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THE WORLD OF SELF PSYCHOLOGY

**Progress in Self Psychology
Volume 14**

Arnold Goldberg
editor

 **THE ANALYTIC PRESS**
1998 Hillsdale, NJ London

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a Common Language Between the Therapist and a Primitively
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THIS IS THE FINAL DRAFT OF THE PUBLISHED PAPER

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THE DEVELOPMENT OF A MORE THAN BINARY SELF
Constructing a Common Language Between the Therapist
and a Primitively-Organized Schizoid Patient

September 1997

Introduction

This Chapter focuses on the beginning few years of work with a patient who is reminiscent of what Fairbairn (1940) calls a person with a "recognizably schizoid complexion" to his personality. The relational foundation we were able to create during this early period of our work together allowed subsequent profound analytic work and development over the following decade, but I will only make brief references to the later work in this paper.

The Literature

Ferenczi (1933), Fairbairn (1940), Winnicott (1945), Guntrip (1971), and Giovacchini (1979), among others, relate schizoid mental processes to traumas in very early care-taking relationships.

Fairbairn (1940, p. 8) sees important schizoid characteristics as omnipotence, isolation and detachment, and a preoccupation with inner reality that might be imposed on outer reality. He believes schizoid mental processes reflect the most deep-seated states, and that schizoid individuals who have not regressed too far are capable of transference to a remarkable degree.

Ferenczi (1933, p. 160) referring to analytic regression states: "The patient gone off into his trance is a child indeed who no longer reacts to intellectual explanations, only perhaps to maternal friendliness; without it he feels lonely and abandoned in his greatest need, i.e. in the same unbearable situation which at one time led to a splitting of mind and eventually to his illness."

Winnicott (1954) refers to a group of patients whose analyses "must deal with early stages of emotional development before and up to the establishment of the personality as an entity." For these patients "the accent is more surely on management, and sometimes over long periods of time....analytic work has to be in abeyance, management being the whole thing" (p. 279).

Guntrip (1971) discusses the schizoid problem evolving from early environmental failures as involving "deep-seated doubts about the reality and viability of their very 'self' (p. 148). Underneath a withdrawn (quiet and introverted) or split (cold and intellectualized) facade is a "vulnerable, fear-ridden, infantile self, showing up in his dream and fantasy world" (p. 151). He notes the terrible bind of not being able to live with or without human relationships.

Giovacchini (1979) sees schizoid patients as having embryonic egos, the result of trauma during the prementational, pre-verbal phase. A lack of psychic structure, causing an inability to sustain object relations, allows these patients to relate with only very basic affects. Feelings and experiences of the self have little mental representation above the somatic level, resulting in a very concrete perspective. The outside world is dangerous, not because of projections, but because of the person's inability to deal with it (p. 120).

Kohut (1971) views the schizoid personality as a necessary preconscious defense against regression toward psychosis that results from an extreme narcissistic vulnerability. He cautions the therapist to precede delicately in an analytically informed mode of therapy in order to avoid severe regression and fragmentation.

Ogden (1989) speaks of the schizoid patient's retreat into fantasized internal

object relations, his omnipotent thought defended with splitting and projective identifications. "It is a world of heroes and villains, of persecutors and victims; a world in which object ties are often addictive in nature, and loved objects are tantalizing and unattainable....When an external object does not act as wanted, then denial, contempt, grandiosity, distortion of perception and/or emotional withdrawal" (p. 85) reduce the impact, allowing the patient to be untouched by the external experience.

Several of the preceding authors refer to the deep level of regression that may be expected in the analytic setting, a return or reversal, not usually characteristic of the patient's level of adaptation in the outside world. In some cases, as with my patient, I think the notion of regression misses the experience of the patient's inner world. What appears to be a 'regressed' state in the analytic setting may, in actuality, be a reflection of a level of development or 'progression,' in the realm of psychological structure. The individual may, or may not, have many other developmentally advanced abilities that allow him to camouflage his developmental deficit.

Constructing a Language in the Therapeutic Setting

"The Patient"

William was referred to me for supportive therapy preceding cardiac surgery at age 29. A congenital, degenerative disease, that usually shortens the life span to less than 40 years, had previously necessitated several major surgeries. He recuperated from the surgery and continued therapy with me, three to five sessions per week, ostensibly because he was so isolated in his world. I later understood that he was also intending to have a romantic relationship with me.

