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VIOLENCE AND THE PATHOLOGICAL THIRD: AN EXAMINATION OF VIOLENCE IN PSYCHOTIC, PERVERSE AND NARCISSISTIC PATIENTS

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This dissertation is submitted for the degree of Doctor of Philosophy

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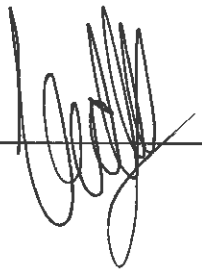
ABSTRACT

This thesis formulates symptomatically violent patients psychoanalytically using the notion of thirdness as a particular theoretical and clinical lens. It examines three psychopathological cohorts, those being psychosis, perversion and narcissism. Each of these three examinations introduces a pathological third. The *prosthetic third* is introduced in relation to psychotic patients; the *Tri-bar third* is introduced for perverse patients; and the *autogenic third* in relation to narcissistic patients. The thesis argues that the pathological third plays a role in the production of violence, and in the process observed in treatment. It also suggests that one of the primary functions of the pathological third is to regulate unbearable and overwhelming affects. The form of affect regulation associated with the pathological third is understood to be unstable and defensive in that it produces a recalcitrant separation of psychic equivalence and pretend modes of experiencing reality (Fonagy, 2002). The thesis also compares the three psychopathological cohorts in a discussion of how each of the pathological thirds produces violence. The thesis concludes by offering some preliminary observations for the treatment and formulation of violent patients in a clinical setting.

This thesis is dedicated to my patients.

DECLARATION

I declare that this is my own unaided work. It is being submitted for the degree of PhD in Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.

Signed: 

Date: 29/05/2017

Clinton Michael van der Walt

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1 INTRODUCTION

1.1 Aim

The aim of the thesis is to formulate violence psychoanalytically by examining the role that thirdness plays in the mind of symptomatically violent patients across three psychopathological personality cohorts. These psychopathological personality cohorts are psychosis, perversion and narcissism. The thesis explicates the relationship of thirdness and violence using psychotherapeutic case material and vignettes. This main aim is constituted of two sub-aims. These are:

a) to describe what may be idiosyncratic about the role of the third in the specific psychopathology cohorts for whom violence is a characteristic symptom;

b) to conduct a comparative discussion of the role of the third in each of the psychopathology cohorts for the violent patients described.

Thirdness may be understood as a mental function that facilitates a capacity for self-reflexivity, relationship-forming, affect regulation and stable contact with external reality (Benjamin, 2004; Fonagy, 2002; Hanly, 2004; Ogden, 2004). Violence is operationalized as an intentional destructive act that results in physical harm to the self and/or the other (Cartwright, 2002). I define symptomatic

violence as a recalcitrant defensive behaviour in response to persistent and predictable emotional dilemmas.

There were two pressing external factors that led to the conception and execution of the study. The first emerged out of a clinical conundrum whilst I was working as a psychotherapist at a university-counselling centre in Johannesburg. I found that I was treating an increasing number of violent students who posed serious technical and formulatory difficulties for me. This thesis was, in part, conducted as a way to become more effective and responsive to my patients. The second was a fortuitous encounter with a special edition of the *Psychoanalytic Quarterly* that gathered contemporary understandings of the concept of *thirdness*. I was struck by the rich theoretical diversity and creativity that the many authors brought to bear in their papers (Benjamin, 2004; Britton, 2004; Gerson, 2004; Green, 2004; Hanly, 2004; Minolli and Tricoli, 2004; Ogden, 2004; Widlocher, 2004; Zwiebel, 2004). The theoretical terrain crossed many different schools of psychoanalysis and yet there seemed to be various threads that connected the theory coherently. I was compelled by this and sought literature that connected violence and thirdness explicitly. I found none, and so the idea of this thesis was born.

1.2 Rationale

Mizen and Morris (2007), in their discussion of the literature on violence, make the following observation.

