BEFORE I WAS I

Psychoanalysis and the Imagination

By
Enid Balint

Edited by
Juliet Mitchell
Michael Parsons

Free Association Books/London/1993
FAB *'an association in which the free development of each is the condition of the free development of all'*

The Guilford Press
New York London

Creative Life

I start with some quotations. The first is not from an analyst but a priest (Drury, 1988):

> Between ourselves and reality we intersperse more or less ramshackle systems of images. Whether it is because real life is not enough for us, or whether it is that it is too much for us, or whether (as seems most likely) what happens in any day is both not enough and too much, we deal with this by making representations of it. . . . We are like Tennyson's Lady of Shalott, weaving away at our looms and seeing the world refracted through a mirror.
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> The painter turns from the mirror to look at the world. . . . He can make marks which are not exact imitations but free parallels, real representations. . . . He has let his body, mind, heart, eye and hand included, be the passage through which nature's alien peculiarities are reborn into wide human meanings.

Van Gogh (1958, letter 531) wrote: 'I can very well do without God both in my life and in my painting, but I cannot, ill as I am, do without something which is greater than I, which is my life—the power to create'. Like other artists such as Cézanne, Van Gogh is saying he has to paint to work out his salvation, to exist. The threat is of not being. The need is to be, in order to avoid a chaos and passivity which is the equivalent of death.

One quotation only from Freud (1939, p. 71): 'Whenever [men] are dissatisfied with their present surroundings—and this happens often enough—they turn back to the past and hope that they will be able to prove the truth of the inextinguishable dream of a golden age'.

My last quotation is from the Russian film maker Andrei Tarkovsky (1989): 'Film directors can be divided into two main categories: those who strive to imitate the world they live in, recreating the world about

them, and those who create their own world. Those who create their own world are usually the poets'.

These profound and thought-provoking words are a background to thinking about my work with patients who have trouble feeling alive in the world or, as I have described it in the previous chapter, in imaginatively perceiving it. In spite of this they may be potential artists. (Perhaps we all are, but that is another discussion.) These potential artists have a particularly traumatic and devastating difficulty in making contact with external reality. They do not die in infancy, however, but get seduced into feeding and living (Winnicott, 1988). Perhaps the parents of such patients had been so seduced themselves. We sometimes find out. These infants feed passively, although desire cannot be entirely absent. Winnicott thinks this involves a split in the personality and assumes that there is always, as he describes it, a silent relationship with a private world of subjective phenomena, which I call imaginatively perceived phenomena, as well as a false and compliant, uncreative relationship with the outside world. If later the infant becomes an artist, Winnicott (1945, 1965, 1988) thinks he will link these first 'real for him' perceptions with the perceptions he has related to in a compliant way.

Like Winnicott, I think the artist's, and infant's, first 'true for themselves' perceptions are the basis for living. Unlike Winnicott, however, I think that if the infant becomes an artist, struggling to overcome the barrier and make his imaginatively perceived phenomena available to other people, he will have to discard the perceptions from the compliant part of himself. People are enabled by artists, as they sometimes are by children's play, to make contact with an experience, an imaginative perception, which they have lost—a loss which has diminished their own awareness of living. It is true that in representing his imaginative perceptions the artist will portray himself, but his compliant world of pseudo-observations need not, and in fact must not, be integrated with the imaginative perceptions which are his own and real for himself. In his art the compliant self must be painfully cast aside.