He was extremely shy and volunteered little even when invited to speak but seemed to derive comfort from the sessions. A particularly short and wiry man with a ghostly pallor, he always wore a tie and a baggy suit that looked as if it were from another era. His shirts usually had blood on the collar from shaving wounds, due to poor vision which necessitated that he hold reading material about three inches from his face. His strong cologne lingered in my office much to the dismay of several other patients. His affect was frozen with deadened eyes and very thin lips, perpetually turned down, as if someone had drawn on a "sad face." There was something about his appearance, although not about any singular feature, that caused people to avoid him and inspired negative or curious comments. His background, which included early hospitalizations, was traumatic, but remains sketchy. His father was at least verbally abusive; his mother was weak, anxious, and unaffectionate; and his brother seemed not to exist to him. A younger sister had committed suicide.

"Bridging the Abyss"

I found it difficult to access his inner world. He would speak only minimally when spoken to, but I held an assumption that we shared a common language, when in fact there was very little intersection of language or experience between us. Our external and internal worlds were different, but more importantly, how we conceptualized, represented, and understood our own subjective experiences was worlds apart. I began to look for ways to bridge this chasm, to better understand his language (which was often communicated through actions), and to allow him to understand mine. We would need some sort of shared communication on which to expand.

Also relevant to this early part of our work is Sifneos' (1967) concept of "alexithymia," a deficit in affective and symbolic function that results in an inability to desomatize affect which Bach, et al. (1994) found to be highly correlated with schizotypal, dependent, and avoidant personality types. Krystal (1978) relates alexithymia to a diminished capacity to self-soothe and self-gratify. Much of my patient's experience of self and other was felt through bodily states. His affect world was mainly represented through concrete goals and actions, and although he was alexithymic, that term does not fully capture the paucity in his relational world and his extreme vulnerability to others.

I was the extent of his non-familial relatedness except for brief moments with his manager at work and periodic visits with his sole friend from childhood. At work he had made some attempts to engage with other engineer co-workers but felt excluded by them as he directly criticized their slothfulness. If he didn't like their style on a joint project, he would come in late at night and redo their work to his satisfaction.

William's most common ways of relating to me was to make demands, act out his wishes, or stare at me in silence. To one therapy session he brought a bouquet of roses, which took me aback, as I politely accepted it, trying to understand the meaning of it with him. In subsequent sessions he beseeched me to become his girlfriend and came to sessions 'courting' me with candy and flowers, describing expensive gifts he wished to lavish on me. This led me to a very concrete discussion about limits in the therapy relationship and my inviting his thoughts and feelings while I tried unsuccessfully to interpret his gifts as reflecting his need to feel of worth. Much later in our work he was able to express that gifts lessened his shame by representing something of worth that he could give since he felt nothing actually within him was of value. However, during this early period, talking about it was not concrete enough to impact his ongoing attempts to shower me with gifts. One Christmas, after a lengthy discussion about parameters, I said I would be glad to accept a token (under \$10) holiday gift. He brought an expensive gold necklace accompanied by a massive floral centerpiece. I experienced the gifts as violating intrusions and impatiently rejected the necklace while attempting some discussion with him. He was wounded and silent. His resolution to 'win' me was met with my further insistence

on boundaries and his withdrawn silences. He never missed a session and was always early, but instead of being able to develop a therapeutic relationship with him, I seemed to be driving him away.

My way of looking at things was meaningless to him. Two separate subjective views were clashing with no way of intersecting. Around that time I learned that he thought of himself as a computer that could only operate in a binary way, either 'on' or 'off.' He believed this to be essential and correct for him. If he was 'on,' it was to pursue the task of getting me to become his girlfriend. Since his esteem was maintained by the excellence of his performance, he worked diligently to 'seduce' me. My failure to comply with the program seemed to overload his circuits, and he would shut down. Somehow I would have to help him expand his binary, polarized mode which was his essential defense against the hostile world.

Over time he revealed that he had been arrested in the past for peeping into the house of a female co-worker who had befriended and then rejected him. He sent gifts and letters to a certain pornography star and a Hollywood film star who in turn sent him notes and autographed photos. This made me feel uneasy about him and his silent world, but at the same time, I was also touched in a distant way by his extreme isolation and his wish to make contact.

From the beginning of treatment William would enter my office and silently sit in a chair facing me as if waiting for me to type in commands. He didn't have conversations with me, but made brief statements, requests, or demands. To even elicit this from him each session I needed to show a strong interest in him, proffer invitations to speak, and ask specific questions. Repetitive ruptures between us occurred by my not providing what he believed he needed: being allowed to court me and to know details about my personal life, most particularly about my sexual life. He would spend whole sessions without moving, as his deadened eyes would unflinching stare into mine. He had no way of speaking to me about what he experienced in his withdrawn states because he had no words, no concepts for what was happening within him or between us.