> Not only does there exist a Tower of Babel in the profusion of analytic models and technical languages used by various analytic 'schools', but even more confusingly there is often a profusion and diversity of meaning attributed to different words. (Mizen & Morris, 2007. p. 2)

The thesis offers an original reading, interpretation and integration of the literature on violence and psychoanalysis using the lens of thirdness. It also documents a way of attending to, and formulating, clinical phenomena with violent patients. The purpose of both of these tasks is to facilitate a coherent way of

thinking about patients who are symptomatically violent in a clinical setting. This is the essential rationale of the work. The rationale responds to three related difficulties that characterise thinking about violence both clinically and theoretically. Firstly the psychoanalytic literature on violence is heteroglossic (and sometimes contradictory). Reading the psychoanalytic literature on violence is as much an exercise in "school" identification, as it is an attempt to grapple with the topic itself (Mizen & Morris, 2007). Fundamental differences in the definitions of violence (Alvarez & Bachman, 2013; Yakeley & Meloy, 2012); its relationship to aggression (Kernberg, 1992; Panksepp & Biven, 2012); its relationship to metapsychology (see for example Freud versus Klein; Kohut versus Kernberg); its relationship to psychopathology (Fonagy, 2002 [borderline]; Morgan and Ruszczynski; 2007; Welldon, 2011; Yakeley, 2010 [perversion]; Kernberg, 1992; Perelberg, 1999 [narcissism]; Raine and Sanmartin, 2001 [psychopathy); its different formulations (Fonagy, 2002; Glasser, 1998; Mizen & Morris, 2007; Yakeley & Meloy, 2012); how it is managed technically (Fonagy, 2002; Kernberg, 1992); and the many different languages that are used to describe it; leave the intrepid clinical researcher with many theoretical tensions to resolve.

Secondly, working with symptomatically violent patients is often difficult and overwhelming, for both the patient and the psychotherapist (Bateman & Fonagy, 2004; Kernberg, 2003; Perelberg, 1999). This requires much supervisory support, additional reading and preparation for the clinical encounter. This lands the clinical researcher in much the same quagmire as is encountered in the literature. Fundamentally different technical and formulatory orientations can saddle the therapeutic process with the burden of confusion. This is a particularly vexing problem when working in an often-volatile clinical situation in which clear, accessible thinking and communication is required. In the clinical setting, the highest order of thinking with, and about, a patient concerns formulation (McWilliams, 1999). Formulation in the clinical setting represents the culmination of relational and theoretical knowledge. It directs and shapes the treatment, and provides the measure against which progress can be envisaged (Cabaniss et al., 2013). It also helps to direct the clinician technically (Alliance of Psychoanalytic Organizations, 2006). It is vitally important that the formulation is in a language

that is authentic and true to the relational experience of the patient and clinician. In my work I have found that thoughtfulness and relationship are the very things that are foreclosed upon in violent symptomology. If we add to this dilemma the problems I have mentioned in the initial section of the rationale, formulation can be thought of as a privileged location of clinical and research interest. Stated in another way, formulation is a site where the tensions inherent in theoretical knowledge are potentially brought into the room with a patient. Finding a language to speak and think clinical truth that is not alienating or confusing has been a fundamental task in my own work.

Thirdly, the task of formulation is further complicated by the fact that many of those supervisors experienced in working with violence often hail from other disciplines such as forensic psychiatry and cognitive-behavioural therapy. How is the psychoanalytically orientated clinical researcher to navigate this (often valuable) input without losing the rich benefits of analytic orientations? Even if the clinical researcher chooses to stay within psychoanalytic expertise, there is still the possibility of contradictory formulation and technique with each new supervisor. Although Yakeley and Meloy (2012) and Cartwright (2002) address the necessities of multi-modal work approaches to violence, there is still no clear psychoanalytic lens through which to read violence as clinical phenomenon and a theoretical topic.

