

Incorporation of an invasive object

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(Final version accepted 22 June 2004)

"I'm a substitute for another guy,
I look pretty tall but my heels are high,
The simple things you see are all complicated,
I look pretty young but I'm just back-dated."

'Substitute'
THE WHO

The author discusses the experience of 'being invaded' that is sometimes communicated by certain severely disturbed patients. The complaint can sometimes be couched in terms of bodily suffering and such patients may state that they have the experience of a 'foreign body' inside. It is suggested that these patients have suffered severe early failure of containment of their projections, whilst at the same time have incorporated primitive characteristics of the object that have been powerfully projected into them. An object that invades in this way, it is suggested, experiences a compulsive need to expel unbearable states of mind using others as a repository. The infant incorporates these violent projections as part of his/her own mental representational system, and normal identification processes are disrupted. There follows impairment of the development of the sense of self. Clinical examples are given of how the invasive experience manifests itself in the analytic setting and in the transference and countertransference. It is argued that this highly complex form of early subject-object interaction (prior to the differentiation of psyche-soma) is more likely to be found in severely narcissistically disturbed individuals. Some reflections on the origins of invasive phenomena are given.

Key words: invasive, invasion, intrusive, object, narcissism, identity

I shall try to sketch out a way in which symbolic functioning appears to be undermined in certain cases of severe disturbance. This failure reflects an identity crisis, some features of which became apparent during the analyses of three patients in recent years, two of which I shall discuss here. Each of the patients, though very different in important respects and brought up in dissimilar circumstances, suffered serious narcissistic disturbances. A characteristic the patients shared in common was the experience of having incorporated an object with random, invasive tendencies, which at times could lead them to the brink of psychosis.

By 'incorporation of an invasive object' I wish to convey a primitive introjection of aspects of an object that creates an experience of inundation by the object that can give rise to personality disturbance. This form of 'proto-identification' takes place in early infancy and is consequent upon precocious interaction between infant and object and, critically, failure of containment and maternal alpha function (Bion 1962).

Incorporation is, under normal circumstances, the earliest mode of relating in which the infant feels himself to be at one with the other and is unaware of separation between the two personalities (Fenichel 1945, Searles 1951, Sterba 1957). This experience decreases if development proceeds relatively unimpeded. If development is impeded the experience can persist leading to an equation between relatedness and engulfment, in which one personality is felt to be devouring the other (Searles *ibid* p39). The impulse to unite incorporatively with the other as a defence against separation anxiety has been discussed by Freud (1900, 1933), Federn (1952), Fenichel (*ibid*), Klein (1935), Searles (*ibid*), Heimann (1942), Greenacre (1958), Rey (1994), Segal (1981) and others. Laplanche and Pontalis note how physical experiences are a feature of incorporation, in contrast to the fantasy dimension of introjection into the ego which assumed importance in Klein's thinking and which she discusses in the context of incorporative activity and the genesis of psychosis (Klein *ibid*,

Laplanche and Pontalis 1972).

The patients I shall describe manifested incorporative self-states in the form of bodily and psychological symptoms. I shall suggest that they probably underwent traumatic disruption to the psyche-soma at a time when the sense of self was barely formed and the psyche-soma had yet to undergo differentiation. A primitive introject appears to have been installed in their minds and bodies and was held by them to belong to their own self-representational system. At the same time it was experienced as the concrete presence of a 'foreign body' inside. The experience of something that is not a part of the self, yet is confused with the self, can create not only psychic conflict but incompatible or 'heterogeneous' states of mind (Quinodoz D, 2000). 'Heterogeneity' is denoted by Quinodoz, following Green, as the product of a 'heterogenous constitution of the ego' (Green 1993, p123). This description reflects Bion's observation that 'there is a psychotic personality concealed by neurosis as the psychotic personality is screened by psychosis in the psychotic, that has to be laid bare and dealt with' (Bion 1967, p.63). Quinodoz argues that heterogeneous present for help because they suffer from their heterogeneity, unlike the majority (Quinodoz 2002), p 14). This heterogeneous condition underlies the intrapsychic confusion of the patients I shall describe and seems to have had implications not only for the way in which my patients related, but also for how their thinking developed.