Such work is creative as children's play is often creative. The infant's early imaginative perceptions remain unconscious, but they are not static. They develop as part of unconscious fantasy life, and when this is shown forth, either in analysis or in artistic creativity, it can produce agonising fear in the patient or artist in case the experience is lost. There is a dilemma whether or not to portray it, in case it is too overwhelming for the analyst, the audience, or the patient's or artist's own compliant self. Either way chaos, madness, or horror may threaten. The greatest fear, though, always seems to be that the experience cannot be repeated and will be lost. There is a search for words or movements that will

represent the forgotten, but not lost, infantile imaginative perceptions; and simultaneously there is an attempt not to represent them. It is essential at these times for the analyst to be quiet and not intrusive, but also absolutely *there*. It is hard to describe this, but what matters is for the analyst simply to go on breathing. He must not put anything into the patient's mind; the patient is occupied in finding his own words or actions. At the end of the session, however, when the intensity is over, interpretation may be needed as the patient returns to his normal world. He usually thinks the experience has gone for good, and he is surprised when the process restarts in the next session.

This experience of perception can exist only in the atmosphere created for it by the artist, or when it happens in analysis. The artist is objectively alone, but must have had some imaginative perceptions as an infant to enable him to create such an atmosphere, while in analysis the atmosphere is re-created by analyst and patient together. In my view the infant cannot perceive reality unless it is perceived mutually with someone else. The mother, who can give complete attention to her infant, is normally the first person to provide this atmosphere, although it is not always possible for her to do so, nor can she always do it without resentment or fear. For the infant, even while there is as yet no other person or object, there is not a void. This absence of void is important, and I have written about it in Chapter 3. There is a space in which the infant lives (Winnicott, 1988), where he can perhaps smell, touch, hear, and hold on to something. It is an alive space, not the dead one so well described by Green (1986, chap. 7). This space can be refound in analysis. It is of paramount importance to the infant's first imaginative perception of the world that that space is partly filled with the content of the unconscious internal world: the other, as yet unperceived, person. It has so often been said that there can be no infant without a mother. We must add that there can be no live breast, either biologically or psychologically with milk in it, without a live infant. The one creates the other. Winnicott (1956, p. 311) says that 'the mother's meaning for the child depends on the child's creativity'. My idea is that the first imaginative perception can only arise out of a state of eager aliveness in two people, the infant with the potential for life and the mother alive inside herself and tuning in to the emerging infant.

As clinicians we are aware of this. We know the need to allow our patients to discover their own words and movements for representing what they feel, and not to have to be compliant and use ours. This is particularly important when the patient is in the very early, receptive, unintegrated state. As writers it is equally important for us who try to describe our analytic observations to use words that are right for ourselves, but that are right for the audience too. They must not be integrated into a concept before both writer and reader are ready, so that the concept does not seal off further creative work.

I use the phrase 'imaginative perception' to describe what happens when the patient imagines what he perceives and thus creates his own partly imagined, partly perceived, world. Drury's words are simple, brief, and right for me, that the artist can 'make marks which are not exact imitations but free parallels, real representations'. The writer cannot use words passively accepted from someone else, which to him are meaningless. He must create his own, but, again, they arise in relationship to another person.

I am going to describe briefly some work with two patients. Analysis always arises, of course, out of a relationship between two people, and so no two analyses can be the same. Attention is centred, however, on only one of the two, namely, on the imagination and perceptions of the patient. Both the infant and the patient in analysis will start to feel concern for the other, and then guilt, and a state of mutual concern soon develops. That depends, however, on being able to tolerate the existence of the other person; and in the phases of analysis I am about to describe such a state has not yet been reached. The patients were aware that they were not alone. I do not think anything can even start if the patient feels he is in a void. He may not be able to perceive any object which he desires or can imagine, but still he can feed, listen, and even take in what is said in a passive way, while sensing that there is something which he has lost or which is missing. He may try to find the missing object which had been imaginatively perceived, or he may repeat the trauma of his loss and feed passively throughout his life.

The danger in analysis is that the patient may try to repeat this passive, accepting 'feed' which the analyst offers by his being there as a person, as well as by providing couch, chair, an atmosphere of warmth, interpretations, and so on. It may take a long time, perhaps years, before the patient can take the risk of looking away from the mirror and rejecting the person behind the couch and what he stands for. Then a new phase is entered and new work can start.