What is common in all my supervisory and therapeutic work with violent patients is a deep-seated desire to go to another place in my mind to escape the difficult dyad, to think, to rest and ultimately attain an elusive understanding. This desire I have subsequently understood to be the need for the "third position" in my own mind. Importantly, it was consistently difficult to achieve this kind of thirdness with violent patients, leading to speculations about the role the third plays in the personality and harmful behaviour of violent patients. It is also important to note that when I was able to think in the face of threatening dynamics, this seemed to be associated with an ability to contain the dynamic. The third, reflexive place in my own mind was the experiential thread that led me into the literature of thirdness. It is this rich theoretical ground in which the seeds of my thinking on violence

were able to germinate. While a reflexive third remains a vital aspect of thirdness in my work with violent patients, it is by no means the sum of it. Thirdness, as I will elaborate and operationalise later in the chapter, is a complex term enabling me to navigate diverse and varied aspects of the literature and clinical experience.

Thirdness is a theoretical construct that runs through all psychoanalytic understandings of the mind (Green, 2004; Hanly, 2004; Minolli & Tricoli, 2004). In this sense it is a construct that has enabled me to draw from vastly different bodies of literature and find the sensible thread without getting hamstrung by the theoretical and conceptual silos so prevalent in psychoanalytic thinking. Of course, the work may well suffer from a theoretical lack of focus, but it also allows for a greater creativity in coming to terms with each of my patients in their own idiosyncratic terms. Clinically and technically this has meant finding and creating metaphorical language to forge understanding and connection. My work with my violent patients has been to imagine and to dream with them their own minds. The metaphors I will discuss in the thesis have emerged primarily from the reveries and dream material from clinical sessions. The conceptual tool of thirdness, has allowed me to link these metaphors to broad theoretical arcs and relevant literature. This then is the raison d'être that directs the rationale.

1.3 Theoretical Framework

The thesis is situated in psychoanalytic theoretical framework. Psychoanalysis was conceived of and developed by Freud between the years of 1895 and 1939. It is a branch of psychology that is broadly concerned with four areas. Firstly, it regards the development of the mind in childhood as having fundamental bearing on character, behaviour and psychopathology in later life (Lasky, 1993). Secondly, it contends that unconscious as well as conscious mental forces shape the personality of an individual (Orgel, 1990). Psychoanalysis regards unconscious determinants of behaviour as more influential than conscious ones (Freud, 1900). Thirdly, psychoanalysis as a technique emphasises the importance of the therapeutic relationship and the manifestation of unconscious material in treating psychopathology (Etchegoyen, 1991; Loewenstein, 1969). Finally, psychoanalysis

is a body of knowledge that conceives of the mind meta-psychologically, that is, as an epistemology that develops theories of the mind that are *psychological* (Laplanche and Pontalis, 1973). More recently, there have been attempts to integrate psychoanalytic metapsychology with neuro-scientific data and research (Solms, 2015).

There are six meta-psychological principles that form the foundation of psychoanalytic thought. The *topographical model* (Freud, 1915) divides the mind into three systems; the unconscious, the pre-conscious and the conscious. The unconscious represents the part of the mind that is most closely connected to the basic drives and instincts of the human subject. Freud saw this part of the mind as governed by primary process (Freud, 1911). Primary process thinking is characteristic of dream life, unconscious phantasies and infantile life. It is not rational or logical. The conscious mind is the site of subjective awareness. It is aware of both internal subjective states as well as external states. It operates according to secondary process thinking (Freud, 1911) that is rational and logical. The pre-conscious, also described as the descriptive unconscious, is a site where non-repressed mental content can be recalled if attention is directed towards it. Repression (Freud, 1915) refers to mental content that is cut off from conscious life. In the initial phase of Freud's theorising, repression was understood to be a conflict between reality and the satisfaction of instinctual needs (Freud, 1911).