Clinical example 1 - James

James, 27, entered analysis after a series of failed relationships culminating in depressive attacks with suicidal ideation. He possessed an exceptionally high IQ and was capable of abstract levels of thought beyond his years, and of grasping the nub of ideas and arguments. There was a paranoid tinge to many of his observations and his attention to others' motivation seemed compulsive. James was a quintessentially self-made man. He had failed at school but became successful as an adult in business. James' father, an addict, died in his forties of a drugs overdose. James was a replacement child. A previous son had died, apparently unmourned, ten months before James' birth, the mother having been advised by her doctor to get pregnant again straight away. James' mother seems to have been an unstable woman preoccupied by grievances. He said that his parents fought during the marriage over affairs each accused the other of having. He recalled as a child sitting in fear in his pyjamas on the stairs whilst his parents brawled. He left home at sixteen and remained un-reconciled to them, seeing his mother again only once, in hospital, unconscious on her deathbed.

I was struck from the outset by the speed with which James seemed to reach the meaning of his fantasies and dreams. He would often get there before me, sometimes with impressive intuitions, without making me feel excluded. I felt

that he strove to be a 'model' analysand. It became apparent that he needed to control the analysis, subtly and diplomatically, and that he suffered intense anxiety when he did not feel in control. He revealed that the controls were, in fantasy, controls over my thoughts. Why he needed to feel in control of my thoughts was not clear. His dream life provided evidence of a serious disturbance of the self. He dreamed repeatedly that he had murdered someone. The body, a male, lay buried under a road; it was a secret but the police were piecing together clues and were on his trail. He developed insomnia to avoid these nightmares.

James' compliant, controlling behaviour decreased as he became more depressed and nihilistic during the second year of analysis. In one session he lay contemplating suicide and said, with piercing dejection:

"I came into analysis to find consolation, as I knew nothing could ever come of my life."

I was affected by this comment, said with no trace of defensiveness, and my response – an intense, lonely sadness - persisted after the session. I realised that I had been struck by, to paraphrase Marion Milner, a 'thought too big for

its concept'¹. I wondered whether 'analysis-as-consolation' masked, for James, the site of an experience of annihilation anxiety. This phenomenon has been referred to as 'a memorial space for psychic death' (Grand 2000), in which unspeakable, traumatic events are always felt to be present, yet by definition must always be absent. Metabolization through language is the means we possess of approaching such catastrophe, yet this is disbarred, as language is experienced as being unable to approximate the scale of the events involved.

I shall pass to a period in the third year during which James decided he wanted to quit analysis and his suicidal feelings took a psychotic turn. He had become disillusioned and was prone to long, angry silences.

'Is this all there is?' he would complain bitterly, following stretches of withdrawal. He could be abusive, accusing me of keeping him in analysis to maintain the vain illusion that I could help him. If he felt I might be close to understanding what he was feeling he would lash out contemptuously – for example:

"This (analysis) is hypocrisy. It deceives, it lies, it's wanking. It's a middle class fix: you haven't got the first idea about me or what people like me go through."

¹ The title of an abstract picture painted by Marion Milner.

He told me he felt burnt out, disgusted by himself and hopeless. The nightmare of having killed someone preoccupied him, including during the day, making it increasingly difficult for him to function. As his condition worsened I became anxious for his safety, as he was immersed in what appeared to be a developing transference psychosis. This situation continued for some weeks. I interpreted his disillusion with me and feelings of unmanageable rage this engendered. An event occurred in which James communicated his rage in a way that I felt revealed his having incorporated an object characterized by invasiveness:

James had spent most of this particular Wednesday session in tormented distraction at his inability to control his feelings of hatred towards his female partner, who he was afraid would leave him. He described unpleasant scenes between them that left him confused and suicidal. The idea that there might be no change appalled him. He twisted and turned on the couch, as though in bodily pain.

I interpreted how afraid I thought he was of becoming more and more like his parents, at home and here, and how feelings of growing resentment and hatred of his partner and of me pushed him into a terrible sense of fear and failure: hating destroyed his power and hope, he felt, turning him into a desperately

needy child. The only way out he could imagine was to kill himself but even this didn't work as still he felt no-one understood what he was going through.

James' writhing stopped and his body relaxed visibly. He appeared to be relieved at having his confusion and fear acknowledged. He then became gradually more restless and what appeared to be a more thoughtful silence turned out to be not the case. He slowly and purposefully got off the couch, stared at me – or rather through me - and shouted with unbridled hatred:

“Keep your platitudes to yourself, you stupid fucking moron”.