Michael Balint (1968) describes work of this kind when investigating what he calls the Area of the Basic Fault. He speaks of how at some phases in the analysis words will have no settled meaning for the patient who can become silent, lifeless, and hopeless. In the same book he speaks of another area of the mind which he calls the Area of Creativity. In my view the Area of the Basic Fault is only overcome when this phase is worked through, that is, when the patient is no longer regressed to a stage where he has no mutual experience with his analyst but becomes silently hostile, disillusioned, and desperate and eventually appears to give up hope. He sometimes does this without reproaching the analyst, who may

wonder what he is doing wrong. He realises, though, that he must not be passively overwhelmed by the patient's projections, which have to be followed even more minutely than usual, and he must also watch his own rigid expectations. This state is overcome only when the patient painfully allows himself to feel alone, in the analyst's presence but with no *person* being there. He may then begin to perceive for himself and to enter the Area of Creativity. The patient is alone with no other person present, but the space is not empty. There is no experience of a void, and the analytic hour is in fact a relief from the previous experience of compliance. Although bringing no apparent satisfaction, it comes to fill the patient's life. To escape from the state of passivity is satisfying in itself. In order, therefore, to get out of the Area of the Basic Fault, my view is that the Area of Creativity has to be entered.

Neither of the two patients I shall describe was a creative artist. I should rather say that neither had achieved or overcome the struggle with what prevented them from being creative artists. Their fear of being abandoned and alone, of having destroyed all that there is, was too great. They both went through periods, short and long, when nobody existed for them, when they could not communicate and words had no meaning; but they showed an immense struggle to create and live. They did not seem to be false personalities, although some traces of this did appear early in the analysis of the woman patient whom I shall describe first.

When she came to analysis she was forty years old, married, and with two children. For the first three or four years I had a real existence for her in the transference. She sometimes idealised me, but it was not long before she swept me off the pedestal. She got in touch with a depressed, almost melancholic part of herself where she felt she could do nothing for anybody, but only destroy those who were close to her. We could work on a period in her teens when two close members of her family died, one of them by suicide. The acceptance of these losses and the guilt and pain which arose out of them led to associations with earlier periods of her life. I thought all this would help her to become less anxious, to love and care for those near to her, and to feel more alive. Before her analysis she could not bear to be with people or to sleep in the same room as her husband, even if she drank and took sleeping pills.

She did get better, but only for about a year. Then she entered a long phase when she was in the Area of the Basic Fault. I was increasingly disappointing to her, and she wanted to do nothing at all. She gave up her previous activities; in particular, she stopped doing things for people she was fond of. Her dreams showed her wish to annihilate them and her fear that she had done so. She became depressed, angry, and disillusioned, with both herself and her analyst. She saw to it that her family and her analyst were worried and hurt. She felt she had lost what she had once had, and in return she rejected life.

This behaviour gradually intensified. There were silent periods in the analysis, and her disgust and disbelief in herself and her analyst grew. She would say that my words were true, but she could feel nothing. I seemed to be talking to her through a long tunnel. She could not perceive imaginatively. She tried to get away from analysis, although she never in fact missed a session. Then she started to paint. At first this was with great fear, and very formal, rather pretty pictures emerged. Slowly, however, and to her own pain and disgust, her paintings changed. Then they stopped. Her silences in the session became alive. She had entered the Area of Creativity.

