Book Information

Book title:

Bion and Primitive Mental States: Trauma and the Symbolic Link, 1st Edition

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ISBN:

978-1032149097

Book Price:

$39.95

Publisher:

Routledge,

Publisher Location:

New York

Year of Publication:

2021

Reviewer Information

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Bion and Primitive Mental States: Trauma and the Symbolic Link, 1st Edition, by Judy K. Eekhoff,  **IBSN-13** 978-1032149097, $39.95,New York: Routledge, 2021, 184pp. Reviewed by Robert. S. White. Robert.s.white@yale.edu

Judy Eekhoff has provided us with a personal exploration into the difficult and sometimes impossible psychotherapy of patients with primitive mental disorders. I say personal as each of us interested in working with these patients must find our own way of working. How can we make contact? What theoretical language do we find useful? How do we deal with the relentlessness of countertransference pressure and enactment? How do we find at-one-ment with terror, death, and negativity? These are the questions that Eekhoff takes up and addresses in her own journey, her own way of working. But this is not a textbook; it cannot and should not be. What is useful about such a book is that it is one possible path to creative ideas on how to think about and work with such patients. Each of us would take a different way based on our personal countertransference, personal way of listening, and unique mix of theory. Grotstein (2009) calls this “sharing personal recipes” (p. 5). I will try to show in this review where my sensibilities and those of Eekhoff may overlap in some general principles. We can learn much from one another’s creativity and innovation.

What is this book not? It does not present a unified theory. Eekhoff draws heavily on the theories of trauma, the theoretical writing of Bion, and to a lesser degree on theories from Ferenczi, Klein, Winnicott, Bleger, Meltzer, Grotstein, and others. First, I suggest we have three different languages here, a psychiatric trauma language, and two distinct psychoanalytic languages: Freudian and Kleinian/Bionian. These languages are not compatible, although it is possible to form bridges among them. In the book, these different languages and concepts derived from them are not delineated and it is up to the reader to know their origins. I think this book would only be useful if someone already had a working knowledge of Klein and Bion, and a familiarity with recent work on unrepresented states; it would be hard to follow without such knowledge.

A second difficulty is that of style. Eekhoff has a post-modern style of taking concepts from a variety of sources, often without clear attribution, which she uses to illustrate clinical points. I would contrast this style with authors that derive their technique from a unified theory. I will use Grotstein’s (2009) book, *But at the Same Time and on Another Level,* as this second type. Grotstein develops a unified theory based on his reading of Klein and Bion to develop treatment principles and always refers back to theory when giving clinical examples. Eekhoff, I think, uses theory as vivid metaphors to capture clinical moments without a need for internal coherence. I am not making any judgements here. I think both styles have their uses and may well depend on the personality of the analyst. Often coherence can come at the expense of spontaneity, while spontaneity can sometimes be wild without the discipline of theory. Coherence often has exclusions while spontaneity can risk being superficial.

A third difficulty is the term dissociation, a psychiatric term used to describe major disruptions of basic memory functions. Under times of extreme stress, frightening experiences cannot be integrated into existing meaning schemes, now called narrative or declarative memory. The memory of these frightening experiences is then stored differently, becomes dissociated from conscious awareness, and can only return to consciousness in isolated fragments, stored in memory as sensory perceptions or affective states, now called traumatic memory (Krystal, 1978, Herman, 1992). While dissociation is often called splitting, it is not the same as Kleinian splitting, all-good and all-bad divisions as a defense.

I do think Eekhoff misuses the term dissociation. In the first chapter, she wants to describe three levels of dissociation (p. 8-9). What she calls dissociation from the neurotic part of the personality is really repression while dissociation from the paranoid schizoid position is splitting; neither is dissociation. But what she calls dissociation from the primal position is an accurate description of dissociation. Here there is attention to bodily processes and the mixture of deadening and overstimulation, with a predominance of unrepresented and poorly represented mental states. They are more primitive than repression or projective identification and represent a push toward negativity or atomization. Clinically, they are characterized by psychic shutdown, overwhelming panic, objectless sensation, excessive projective identification, and dissolution of the self.

For Bion, trauma is not a technical term. He does use other similar terms -- terror, nameless dread, catastrophe -- and he certainly knows about trauma from his own wartime experiences (Bion, 1982). Bion’s language is derived from Klein, along with his own unique concepts: container/contained, T and K drives, beta and alpha, the state of O. Can we map Bion’s concepts onto dissociation? Only, I think, with great care.