This outburst of violent narcissistic rage seemed also to embody a desperate effort to try to rid himself of an alien presence or state of mind, of which I appeared to have become an incarnation. He fell silent, walked unsteadily round the room, distracted, and eventually sat on the edge of the couch, trembling. I felt assaulted by the attack – fear and anger welled up inside me. I could not think of anything appropriate to say, only a wish to protect myself. I felt stripped of a capacity to contain the situation. James sat for some time holding his head in his hands. I recall the session ended with me asking him whether he felt able to manage getting home. The next day James was in a distressed, confused state:

“I don’t understand. I can’t remember it clearly..it is like a fog..something just came over me. I don’t know how to explain it..I’m sorry. I feel a bit like it now, kind of stunned. My head feels full..there is so much going on that I can’t think and my legs feel like lead..like my body wants to collapse. I don’t quite know where I am in this. I don’t know why I should scream at you like that...

He continued in this bewildered, anxious way that seemed to combine guilt about what he felt he had done to me and confused feelings of dread and relief at having lost control. I said to him that although he felt a need to apologise, what was striking to me was that he had allowed me to see some of his deepest feelings, including about me, without camouflage. We discussed his anxieties further and he said:

“I don’t think I had a choice; it doesn’t feel like I did...it wasn’t taking a risk. Something exploded. It was anger but there’s something not right about that... it’s not the whole feeling. Something in me could have killed you. I wasn’t thinking this when it happened but it makes me think that something in me wanted to smash and smash you and shut you up so I didn’t have to listen any more. As I say this it reminds me of my mother and how I couldn’t stand the shouting but I couldn’t do anything about it. Maybe I was fighting her...maybe

even being her - or being like her somehow - but in another way I was outside it, watching it going on.”

He talked about a ‘blizzard’ having descended, pains in his head and a heavy sensation in his body. I was led to think that he had been in a psychotic transference. During ensuing weeks James experienced much confusion and worsening bouts of withdrawal. Further attacks occurred, usually when I least expected them. They seemed to be precipitated by contact with James’ infantile self that he despised – that is, when he felt a childlike need for me or when I said something that touched him. His withdrawals took on at times what I thought was a psychopathic quality: it was as though I could suddenly cease to exist for him. Although each attack had seemed, in the beginning, to free something in him, I noticed that his rages could be accompanied by a malignant, anti-life attitude that destroyed opportunities for his infantile needs to be met. What had been a form of letting-go could come to resemble a sadistic, narcissistic defence. James’ responses to his attacks varied from obliviousness to persecutory anxiety to acute paranoia. Yet, after one outburst he commented:

“I feel bad about what just happened. I hate you and you make me furious with the things you say, but I think it was out of proportion – my reaction, that is.”

I queried his feelings and he said:

“I don’t know how real my hatred of you is sometimes. It wells up..it is true. But it can feel like an automatic thing...a gut reaction...sometimes it doesn’t really matter what you’re saying, it erupts without me having any control over it, as though I just have to silence you.”

I felt that James was experiencing anxiety possibly over feelings of frustration and rage towards me, but was also confused by a psychotic identification that precipitated attacks in order to try to annihilate our relationship. Non-psychotic and psychotic aspects of his personality seemed to vie for expression. James behaviour outside the session reflected his confusion. Here is one example: at home one Sunday he heard a dog squealing in the street. He dashed out to find a large dog belonging to some drunken youths pinning down a small dog by the throat. He dived between them, prising open the jaws of the larger dog until the smaller one was freed. The youths turned on James but his unassailable resolve caused them to back off. In his session, he could not account for his impulsive behaviour, was not proud of it and yet felt oddly better. He showed little indication of overwhelming guilt or confusion. He had to separate the dogs, he said, and he could see that many people would think that what he did was crazy. He wanted to know why he had been compelled to act. Later in the session he remarked:

“The thing with the dogs has made something clearer to me: it sounds obvious but it isn’t. Although it does sound mad. I think I thought that the fight that was going on was my fault, but it wasn’t.”

This insight permitted work on feelings of ‘being intrinsically wrong’, as he put it, in the eyes of his mother. He conceived of this as:

“...nothing I did was right. It wasn’t only about making mistakes or doing things that annoyed her. It was like I got everything wrong as a matter of principle...when I was small I thought I could please her and I tried to but by the time I went to school I think I felt defeated. Nothing worked...she couldn’t bear to look at me...not disapproval exactly, although there was a lot of that...more that I was some terrible burden she’d had forced on her and couldn’t stand. It was bewildering...there were times when she would suddenly be incredibly nice but these would only last for a few minutes. I stayed out of her way, but I often forgot and got screamed at. It took years for me to realize that the whole thing was impossible...she was on a different planet. I know that by the time I was 7 or 8 I had thoughts that I’d be better off dead. I would feel relieved when I went to bed that I’d got through another day and pray that I wouldn’t wake up. For years I went to bed early to blot things out.”