I learned that William assumed I, too, organized things in a binary way. I began referring to his binary mode as black and white, which seemed accurate to him and allowed an intersection of our conceptual worlds, one that at least had a potential of becoming more than binary, there being a range of grays. When he retreated to the black, 'off' mode because of my failures, his stillness could last for days or weeks, reminiscent of Giovacchini's (1979) description of a schizoid patient's massive defensive withdrawal that can assume a catatonic-like state. Stewart (1992) noted, there is very little in the psychoanalytic literature about "inner space."

I then began to do what I came to think of as 'monologues.' I knew by that time that William had an uncanny memory for everything that I said no matter what state he was in, so I hoped that he might at least hear me. I 'listened' to his

silences in a particular way, perhaps with 'maternal intuition,' allowing myself to almost float into his eyes with my own associations. At the same time I tried to hold in the background of my consciousness a sense of what had most recently transpired between us; of what I had grown to know about his collapsed, binary world and his protective need for it; and of his truth that he had never even conceived of anything other than rigid, binary-type experiences. I would find myself envisioning him as an infant in pain; as a terrified pre-verbal child; as a silenced, traumatized four year old staring into his parents' room, unnoticed. I imagined the infant undergoing medical procedures with no one attempting to comfort him as his weak, overburdened mother turned him over to the medical 'authorities.' I thought of the binary aspects in his family: mother was 'on' (directed toward him, dispassionately but not unkindly) or 'off' (directed away from him). Dad was 'on' (directed angrily at him, terrifying or shaming him) or 'off' (directed away from him).

For months I spent whole sessions hovering in this state, facing his silence. I spoke only when I felt impelled and shared a range of speculations, sometimes speaking once a session, sometimes frequently. Sometimes I just withdrew from him for my own needs. It was difficult to sit with his pain and emptiness and easy for me to feel I was both a perpetrator of violence, as reflected by his visage, and impotent to offer him anything of value. I felt at times as if I were staring into the face in Munch's painting: "The Scream."

The best I could do was attune to my own associations to what I was witnessing. Since everything he was revealing declared his horrifying aloneness, I wanted to communicate a sense of being there with him in this process. In retrospect my communications to him were of several types, but what was common to all of them was that they were only spoken when I was aware of feeling something, so that my affect was being communicated along with my words.

I would ponder aloud about what I had said or done, and how that might have made him feel, which expressed a notion that one person can do something that affects another in an arena of feelings. Since he would give no response, I might substitute other possible feelings. Sometimes I would describe how he seemed to me at the moment and speculate aloud how I might have triggered that state, hopefully transmitting the idea that affects can be non-verbally communicated from person to person, as well as the notion that one person could cause another to have a feeling. Occasionally I would share my own response to a type of situation, letting him know that others can have a range of feelings about things. I would also communicate my feelings about him, and how he was impacting me, which underscored a notion that he could impact on others.

After anywhere from a few to a dozen sessions like this, William would become slightly more accessible in the room until the next injury. But he was not yet able to talk about what had transpired for him during his 'absence.' After months of this kind of work, it seemed that he could retreat, with his eyes not quite as

vacant. I considered the degree of vacancy as an indicator of the depth of injury he had experienced. The withdrawals were now on a continuum, not just an 'on' and 'off,' binary mode. I began to comment on the degree of withdrawal I thought I was witnessing, describing in relative terms how far away he seemed from me. Many hours I felt that maybe I was delusional, just imagining shifts in him.

He eventually learned to talk very simply about what he had experienced during his retreat, confirming or disconfirming my speculations. His rigid commitment to being honest with me helped me to feel an increasing security in my work with him.

Over a few year period his shut-downs became much less frequent, and when they did occur, he was able to rapidly re-engage, sometimes even during the same session, providing quite a detailed description of what he had been experiencing cognitively and emotionally during his 'absence.' His language of affects expanded. His way of perceiving both his inner and outer world was very gradually changing.

An unusually expansive quote from William occurring about five years into our work will end this section in which I have attempted to describe this early and essential work of building a language of relatedness between patient and therapist. William now had an expanded way of conceptualizing our relationship, expressed one session in a particularly moving way. In speaking about our extended work together he said, "I don't feel that I'm just in a binary mode with you any more. Originally it was as if there were a line between us, and everything was either good or bad, yes or no. But about two years ago I began to feel that there was this area of gray between us....that not everything was black and white....I could feel good about something with you and at the same time disappointed about something else. Now the gray area is getting even wider, and it shifts and is more fluid. Sometimes things seem to be about me, and how I am about something, and sometimes about you, and how you are. It's really exciting, but it's also very terrifying."

