what I have called an "as if" goal that we can drop at any moment with no regrets. It is a goal that is not invested with real desire. It is also strictly a momentary goal that is not tied up with the past and therefore with memory. In therapy an "as if" goal allows us to stay connected with what is truly happening with the patient without the

commitments and constraints of a real goal. The sting of the word "manipulation" fades when we think of it in the spirit of an "as if" goal.

We not only manipulate emotional distance by actively suggesting something for the patient to do or where to focus attention. The analyst may be unaware that he may also be doing more than interpreting the patient's behavior and focusing on the obstacles to his thinking. It is possible that in what he chooses to interpret, in the way the interpretation is made, or in the timing of the interpretation, he is also manipulating emotional distance so that assimilation and thinking can develop.

Interpretations are formulations intended to display an underlying pattern and, therefore, will attempt to show connections that for the patient may be premature. They may create the same reactions in him that the art teacher may produce in his students. The process of development may be disrupted. Talking about interpretations, Bion says, "At their best they make us aware of coherence and order where, without them incoherence and disorder would reign." (p. 131, "Second Thoughts") [*italics mine*] It is clear from this description that Bion is talking about the role or value of the interpretation for the therapist. He would certainly have agreed that what is good for the therapist is not necessarily good for the patient. Therapists need to achieve coherence and

order -- they are dealing with their own alpha elements and complex theoretical structures into which they fit and connect rather nicely. The psychotic patient Bion talks about, or the operating psychotic part of the non-psychotic personality, is far from needing coherence and order. The patient does not care about overviews and looking at the whole picture -- he has to be able to focus on a small experience at the time and learn to transform it from beta elements to alpha elements, to digest it and have it become part of him, a part he can later utilize. Only then can he join the therapist in the linking process of creating the whole picture, or, better yet, creating the whole picture himself, at least at times.

It may be a paradox that therapists are trained to look at whole pictures and present these to their patients in the form of an interpretation when the patient may need more help in looking intently and fully to single aspects of his experience, something the therapist is not usually trained to do. In order to do that the therapist needs only to be there fully, slowing down the patient's actions, immersing himself, as it were, in the patient's experience to know and feel intuitively if the experience is full or not. If it is not and the patient has reached a dead end, to help him lower his anxiety level by having him focus attention away from it and into an experience -- his own or someone else's -- that he can look at and come to understand in its relationship with

the beta experience that he cannot break up. He may then be able to come back to it with a restored alpha function that will allow true assimilation. A painful paradox indeed is that in addition to all the restraints the analyst is supposed to exercise for the sake of objectivity, one would have to add the notion that his sole role, interpreting, might be the wrong thing to do for the patient in certain developmental stages.

The purpose of this paper has been to examine the vicissitudes of assimilation which makes learning from experience possible. Bion seems to equate assimilation with the capacity to think. I have tried to expand his ideas by comparing the experience of a patient unable to think with that of the artist unable to create. From what the artist does to resolve his impasse one can begin to question the value of an interpretation for a patient in a similar impasse. I have used some clinical material to elucidate the developmental issues involved in the capacity to assimilate and to suggest alternative therapeutic interventions.

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