I said: “You feel you died as a child.”

He replied: “ I do (cries)..everything went wrong and I have been stuck with it all my life. I think my childhood was ruined..now I am like her and I ruin it myself.”

I said: “You feel you died and yet somehow you managed to go on; not only go on but do well eventually.

He said: “I can’t explain it. The only thing that comes to mind is that I realized a few years ago talking to my grandmother that my mother must have been delighted that I was born healthy and lived. She must have been desperate not to lose another child. My grandmother said I was doted on – given special orange juice and supplements to build me up. But she told me that the marriage was in trouble and my mother started having affairs when I was born. I do recall different men came to the house from as far back as I can remember. I don’t know...maybe I was made to feel very special in some way and that gave me a kind of good start. What I’ve always felt is that my life wasn’t my life. I felt I was somebody because of what I did for others.”

The analysis focused, in the transference, on the feelings of having died as a child and how his attacks and withdrawals defended him from the painful experience that his attempts to live felt like a lie, so confused was his sense of his own self. Gradually, he became more able to work at understanding the

relationship between feelings of love and hate and a welling up of psychotic rage against me that expressed his destructive narcissism. These eruptions were preceded by a visceral sensation, blood coursing through his veins, he said, or tinnitus-like ringing; then outbursts that bore a resemblance to accounts of his mother's aggression. As they came under more control (they ceased in the seventh year) he told me he had always had a 'wild side' to him of which he was ashamed. He felt the same hatred of people his mother had shown, with no justification. He did not evade responsibility for this, but was concerned that it did not represent the complexity of his feelings, even at his angriest. He described it as 'default extremism' or a 'scorched earth policy'. James had indicated how frightened he had been of his parents, but his intimidation at his own and his mother's mood changes only now became apparent. These had left him disoriented as a child. He said that his mother's attacks had occurred from as early as he could remember and he had been convinced he had provoked them. He began similar attacks from the age of about 7, he thought, including on his mother's dog that he had tormented. The need to attack others 'when they got too close' was lifelong and compulsive.

I came to think that James had sequestered and tried to kill his identity and that his life had become a sham. He had evolved an impenetrable, seamless second skin that afforded him a false sense of integration (cf. Symington, 1985). Within this illusory maturity lay the experience of being unrecognised for himself and uncontained in his feelings. When James' true, alive self stirred, he was susceptible to feeling that this was a betrayal of his reality, leading to

confusional states. I surmised that a defensive, imitative introject of an object that could not bear loss (and, hence, life) could then be triggered, generating narcissistic rage and masochistic compliance in an attempt to preserve a sense of coherent selfhood (Williams 2001).

After much work on the defacement of his personality, his primitive identification with invasiveness receded and he acquired greater tolerance for his emotions and limitations. He also began a more articulated grieving process that was paralleled by a reluctance to comply with others' demands. His relationship with his female partner improved and they began a family. The love between him and his baby daughter, though sometimes painful, afforded him awareness of his value to another person, something he had not previously been able to experience. This helped to offset his sense of loss at what he had missed in his life because of his behaviour. In the eighth year of his analysis he said:

“I feel I have to pay attention every day to that child I was. It's like visiting someone in hospital or a grave. If I don't think of him or hold his hand I can feel lost. I will never let him go again.”

I felt that James had buried his childhood identity and evolved an impenetrable, seamless second skin that afforded him a false sense of integration (cf. Symington 1985, Winnicott 1960). Within this illusory maturity lay an

experience of being unrecognized for himself and uncontained in his feelings. When James' true, alive self stirred, he was susceptible to fears of abandonment and disintegration, triggering, amongst other things, a defensive, imitative introjection of an object that could not bear loss (and, hence, life) and which reacted invasively.