Closely linked to this early phase of Freud's conceptualisation of the mind is the *economic model* (Freud, 1900). This is a model that proposes that instinctual life, derived from basic biological correlates, is an energy that drives psychological processes. Economic models of the mind conceive of certain amounts of psychic energy being expended in certain ways. This is an important principle when considering violence as it is often characterised by a massive expenditure of psychic energy that is not governed or transformed by consciousness and its secondary processes. Violence in many instances has a close relationship to the instinctual energy of aggression (Mizen & Morris, 2007).

The *structural model*, also called the second topography (Freud, 1923), is a revision of the topographical model. It introduces three sites of the mind that have unique characteristics and whose interactions account for human behaviour and psychopathology. The id is the location of the instinctual drives and the reservoir of repressed content. The superego is a location of internalised parental and environmental identifications that ultimately curtail socially prohibited expressions of the id. The ego is a reality-based mediator between the demands of the id and of the superego. The adaptive role of the ego is an important metapsychological principle in the study of symptomatic violence. Its affect regulation and reality testing capacities are often compromised (Fonagy, 2002). Superego pathology is also important in the consideration of certain types of violence in perversion and narcissism (Kernberg, 1992). In part the structural model was an attempt to account for how social and environmental factors came to play a role in the internal workings of the mind (Bateman & Holmes, 1995). Closely related to the structural model is the dynamic model. The *dynamic model* conceives of mental outcomes as the sum of pressures and forces that are negotiated between the conflicting imperatives of the id, the ego and the superego.

Finally, the genetic model (Freud, 1895) and the adaptive model (Lasky, 1993) describe how the immature psyche is the fundamental template on which all later psychology will play out in later life. The reason for this is that the immature human subject as a child is ill-equipped to manage the numerous dilemmas that he or she faces in the attempt to get fundamental needs met. This results in a heavy reliance on repression, which in turn shapes the character of an individual, and populates the dynamic unconscious with numerous unmet needs that constantly seek expression throughout the duration of life. These childhood repressions, and the defenses and symptoms that are mobilised to keep the repressed unconscious in place, fundamentally impact the development of the ego and the superego. The ego and the superego, and their functions, are heavily implicated in symptomatic violence in the psychoanalytic clinical setting (Perelberg, 2009). The psychoanalytic clinical setting is the context in which the research has been conducted.

While many schools of psychoanalysis have modified and reformulated these metapsychological principles, they remain the essential structure around which psychoanalytic ideas are articulated (Bateman & Holmes, 1995).

1.4 Structure of the Thesis

Chapter two reviews the literature on thirdness and violence. Thirdness in the literature is examined by describing how various psychoanalytic thinkers address the concept. The section draws these observations together in a working definition of thirdness for the thesis. Violence is addressed by looking at four central themes in the literature. Firstly, the general descriptions of violence are examined. Secondly, violence is discussed in terms of attachment, mentalisation and early traumatic disruption. Thirdly, violence is reviewed in relation to internal objects. Fourthly, violence and its relationship to personality psychopathology are discussed. Finally, the general contours of violence are summarised.

Chapter three denotes the method of the thesis, including the data collection and data analysis procedures. It also details the ethical considerations informing the work. The phenomenological case-study method is described and the threats against its reliability and validity are addressed.

Chapter four represents the first application of psychoanalytic notions of thirdness to the psychopathology cohort of psychotic patients who are violent. The chapter introduces the *prosthetic third.* The prosthetic third describes the semiotic objects used by psychotic, violent patients to cohere their minds. The chapter argues that this object is used as an artificial ego, taking over its affect-regulation and reality principle functions. The chapter illustrates how each of these prosthetic thirds functions for various psychotic and violent patients. Mr J uses psychiatric discourse, Mr R uses music, C, a child patient, uses a highly organised game, and Mr K uses his own autobiography. The chapter suggests that each of these prosthetic thirds functions so as to manage disturbing and unbearable aspects of reality. The chapter proposes that this reality is linked to an annihilating other that threatens

the psychic integrity of the patient. The chapter also argues that when the prosthetic third is challenged, or breaks down, violence may ensue.