The analyst then started to feel alive, and was felt by the patient to be alive, not at first as an analyst or even a person, but as a place to be in. Much later it was as a person, about whom the patient began spasmodically to be concerned and guilty because she was horrified at what she had done to the analyst. She resumed painting and it became increasingly important. It still took a long time before she could begin to imagine a good session, or even part of a session as a free and mutually satisfactory time. When she did, it was a blissful state of joy to her, but it did not last and she was afraid she would never get back to it again. She always wanted me to tell her what had happened and could take it in when I interpreted the similarity between her experience with me and the experience during the first few days of her life. This made sense to her, not intellectually but in strong feelings in her body. I should add that during the first weeks of this patient's life the patient's father was extremely ill and the mother who tried to feed her child must have been distracted and, therefore, ceased to exist, or became dead, for the patient. When the mother stopped being worried about the father, she was over-enthusiastic and overwhelmed her baby, who then shrank from her and came to prefer a life where there was no one to a life where there was someone who repeated the experience for her of those first few weeks. She had imagined and perceived a marvellous 'object' or atmosphere, which had gone and was apparently forgotten. She feared to refind it and so, as Drury says, saw life through a mirror. Her mother probably could not repeat the first few good days, but could only remind her of her failure, which the patient then experienced as her own.

Later in this patient's analysis her interest in painting and in looking at pictures enabled her to feel at home with at least part of the world. She could create it by her imaginative perception of it, and briefly and unexpectedly she would become blissfully alive, although there were still periods when she regressed again and the analyst ceased to exist for her.

In the transference, projective mechanisms were very active and had to be followed minutely. The ebb and flow of belief and disbelief, of illusion and disillusion, were felt by the analyst as well as the patient. I had to work hard to avoid passively accepting her projections. When I was accused, for example, of being jealous of her and destructive about her painter friends, I had to be sure I was not; but I could be made to feel I was and that they were getting between me, the real feeder, and the infant who needed real food. I have mentioned passivity in this patient as a contrast to imaginative perception, but I should say that even in the first few years of the analysis passivity never led to a completely worthless, lifeless state. It was always interspersed with periods of violent despair which were alive and in which she objected to what she saw as the life offered to her by the analyst. In the areas of the Basic Fault and of Creativity which I have described, there was no instinctual satisfaction for her, as there is with patients who imaginatively have a feed or orgasm and then are satisfied and replete. Here I am describing a state which precedes the instinctual satisfaction of a real feed, but which must be present if the feed is to be a real one and not just compliant sucking.

The second patient, who is the 'Mr. Smith' of Chapter 7, was in fact creative in a particular field; but his wish to write a story using his own words and thoughts, and not the thoughts and words of others, was so intense that he was virtually unable to write or perceive at all. When he was born, his mother had recently lost her brother and she called her baby after him. It seems that she could not relate to the baby himself or accept him as her son. Not being able to see a live baby boy, she denied him an existence. His response to the compliance this demanded of him was to deny his mother's and his father's existence, and he continued to do this in later life.

He started analysis with me in his late forties and was already working, or existing, in what I felt to be the Area of the Basic Fault. He had been to two analysts before me, and he warned me at the consultation that I would find him very difficult to understand. When he arrived for his first session, and for months or even years afterwards, I realised that what he was seeking was the analytic room, the couch, and the cushions, so that he could discover a thought and a language. I, as a person, did not exist for him. He often told me that he never thought about me when he was not 'in the hour', but in fact he never thought of me as a person at any time at all. In the first part of a session his movements and sounds were like an infant's, but when he came out of this state of infantile frustration, in which there were no acceptable objects and no words, he spoke lucidly and clearly. My interpretations were useless or even made him feel chaotic; and it was clear that the one thing he could not stand was for me to put into him words which should have meaning, but had no meaning for him. My job was to wait for him to find words, meaning, and thought. Gradually, after about two years, he began to do this. 'Thought' appeared in the form of myths and stories which represented his earliest experiences. A few memories also appeared. He struggled to create experiences or relationships which were truly his own. He had found words that suited him when he began to read good poetry and drama in his early teens, and he often recited bits of poetry to me. It was not the content or meaning but the words themselves, which he almost spat out at me, that he conveyed as his own and not mine. This patient's response to passive feeding did not lead to the construction of a false self or even to any particular rebelliousness or passivity. Instead, he rejected what was offered to him and was determined to create something for himself. In some parts of his life he did indeed manage to do this. Creation was, for him, the essence of his being, but there was only one person. The word 'we' did not exist.