Clinical example 2 – Ms. B

Ms. B., 49, was diagnosed in her thirties with a paranoid psychosis although I came to think she suffered from a borderline personality disorder. She came into analysis thirteen years ago. The middle child of a working class family, Ms. B complained she had had no relationship with her mother who passed her from birth onto her father because mother favoured the first child, a boy (her other sibling is also male). Her rage at her mother's rejection of her was unremitting – 'she never showed any sign of wanting me – never' was her refrain. The father appears to have been paranoid and periodically incapacitated by his difficulties. Ms B said that at around two or three years of age she had retreated into a fantasy world, becoming friendly with creatures from outer space who promised to take her away. She also came to believe that she was a famous actress. She maintained that she and her father had had an incestuous relationship up to her 14th year. She told me she had acquired a manager, a pimp-like figure called 'The Director', who controlled many of her actions, feelings and thoughts. 'He' was to emerge in the analysis as a pseudo-hallucination. After four months of

analysis Ms B. reported the following dream:

“I am being fed. A hand slaps me across the face
hard. Then I am on a terrorist exercise, rolling
down a hill clutching a male officer. We fall off a
cliff or shelf.”

I interpreted that she was letting me know of a catastrophe, a loss in her life that she felt could never be made up, and that she had turned to men and sex to try to compensate. I rapidly became an object of idealization, whilst her violent, perverse pathology was acted out, mainly sexually. By the second year Ms. B. had begun to cut herself; she took a non-fatal overdose and jumped from a still moving train, injuring herself. A psychosis asserted itself: this is a dream from that time:

"A minibus crashes through the front of a food
store. There is a huge explosion. My older brother
helpfully leads people away. There are many dead

pregnant women. I touch the stomach of one but there
is no life. Tins of food are embedded in people's
faces. They are missing arms and legs. The manager
says "We carry on, we stay open". I try to stop him I but can't."

She was unable to consider the themes of murder or dead mothers and babies in this or other dreams. Her behaviour became more disturbed and she was hospitalized following attempts to swallow a lethal dose of lithium medication. After a two year period in which there was a good deal of extreme disturbance, which I do not have space to describe here, the direction of the analysis began to shift towards a more verbalized, transference-oriented hatred of her dependence on me. The patient moved from a predominantly paranoid position and acting out to one of sadistic, abusive attacks. From having complained of abuse, she became an abuser, of me and the analysis. For the purposes of this paper I want to illustrate how the patient seems to have incorporated an invasive object that combines characteristics of the patient's projective activity with features of both parents.

In a Monday session during year two Ms B complained at length that she was no good because girls don't get love. Love from mothers is "lesbian", she said,

and this is the most awful thing in the world. The way to get love was to be a boy like her older brother, or like her father. She was a boy, really, she said: she could do anything boys could. She recounted how when she masturbated she fantasised that she was a man and that women queued up to have sex with her. She sometime strapped a dildo to her waist when she went out to make her feel like a man. She talked further about childhood fantasies of being a powerful boy and that she had changed her sex (although the patient was talking about fantasies, I was unsure as to whether she actually believed she was male as she spoke).

I said:

“I can see what you mean about the advantages you felt boys had, but I’m wondering about and remembering that you were born a girl; where is she? What has happened to the longing for love you wanted from your mother, that you have told me about? You often tell me how lonely you feel and how much you want to talk to me, especially during weekends. That person seems to me like a little girl who feels her needs are being ignored.”

Ms B became agitated and shouted:

“Keep out! Lock the doors...the walls are moving. Lock the doors, shut up, lock them! Keep them out”

I said:

“Something I have said has alarmed you. Can you tell me what’s happening?”

She replied:

“It’s the Director...he’s telling me somebody is coming in. They’re coming in and they’re going to get me...they’re going to kill me!”

This intrusion of the psychotic ‘Director’ figure was to happen frequently and exerted enormous influence over the patient. The technical problems associated with interpreting these paradoxical ‘influencing machines’ that purportedly protect but in practice deny the patient any good object-relating experiences, are obviously considerable. What I wish to stress here is that these paranoid outbursts revealed, in my view, not only Ms B’s deep-seated fears of her own destructiveness and invasiveness, but also evidence of miscarriage of early introjective processes. The invasive narrative of Ms B’s ‘Director’ (which always involved accusations of people getting in, breaking in, stealing and attacking, when not manically advocating sex) displayed certain elements of concordance with the patient’s accounts of her father’s paranoid anxieties and of the rejections she attributed to her mother (and which she herself made). Observations by her about her father over several years of analysis, often inadvertent and spontaneous, were paralleled by ways in which she herself could think compulsively when in the grip of a psychotic transference characterised by invasive fantasies and feelings of fragmentation. The ‘Director’ seemed to afford her a sense of identity when in crisis. ‘His’ underlying objective was, as I have suggested, to influence the patient’s ego to reject

human contact and pursue a course of pathological, narcissistic withdrawal, reflecting her primary narcissistic crisis.