Chapter five introduces the autogenic third in relation to a violent narcissistic patient, Mr L. The autogenic third is proposed as an unconscious conviction, a phantasy, that the patient has created his own reality. It is argued that this conviction is especially negating of certain psychosexual realities. It is suggested that the autogenic phantasy is a shield against the painful mourning and virulent envy that result from realising that two others have come together to create the patient in the reproductive act; and that reality (including the reality of the self) is not of one's own making. The chapter illustrates that when the illogical imaginings of the narcissistic patient are uprooted by the reality of a procreative couple that exclude him, violence may ensue in order to restore it. This illustration supports the observation that there is a sequence to violence that may be described in the lead-up to violence for the narcissistic patient. The chapter also aims to show that the autogenic third serves pathological affect regulation functions by negating mourning and envy. It concludes by suggesting that violence may be an attempt to restore the patient to a narcissistic, affective equlibrium.

Chapter six describes Tri-bar mental structure in masochistic perversion. This Chapter introduces the concept of a Tri-bar third in relation to a perverse, violent, masochistic patient, *L*. Using the visual metaphor of the Penrose Triangle, a series of theoretical and clinical observations exemplified by case material are discussed in relation to a) the patient's symptom structure, b) the transference and countertransference, and c) the patient's management of affect. The masochist's symptomatic oscillations between mindless bodily symptoms on the one hand, and rigid cognitions and relational deadness on the other, are understood as two different defensive strategies to save the masochist from knowing about a terrifying object in her mind. Although this annihilating object threatens her very ego integrity, the chapter argues that she seeks to maintain a relationship with this object in the compulsion to repeat her infantile trauma. The chapter then discusses the way in which the split in the pervert's symptoms and her relationships may relate to two different ways of organising her affects: in pretend mode and psychic

equivalence. The chapter concludes that Tri-bar structure, although resulting from severe developmental arrest, also serves a defensive function that protects the masochist from full awareness of her persecutory emotional world. The chapter suggests that the collapse of the split mind in perversion may lead to suicidal despair and violent psychotic breakdown.

Chapter seven discusses violence and its relationship to pathological third formations in psychotic, narcissistic and perverse patients. The pathological third is a defensive formation of the compromised psyche that distorts the patient's relationship to reality in order to make it emotionally bearable. In psychotic (Mr K) and narcissistic (Mr A) patients who are violent, the pathological third truncates a disturbing relationship to the reality of the self and others. When the pathological third operates unperturbed, it defensively regulates affect by consciously rendering it of no consequence. When the pathological third is disrupted, disturbing and unmanageable affects arise and threaten the ego with annihilation. Violence then ensues in order to protect the ego and restore the pathological third. In perversion (Mr D), violence produces and maintains the pathological third. Here, the pathological third is characterised by a split in the ego producing two different forms of violence and subjectivity. One is cognitively rigid and emotionally dead; the other is intensely somatic and thoughtless. Affect is regulated by keeping these two violent subjectivities separate. The chapter illustrates the pathological third and its relationship to violence using clinical material. Some observations about work with violent patients are offered. Chapter seven concludes with a discussion about the possible technical innovations that are implied in the clinical work of the thesis. The importance of mentalisation-based approaches, interpreting close to the drive-derivative, working associatively with violent symptomology and engaging with subjective, intersubjective and objective realities are discussed in relation to the clinical encounter.

Chapter eight concludes the thesis by discussing the contributions that the thesis has made, as well as its limitations and potential research directions. The conclusion outlines the primary technical and diagnostic contributions of the research. Firstly, the conclusion shows how the thesis offers a novel way of

formulating, conceptualising and comparing violently symptomatic patients using the psychoanalytic notion of thirdness. Diagnostically, the conclusion qualifies the notion that an inability to mentalise is a monolithic state of mind in violent patients. Instead it argues that mentalisation difficulties are specific to each psychopathology cohort. Each psychopathology cohort defensively compromises the capacity to mentalise in an idiosyncratic way. Finally the conclusion draws to a close with a discussion of the limitations of the research and outlining potential future investigations.