My patient reminded me of an autistic child who accepts the words of others but does not comprehend or reply. He could come alive when he read poetry and drama of a certain kind, particularly where ideas of loss and separation were predominant. But what really enthralled him was the sound of words that were 'real for him'. Such words were not seen through a mirror or accepted passively, but were real perceptions. Sometimes in the analysis he could accept ideas or words from me, with great pleasure, but also with great care. It was essential for me not to make him take in my ideas and words unless they were part of his imaginatively perceived world. When they were right, however, he remembered them and told me later what I had said, usually saying that he had thought of it himself before.

In this paper I have described people whose struggle to communicate with and contribute to the world in which they live is difficult, but who try unceasingly to do so because otherwise they live as uneasy, bewildered acceptors of a world that is meaningless. As patients they may accept their analysis, and it may seem to them that they have found what they have been looking for; but after some normal analytic work of that sort, a phase is reached when the effort to continue is no longer worthwhile for either patient or analyst. They then reject the analyst but not the analysis, and painfully, as if alone in the session, they try to regain what they have lost or create what it is that they need. They try to regain a state where they can imaginatively perceive, or create, a sense of being alive and not dead, which they hope will arise in the analytic hour. The session itself is present and sought after. Periods of fear and terror become interspersed with feelings of being alive, although often this too is terrifying. Later they may feel that something is being created between

themselves and the analyst, who does then exist, but it is not at all clear what that something is. The analyst is still not always a person for them, but he is certainly not absent.

These patients may all be potential artists. I think that is true of the ones I have analysed. They seem to have been forced as infants, at a very early stage, to look at and experience the world through the eyes of mothers or mother substitutes who could not look at them so as to reflect a live infant back to them, and who did not make the infant feel or know what he looked like or smelt like or was. These patients then had no mutual experience which enabled them to feel at home in the world, to get something from it, or to give something to it. The alternatives were passive acceptance or rebelliousness and rejection. Instead of live infants, they were seen, perhaps, as frightening objects who might easily die, and so they experienced their mothers and the world in which they were living as full of dread and fear. The effect of all this is to produce an intense desire and need to create their own words, images, sounds, and movements, a need which may be a driving force in all artists.

These patients are different from those described in Chapter 3, whom I saw as being empty of themselves. These patients are full of themselves but get no acceptable feed-back or reflection from the people in their world. It is therefore the world that appears empty, and they have no mutual relationship with it. Unlike the patients who are empty of themselves, they do not live in a void, because there is not a total absence of reflection from the external world. They have probably had, even if only briefly, some real experience at some stage of their lives, some acceptable feed-back which was not totally discarded or annihilated. This gives them something which they can struggle to recover, to refind or create, out of the memories which they have lost and which do not necessarily ever reach consciousness again.

chapter 9

The main theme of 'Unconscious Communication' is the idea, touched on in Chapter 7, of direct communication between the unconscious minds of two people. It also hinges, like Chapters 7 and 8, on the concept of imaginative perception.

The importance and originality of the clinical work and the theoretical understanding deriving from it will be evident, though possibly controversial. In brief, Balint proposes that an unconscious transmission can bypass one generation and appear compulsively and destructively in the psychic life of the next generation. Retrospectively its presence in the bypassed generation may be deduced from, for example, unacknowledged physical illness. Here, the history of the grandmother's relationship to her own baby lives on as a 'foreign body'—an idea that has already appeared in Chapter 6 (p. 79)—in the unconscious acts of the granddaughter. Something is taken in by the baby, but it cannot be identified with or recognised. Such processes are qualitatively different from the more familiar mechanisms of projection and projective identification which they predate both developmentally and historically.

'Unconscious Communication' has not been published previously. A version of it was presented on 2 November 1990 to the Academy of Medicine in New York City under the auspices of the Institute of Contemporary Psychotherapy.