I will illustrate some of the themes in Eekhoff’s book that I find particularly important, while leaving out many others. Eekhoff brings us to the heart of the clinical dilemma. These traumatized patients desperately want to connect and be heard, yet they are deathly afraid at the same time of contact, of being retraumatized, of breaches in the contact barrier, of re-emergence of trauma -- bombarded, humiliated, forgotten, controlled. Eekhoff describes working with such a patient:

If I am silent, he dissociates and is psychically gone from me. From his experience, I am the gone one. When I speak, I am too big, and he dissociates, becoming one with the patterns of my carpet on the wall behind the couch. (p. 131)

Explosions of massive projections alternate with experiences, of being sucked inward and drained of psychic energy. Action and affect take over; it is impossible to think. Any contact with the analyst, any good exchange must be nullified and attacked, lest any dependency surface. Eckhoff says: “The analyst’s presence amplifies the raw affect without containing it.” (p. 26). The analyst must be prepared to live with this state, must be able to absorb the patient’s projections of hate and despair, and must tolerate unknowing. Eekhoff points to the very real danger of mimicking, of being the good or even ideal patient, seemingly taking in the analyst’s interpretations, yet nothing happens, the coldness remains. There is a failure to reach the “molten core.” (p. 27), and a retreat into an “autistic encapsulation.” (p. 28).

Eekhoff uses the term black hole. Tustin (1988) was the first to use the metaphor of black hole to describe the autistic experience of the terror and rage associated with separation. The metaphor is derived from an historical episode in which 146 British soldiers were shut in a small dungeon in Calcutta, India; most of them suffocated. The term black hole has come to signify a cruel and deadly place. In more recent times, a black hole is a term for a collapsed star, where the gravitational forces are so great that light and all matter is literally squeezed out of existence. Bion (1970), while not using the term black hole, describes the difference between no-thing and nothingness. “The patient feels the pain of an absence of fulfilment of his desires. The absent fulfillment is experienced as a no-thing.” (p. 19). The no-thing is a representation of the lack of fulfilment and its possible realization. Opposed to this there is nothingness, “the domain of the non-existent.” (p. 20). Then, “the non-existent becomes an object that is immensely hostile and filled with murderous rage toward the quality or function of existence.” (p. 20). Green (1973) takes up the nothing of Bion, which he now calls a black hole in the psyche, a result of decathexis, the need to defensively destroy one’s own drives and any connection to objects, to create a nothingness of no desire. For Grotstein (1990), the black hole becomes “a catastrophic collapse of the self.” (p. 40). It is a state of mindlessness and nothingness, where “everything has gone out and nothing comes in.” (p. 41). Eekhoff’s use of black hole is close to Bion and Grotstein, yet, as she rightly points out, the black hole is also felt as safety, a landscape within which the patient can hide and feel protected. She quotes a patient: “It is nice in the Black hole of myself. I just lay down in the sludge of it.” (p. 44). In the black hole experience, the patient cannot use live people for contact and solace. The other at best is a part-object, to be used and discarded at will, but at times is experienced as part of the black hole, sucked in, pulverized and fragmented. The analyst must be prepared in live in this space, sharing the terror and dissolution. This, I think, is the most difficult part of working with these patients:

Analysts may be fooled by this somatic use of other people, including themselves, and mistake the sensual for an emotional bond. The psychic collapse and the resultant black hole of a no-object suck in and destroy emotional connection. Physicality and proximity bring defensive comfort, but are not emotional. They provide momentary distraction. (p. 42)

Eekhoff describes her vivid work with patients:

A white porcelain bathtub, red blood dripping into clear water, and of her mother’s face. The tub is cold against her skin. The water is hot. Her mother’s face is particularly disturbing to her…her mother seems gone from her face. (p. 43)

This is not Klein’s unconscious fantasy. It is a collection of sensory bits, beta elements in Bion’s terms, white and red, hot and cold, death and life. The terror is contained in the gone mother’s face; no-one is present: “there are no words. They are powerful sensations…She cringes away from me as if I would hit her” (p. 43). The blood contains death and suicide. The analyst must tolerate all of this. The office becomes a place of torment and suffering. Eckoff says:

I am the one who is putting her experiences together. I am remembering her and holding herself inside my body and mind. I am able to do this because I believe these experiences are related. (p. 45).

She is evoking Bion’s concept of containment here. But containment here means sitting in terror and nothingness, tolerating, not knowing, not rushing to any conclusions, not rushing to words, as the patient expects to be flooded, crushed, thrown away. This is one meaning of Bion’s concept of O, of being in a state of not knowing and not trying to know; just be with. This also requires what Bion calls faith, holding onto knowledge when faced with nothingness. “She wants me to feel it without dressing it up with words.” (p. 46). But words are all we have and the analyst struggles to find words that convey experience without precipitating enactment or flooding. I find it is important for me to tolerate extended periods of having no idea what to say and being able to wait for the right phrase or metaphor to appear in my reverie. Collusion between analyst and patient is a real risk; the urge for the analyst is to rescue but this only signals to the patient that the analyst is afraid and wants to escape:

If the analyst is able to bear the horror and terror of the Black Hole, tolerate the frustration inevitably present, and find the words for these unnamable experiences, the patient slowly over time, is able to recover the processes of representation. (p. 48)