Invasive experiences and the Self

To avoid misunderstanding, I want to stress that I am not suggesting a simple concordance between this patient's and her father's personalities or a linear causality between the external object's influence and the patient's fantasies. There is no direct equivalence between her father's projective activity and the patient's identification with invasiveness – or for that matter between the patient's narcissism and the mother's psychopathology. The same applies to James, I suggest, or to any patient with this kind of disorder. The intra-psychic situation I refer to is likely to be extremely complex, involving pathological aspects of the patient's infantile self becoming confused and amalgamated with sequelae of uncontained projections and with the projective activity of the object. Identification with the aggressor is evident, but the process has a primitive, fragmented quality linked, in my view, to threats to the core sense of self. Inadequately contained objects and part-objects become installed in the psyche of the infant generating confusion and anxiety. Gaddini provides an account of how this early crisis might evolve. He studied how normal imitation or mimicry, an oral introjective activity which takes place prior to identification, can develop pathologically. Precocious conditions of oral frustration may cause disturbances in the psycho-oral area and in introjective mechanisms. Imitative

introjections, instead of acting as precursors to normal introjections, may substitute for true introjections and, as a consequence cause internalization processes to fail (Gaddini 1992 p4). Imitation may then be used defensively to avoid introjective conflicts. The child's fragmented personality and thinking will then develop on the basis of this failed identification process, imitation being substituted for genuine object relating. Weiss, in distinguishing imitation from identification, stressed that 'no simple imitation' takes place in the mind of the infant. There is, he suggests, a form of 'reproduction' or 'autoplastic duplication' (following Ferenczi) in which the organism acquires and modifies its shape and functional parts (Weiss 1960). In my view it is probably a defensive use of autoplastic duplication that gives rise to the concordance between certain primitive elements of the patient's disturbed personality and invasive projections. Prior failure of containment and breach of the 'contact barrier' (Bion 1962) in the mother-infant relationship probably renders the individual vulnerable to excessive permeability, and development of the self is then impaired at the stage of mimetic introjection. This disturbed early attachment process seems to have created, in my patients, a backcloth against which a pathological amalgam of projections arose and expressed itself corporeally as well as mentally. Although there is no space in this paper to discuss the relationships between phantasy, projection and introjection in these states, especially the influence of unconscious sexual phantasies, the organising roles of unconscious phantasy and memory, the impact of deferred action (*après-coup*) in their aetiology and evolution and the re-elaboration of psychic

reality that follows, would need to be taken into account to clarify the resulting amalgam of projected and introjected elements. My aim in this paper is to emphasise the complexity of these early object relations experiences - what might be termed metaphorically as encounters with 'fractal' objects'² - and to indicate how, through attention to a range of transference communications it may be possible to identify, a posteriori, introjective patterns that underlie failures in identification formation. Such investigation is analogous to identifying the 'sensitivity to initial conditions' in deterministic chaos theory, through which one or more variables can come to have an enduring, disproportionately perturbing effect on a complex system³.

If we think of the self as a developmental achievement deriving from the infant's need to mentally represent internal states, using the mind of another, then recognition of the intentionality of the caregiver's mind permits the infant to establish an internal representation of himself as a truly separate, intentional being. The quality of the caregiver's image of the infant as an intentional being is critical for the formation of this representation. If care-giving fails to contain and reflect the infant's experiences and anxieties, a mis-representation of the infant will be internalized corresponding to the partial or distorted representational capacity of the other. The patients I described experienced, I

2 A 'fractal object' is a structure that repeats itself infinitely and remains identical whatever its scale.

3 I am grateful to Jean-Michel Quinodoz for the observation that 'sensitivity to initial conditions' refers to one variable amongst many being responsible for modifying an entire course of events. It is possible to predict only the short term evolution of such a system: however, it is also possible, *a posteriori*, to go back to initial events and to determine one or more factors that may have triggered the perturbation of the system. Quinodoz has discussed this analogical model in the context of psychic change (Quinodoz 1997).

believe, during this early developmental phase, failure to have their projections contained and metabolized leading to an experience of emotional violence. If assailed by invasive projective activity, the trauma would be an amalgam of inchoate experiences, the residuum or precipitate of which may correspond to the 'foreign body' experience lodged in the unconscious and in the body and which lacks mental representational status.