Discussion

This section will include some thoughts culled from current infant development research that have begun to influence psychoanalytic theory. For William some very fundamental developmental foundations had been derailed, and for a language to develop between us, these deficits needed to be recognized.

Emde (1988, 1989) views certain caretaker functions as being essential to early development of affect. The caretaker provides affect regulation through attuned responsiveness and sharing of affects, and promotes positive emotions that influence motivation toward social interactions. Relating to Stern's (1985) view that early infant relationship experiences are stored as averaged prototype memories, Emde posits that affect responses can also become prototypes; and

negative emotions, which are organized differently from positive ones, might be encoded more specifically than positive ones. This relates to Clyman's (1992) description of emotional procedural memory, which develops in infancy and can subsequently be enacted but not accessed at a declarative level, providing pre-conscious continuity of emotional functioning throughout life. William's averaged relational and affect prototypes as well as emotional procedural memories would have been heavily weighted with disruptive, negative experiences.

Sharfman (1989) ponders the impact that the analyst's emotional range and availability--which may or may not coincide with those qualities in the initial caretaker--might have on the analysand. I brought in a range of authentic affects to this man whom I saw as deficient in this area of experience, but there was a bind that was to later become apparent. He looked so miserable that I could almost never reflect happiness with him. At times I felt really good, warm, content, and really pleased to be working with him. Over time I felt lovingly toward him, but it was years before I was able to feel excited or joyful with him. In our later work he told me that my lack of smiling with him meant that he didn't make me happy, and if he wasn't making me happy, he must be making me unhappy. (Later still he would say that he now experienced my soberness as reflecting a deep understanding of him.)

I believe (and it was later confirmed by William) that the tortured hours we spent together in his silences provided several essential aspects for affect development and our increasing ability to relate to one another. I was laying down a language of affects with him, almost in a word-by-word manner as a mother does with an infant in early language development when she enthusiastically asks for example, "Where is the light?" as she looks from the infant's face to the light, speaking in simple sentences and perhaps highlighting one word. Endless hours of my speaking about feelings, while revealing some of my own in a very simple way, helped provide alternative ways of organizing some of his somatic experiences and binary perceptions.

Imbedded in my words and way of talking about things with William was the concept that humans impact one another: a relational perspective. Additionally, I think that my being there, my tenacious attempts to repair and make contact, that equaled the strength of his withdrawal, as well as my refusal to turn my back on him had a profound effect on this man who was forever experiencing human faces turning away from him, having literally been shunned for most of his life. We had not overthrown but had at least somewhat disrupted his rigid, dualistic, safe, but hopelessly alone system. Consequently I was more real to him, his feelings were more real, and the relationship was more real. His attachment to me grew in a multifaceted way, not just as the object of his binary pursuit. When I was just a fantasy object, if I endangered him, he needed only to shut off the fantasy and me. This new relatedness, which I won't detail in this paper, characterized the next phase of our work, in which the relationship could now lift him to new heights but then dash him to the rocks below, causing unfathomable injury. The

very act of my ending a session was experienced as a profound abandonment of him, causing everything positive about the session to cease. It was as if the development of our relationship connected to a great, gaping fistula within in him, perhaps represented somatically in his chronic, ulcerated intestines and stomach, and that while he was with me, this area was temporarily plugged; but when I catapulted him from my office, I pulled the plug.

Referring to the disturbed object relations found in patients with schizoid personalities, Klein (1946) describes the phenomenon of massive projection, which makes the person toward whom this is directed feel like a persecutor. I imagine she would have viewed my experience with William in this vein. I feel otherwise. While it was difficult for me to tolerate his silent and sometimes not so silent accusations of my cruelty and my willingness to destroy him, I believe that the truth for him, and not his projection, was that my being separate, having my own initiative, and not always ministering to his needs was, in fact, agony for him. His expectations of what I could do or provide may have been unrealistic, but I don't believe he projected 'badness' into me. It was, in a way, an act of cruelty not to provide the 'infant' William, which existed in an adult body, with a level of care that included continuous holding.

I believe it would have been a therapeutic mistake to address the notion of projection with him or even conceptualize it that way for myself at that point in the treatment. His hostile feelings were a response to my injuring him. I learned to better tolerate the burden of guilt for being an injurer and not defend against it, allowing me to get closer to his truth. As therapists and as analysts, we activate real aspects of the other--sometimes very underdeveloped aspects--and in that process we can hurt, damaging even more if we back away from the patient's innocent recognition that we have hurt him.