In Chapter 4, Eckhoff brings up the concept of primary identification, originally found in Freud (1923) to mean “a direct and immediate identification and takes place earlier than any object-cathexis” (p. 31). Winnicott (1956) picks up the primary identification, which he equates with the stage of absolute dependency when the environment is not yet differentiated from the individual. In good enough development, primary identification provides a background of safety and trust. But with early traumatic experiences, primary identification does not develop. It can lead to entanglements in children and adults. They live inside others, a cocoon, or a parasite, never really separating, and stuck in physical and concrete attachments. Or they may present in more of a confusional state, where there is a deep split between the need for fusion, yet denying any dependent relation with objects. They cause confusion in treatment, as they pull for massive identifications, yet appear concrete and unavailable to the analyst. The analyst, too, is not a person, but rather just an interchangeable need satisfying (or persecuting) part-object. Eekhoff makes the interesting observation that in interpreting symbiotic functioning, it is often the analyst who subsequently feels confused (p. 65), evidence of a symbiotic transference and projective identification. This confusional state is often felt somatically and, I find, is particularly hard for the analyst to contain and find words for. Here is Eekhoff’s description of one such encounter:

I felt nauseous and weak, like I would not be able to stand. She was smiling and laughing and said she really needed me, that somehow this therapy was her last chance and she felt I really got it. (p. 67)

In Chapter 6, Eekhoff brings up the concept of introjective identification. It is Money-Kyrle (1956) who first uses the term introjective identification:

Identification seems to oscillate between its introjective and projective forms. The analyst, as it were, absorbs the patient's state of mind through the medium of the associations he hears and the postures he observes, recognizes it as expressing some pattern in his own [unconscious](https://pep-web.org/search/document/ZBK.069.0001u.YP0013420666620?glossary=) world of phantasy, and reprojects the patient in the act of formulating his interpretation. (p. 364)

Scharff (1992) thinks of projective and introjective identification as process present all the time as the background glue between couples and other small groups. Grotstein (1994) describes total and forced projections, which become an obligatory mass lodged in the analyst’s mind. Eekhoff states:

[Introjective identification](https://pep-web.org/search/document/ZBK.069.0001i.YP0016834269210?glossary=) is the capacity of the analyst to be at one with him or herself and the evolving experience of the moment with the patient. The identification involves psychically fusing and merging with the patient, both via reception of their projective identifications and introjecting them. Processing comes after psychically separating. (p. 81)

Eekhoff is especially interested in the negative consequences of forced and controlling introjects which results in “the broken fragmented debris of the self.” (p. 81). How is this experienced by the analyst? By not being able to think, what Bion would call -K. This can lead, in my experience to a negative vicious cycle. The analyst cannot think, the patient feels increasingly abandoned, which in turn increases the unconscious pressure on the analyst, who gets even more stuck, and so on. Eekhoff describes such interactions. She wants to differentiate between merger and fusion. Merger is fluid and maintains some separation between self and object while fusion is parasitic and involves a destructive attack on the container in the attempt to avoid total dissolution. It is the latter fusion states that lead to introjective identification.

I want to emphasize a point Eekhoff makes about the idealizing transference. With such traumatized patients there is often an unconscious and secret agreement between the analytic pair not to disturb or analyze idealization. This allows the patient to maintain his or her current adaptation while the analyst does not have to face the rage or helplessness of his or her patient. The result is a chronic impasse where nothing changes. This is often completely unrecognized by either party who may think the work is going well.

Eekoff brings up the mystical concept of Bion, what he calls the state of O. O, as I see it, is the mental state of complete openness to any possibility, of trying to capture what is not represented in language. It means listening to the patient with no preconceptions, no particular theoretical ideas, and putting aside what happened in previous sessions or what we know of the history. It is not that we have no theory or history but we see what gets pulled into our mind as we listen. We consult reverie, those “ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions, images emerging from states of half-sleep, tunes and phrases” (Odgen, 1977, p. 568), running in the background of our minds   This, I think, is what Bion calls transformations in O. Remaining in O, in the unknown, is difficult. It is tempting to stay with what is known. I believe each analyst must find a way to work with his reverie. I, for instance, will often recall a work of art or a passage from a novel while also paying attention to shifts in my bodily state. We wait until an intuition organizes itself in our mind. How to organize such intuitions and when to speak cannot be specified; it is the art of the work, what Bion calls O to K, the movement from intuition to knowledge. Working as such in the countertransference is fraught with difficulty. We cannot ever tell with certainty what is the transference of the analyst to the patient – the analyst’s pain – and what is the countertransference of the analyst in accepting what is projected by the patient – his containments. Countertransference can often be misused to justify interpretation and action on the analyst’s part, which may be wrong or misguided. How to fashion psychoanalytic knowledge from this chaotic internal field is the heart of the work with these traumatized patients. Eekoff calls it “the bridge of psychic pain” (p. 130) and this seems apt. It is one area where I wish Eekoff would have elaborated more. How the K link can emerge is difficult to know and describe. She calls it “a pulsing interaction between acceptance and avoidance of emotional experience.” (p. 133). Change can be dramatic, “an intuitive leap in the dark” (p. 133), or gradual naming of affect fragments.

 I hope to have conveyed my sense that Eekhoff has contributed significantly to the literature on working clinically with severely traumatized patients who use dissociation as a major defense and have a predominance of unrepresented or weakly represented self and object states.

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