Attempts to repel invasiveness through the counter-use of projective identification are likely to heighten the intensity of the pathological interaction as it is the identification with invasiveness (associated with projections by infant and object) that is employed defensively. The infant's body is implicated in the trauma in that it carries the status of a primary object to which the infant relates and which can become installed as an internal object. Egle Laufer has discussed how uncontained bodily states due to poor handling of the infant by the caretaker can create adverse developmental conditions (Laufer 2003). I think that such deprived conditions could pertain to incidences of invasiveness. Indeed, extremely deprived infants may 'invite' invasion or at least incorporate avidly powerful projections as a consequence of extreme need.

Those who are compelled to expel unbearable mental states force the mind of the other to deal with what the invasive object's mind cannot. I became aware in my patients that once an offending mental state had been expelled, an invasive

object ceases to have use for the subject as an object and reverts to a position of narcissism. Perhaps it is more accurate to say that the invasive object returns to a narcissistic state of unconscious fusion with an idealized internal object. Developmentally, managing a foreign body inside destroys mental space allocated to the symbolising activity by the ego. Identification with characteristics of invasiveness disrupts processes of integration of experiences necessary for secondary process thinking. The individual who has incorporated an invasive object is likely to feel unstable, depleted of personal meaning and occupied or haunted by unidentifiable bodily perceptions. Complaints of feeling controlled, alienated, possessed, ill or diseased may accompany these self-states. During analysis, the transference neurosis can come to resemble a psychosis, with the patient able to think only intermittently and prone to interaction that reflects the dynamics of invasion. The patient may employ stereotypical ideas and language displaying power without conviction, and if pressed may become disorganized. Identity diffusion can occur and there may be acting out. Such patients are unsure of who they are, and under stress can communicate by proxy through their bodies.

Intrusion and invasion

Although by definition invasive objects intrude, I have found it useful in my clinical work to distinguish between intrusive and invasive objects. Intrusive objects tend, at least in my experience, to be motivated by a need to occupy or

become a feature of the subject for reasons that can include parasitism and sadism. Invasive objects seek primarily to expel unbearable, infantile conflicts using, for the most part, excessive projective mechanisms. Expulsion is compulsive and violent and they do not appear to strive to colonize or become a feature of the subject in the same way, as their aim is to mould a repository for evacuation prior to a retreat to a position of pathological narcissism. The identity of the recipient of the projected state is less important than securing a mind into which the state can be jammed. I think of invasive projections as akin to 'psychosomatic missiles' that are expelled or 'fired' into the other. The dream of Mrs B, in which tins of food are embedded in faces and unborn foetuses are killed, seems to be a vivid image that reflects oral invasiveness. Ms B's failure to internalise benign representations of her mother probably induced an identity crisis of critical proportions at the oral stage, exposing her to uncontrolled envy and murderous feelings towards her mother and brother. Perhaps her gender confusion contained a wish to be her brother as a way, in phantasy, of attempting to resolve her identity problems. She seems to have violently rejected her mother, incorporated aspects of her mother's rejecting attitude and became consumed by fantasies of invasion echoing themes evident in her father's paranoid personality. I thought that a claustro-agoraphobic dilemma in relation to her mother (Rey 1994) had forced her to turn to her father and assume a phallic omnipotent stance in relation to her objects. Her abnormal superego (O'Shaughnessy 2001) usurped central ego functions, directing her thinking predominantly around the theme of invasiveness via the

psychotic figure of the 'Director'. The fluidity and confusion of identificatory processes in Ms B's early life seem to have rendered her vulnerable to feeling inundated and overwhelmed, and subsequently she experienced herself as having little or no core personality of her own. Fonagy has discussed how violence in certain patients may be employed in an attempt to establish a sense of identity, and I think the advent of Ms B's 'Director' probably reflects such a process (Fonagy, in Perelberg [Ed.], 1999). Interestingly, after 12 years of treatment, Ms B reported that she was no longer sure whether sexual intercourse had occurred between her and her father. How true this statement is I do not know, but it made me wonder whether it is possible that incorporation of aggressive, sexualized part-objects of the type I have described may lead a disturbed infant's mind to phantasise, via the somatic dimension of the incorporative process and confusion between inner and outer reality, that sexual contact has in fact taken place.