Some Implications for Psychoanalysis

This early work with William is an aspect of analytic work that can be conducted with some very primitively- organized patients. Giovacchini (1979) relates a case in which he found himself behaving unusually with a hospitalized schizoid patient and later conceptualized his own unusual behavior as having intuitively enacted this man's non-verbal wish. Giovaccini notes that differences in the developmental level of the patient and therapist can cause disruptions or blocks in the treatment, requiring the therapist to attend to non-verbal, primitive messages. "To be understood in the midst of a regression....can be especially meaningful for these emotionally locked-in patients (p. 120). He cites Winnicott's (1956) idea that the responses of the attuned mother help the infant to organize somatic states into higher mental levels of needs and desires. When development is arrested at prementational levels, the patient "will not have achieved the ego integration that promotes...the ability to construct symbols in a meaningful communicative pattern" (p. 122). Giovaccini questions whether his attempt to respond directly to the patient's gesture is analytic and then argues that it is.

Interpretation "is supposed to produce intrapsychic changes by making the patient aware of something that previously had escaped his consciousness and understanding" (p. 129), moving the patient in the direction of ego integration; and Giovaccini was responding to his patient's traumatic, infantile experience revived in a primitive transference.

Stolorow (1994) writes that the impact of correct transference interpretations is embedded in the analytic bond and includes the analyst's ability to attune to the patient's developmental longings and affect states. In interpretation, the analyst makes "empathic inferences about the principles organizing the patient's experience, inferences that alternate and interact with the analyst's acts of reflection upon the involvement of his own subjective reality in the ongoing investigation" (p. 46). Interpretation "illuminates personal meaning" (p. 43), allowing the possibility of developing new organizing principles to co-exist with already existing psychological structure. Describing the analysis of ruptures in the selfobject transference that replicate primary selfobject failures, Stolorow et al. (1987) stress the importance of exploring, from the patient's perspective, the many facets to the disruptive experience.

In light of the descriptions of Giovaccini, Stolorow, and Stolorow et al., much of the process in which William and I were engaged falls within interpretive and exploratory analytic categories, albeit at a very fundamental level. My patient evokes the description of Stolorow, et al. (1987) regarding the selfobject aspect of the transference which exists when "the restoration or maintenance of self-organization is primary in motivating the patient's tie to the analyst" (p. 41). As I spoke during his withdrawals, groundwork was being laid for later, transference analysis. The language-building explorations made during his silences may be viewed as interpretations in that they led to insight, change, and structure building (Giovaccini, 1979) and illuminated a personal meaning for the patient (Stolorow, 1994).

Infant development literature has led Shane (1989) and Sharfman (1989) to ponder the effectiveness of the use of the couch for some patients who have experienced early deficits in caretaker affect attunement and responsiveness. They wonder if those analysands might benefit from face-to-face sessions where both analyst and patient can see and respond to a whole range of affects. I did not use the couch with William, believing he needed more than my verbal presence to help him out of an encapsulated self, and I needed all of the non-verbal cues that I could discern.

Over time I developed a profound caring for this man who eventually exposed the depth of his being to me, taking great psychological risks to continue the therapy and expand upon what he later called "the most meaningful experience" of his life. Continuing health crises necessitated a third open heart surgery which we thought he might not survive. (He did survive it.) Our last meeting prior to the surgery was a home visit. His body had wasted away. He said he would miss me

if he died and gave me a commercial audio tape of an actor reading romantic poems to music. The tape was called "Beauty and the Beast: Of Love and Hope." One of the poems entitled "This Is the Creature," succinctly and poignantly captures much about psychoanalysis with deeply wounded beings, and the analytic relationship's potential impact on existence. The struggles that William and I have gone through together have been some of the most rewarding experiences of my professional life and have deeply affected me. The poem follows:

"This Is the Creature"

Ranier Maria Rilke
(Translation J.B. Leishman)

This is the creature there has never been.
They never knew it, and yet, none the less,
They loved the way it moved, its suppleness, its neck,
It's very gaze, mild and serene.

Not there, because they loved it,
It behaved as though it were.
They always left some space,
And in that clear unpeopled space
They saved, it lightly reared its head,
With scarce a trace of not being there.

They fed it, not with corn,
But only with the possibility of being.
And that was able to confer such strength,
Its brow put forth a horn, one horn.
Whitely, it stole up to a maid — to be
Within the silver mirror and in her.

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