James, in contrast to Ms B, incorporated the impact of a refusal to acknowledge his very identity. This derived from what appears to have been projections by a narcissistically disordered mother unable to mourn the death of her first child and who became 'centrally phobic' to experiences of loss (Green 2000). James' feelings of authenticity were destroyed and he consigned himself to living out a counterfeit, shame-filled life in identification with this denial of his separate existence and his brother's death. It is possible that there are different forms of incorporation of invasive objects. For example, the impact of a projectively

invasive mother as experienced by bulimic patients may point to how projected 'missiles' can later be re-projected physically as well as mentally (Williams, G. 1997). Invasion fantasies also feature in the psychodynamics of anorexia (Lawrence 2002). In certain psychoses auditory or command hallucinations can reflect incorporated aspects of objects, drawing on unsymbolised sexual and aggressive impulses (cf. Jackson and Williams 1994). Perhaps the dynamics of rape and their implications for the types of personalities involved could merit study from the perspective of experiences of invasion by an object. It seems that invasive experiences can occur under a variety of circumstances and are linked to faulty or over-fluid identificatory processes. What they appear to have in common is the production of pathological internal part-objects that disrupt ego functioning and the evolution of a sense of self. The confusion with which the subject lives reflects multiple axes of relatedness (projective and introjective) to these part objects - a subject about which we currently still know relatively little.

The literature on early objections relations conflicts touches on issues raised in this paper from different perspectives. Richard Sterba and Anna Freud studied the impact of oral invasion that leads to overwhelming identification with a rejecting object (Sterba *ibid*). Paula Heimann described miscarriages of sublimation linked to experiences of intrusiveness (Heimann *ibid*). Rosenfeld depicted vividly the clinical consequences of introjected part-objects, particularly their 'mafia-like' qualities that 'protect' the ego through

intimidation whilst countermanding any opportunity for recovery and development (Rosenfeld 1975). Sohn in the UK identified in, sudden, unprovoked assaults a form of primitive identification with a violent, uncontained object he calls the 'identificate' (Sohn 1985). Gaddini made the observation that the primitive self of the infant that reverts to a pathological use of mimesis can experience subsequent attempts at integration as a threat to the fragile sense of self, if a fragmented identity has come to be relied upon defensively. This defence can perpetuate developmental arrest (Gaddini 1992). Winnicott's concept of the false self is a detailed portrayal of one of the ego's principal, radical responses to such infantile crises (Winnicott *ibid*). Bion, above all, identified the consequences of failure to contain an infant's projections and how this can give rise to states of terrifying persecution, (Bion 1962, 1963, 1977). There is considerable consensus, irrespective of theoretical persuasion, that without the establishment of a 'third' position based on a capacity to incorporate the 'mother-as-environment' (Winnicott 1967) leading to the acquisition of 'reflective function' (Fonagy & Target 1998), 'binocularity' (Bion 1967) or 'intersubjectivity' (Trevarthen 1993), ego capacity is consigned to managing psychic trauma and development is impaired. The examples I have given indicate that no 'third' position had been established. If characterological disturbances within the parents are projected into the offspring throughout their development, leaving no stage of childhood untouched, a third position is probably unattainable. From this point of view, object relations disturbances are lifelong, starting in infancy and impacting on each unfolding developmental

stage (Martindale 2004, personal communication).

The appearance of invasive objects in treatment is often seen as unpredictable and based on disorganized patterns of attachment (cf. Fonagy 2000). I think that these invasive assaults may, on examination, be more predictable than they appear, being patterned according to the ego's phobic responses to particular constellations of primitive affect (Green *ibid*). Recent developments in neuroscience suggest that assaults on the psyche-soma of infants during the first year of life can indicate loss of cortical function in the fronto-temporal areas (Perry 1997). The long-term neurological and psychological impact of invasive experiences may be significant in understanding serious disturbance in infant development.

To conclude: incorporated aspects of an invasive object can become confused with the nascent infant self and are subject to idealization. In analysis, the prospect of relinquishment of a mimetically constructed, incorporative relationship for one with an ambivalently cathected, separate object can be experienced as catastrophe, as this is equated with loss of the ongoing sense of self. It may be necessary for the patient to endure a period of psychotic confusion as the process of un-incorporation and dis-identification takes place. Without this, the invasive object remains active in the unconscious. The patient may attack the therapeutic process in order to prevent the experience of

catastrophic change (Bion 1965). This defensive activity is, in my view, a response to the confusion that derives from the 'foreign body' inside that must be got rid of if disruption to psychic functioning is to be halted and personality development restored, but which the patient feels cannot be forsaken as it is experienced as a part of the self.

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Word Count 7903

March 26th 2004