2 LITERATURE REVIEW

2.1 Thirdness

The treatment of thirdness in the literature review is broad. The reason for this is not to burden the reader with excessive repetition. In each subsequent chapter of the thesis thirdness and its relevant theoretical arcs are discussed in relation to the formulation. The review aims to do three things. Firstly, it aims to present a brief outline of thirdness in the psychoanalytic literature. Secondly, it will describe how prominent psychoanalytic thinkers address thirdness in their theories. Finally, there will be an attempt to draw these understandings of thirdness together in the form of a working concept of thirdness for the thesis.

What is thirdness psychoanalytically speaking? In a semantic sense thirdness is a nominal adjective; a designation of *one, two* and *three*. The meaning of that designation is given by the specific psychoanalytic discourses from which they hail. Thirdness also conveys a sequence, something followed by something else in an escalating level of complexity. Finally thirdness denotes the quality of that designation, as having the defining features of whatever characterises the one, two and three of the sequence. Gerson (2004), in his review of the concept of thirdness in psychoanalytic literature, indicates that it is used in three different ways: relationally, developmentally and culturally. The relational third is what is produced in the minds of two people when they make contact (Benjamin, 2004; Gerson, 2004; Hanly, 2004; Ogden, 2004). Each party in the relationship can use

this third in different ways. The relational third is the idiosyncratic mental activity that characterises the relationship, but that is more than the sum of each individual's contribution. The cultural third (Freud, 1910; Lacan, 1977) refers to an external, organised object, like a system of symbols, an institution or a person who embodies an ordained function. This third object intervenes with, and governs the interaction between others. This referee-like entity keeps and enforces the rules of engagement in a dyad. Finally, the developmental third is achieved when states of infantile dependence and solipsism (one in the developmental series) make way for dyadic relating where the need for the other is narcissistic (Minolli & Tricoli, 2004) (two), which in turn evolves into a self-reflexive state in which meaningful separateness from a recognised other is achieved (Gerson, 2004). Seen in this light the developmental third incorporates both relational and cultural dimensions. Thirdness also implies the development of a self that is able to use language to represent and reflect upon reality (Fonagy, 2002). This reality includes the various emotional realities of the self, as well an external reality that includes other separate minds (Fonagy & Target, 1995) and what Money-Kyrle (1971) calls the "basic facts of life" (p. 443). These basic facts of life refer to the realities of sexual difference, generational difference and the reality of mortality and the passing of time.

2.1.1 The Freudian Third: the father and the superego

The Freudian third, according to Gerson's (2004) breakdown of the literature on thirdness, includes relational, developmental and cultural dimensions. The Oedipus Complex, so named by Freud in 1910, is the most well known developmental description involving the "third". Relationally and culturally the father is in the third position. His position, underscored by his generational superiority and his culturally sanctioned authority (in patriarchal societies), triangulates the mother-child dyad. This position limits the desire of the child to have an exclusive claim on the mother. Relationally, the child's fantasised fear of retribution, in addition to his own childhood insufficiencies, lead to the internalisation of a law that governs his desire and sets the terms of reference for his psycho-sexual identity in adult life. Relationally the *one*, *two* and *three* in sequence designate the phallic stage child, the mother and the father. Culturally the

paternal authority is the third position that intervenes in the child-mother dyad and defines the rules of engagement. Developmentally this third is internalised in the form of a superego (Freud, 1940); an intrapsychic agency that identifies the child generationally and psycho-sexually. The superegoic "third" is the internalization of the rule of law that governs and curtails the aggressive and libidinal impulses, which in turn organizes and governs external social relations making society possible.

Chasseguet-Smirgel (1985) states that a successful Oedipal outcome results in the internalising of the basic elements of human reality, those being the differences between the sexes and between generations. This symbolic and mental correlate of the parents' (and ultimately species') capacity to reproduce also forms the basis for a relationship to other fundamental ordering principals such as time, autobiographical history and stable multi-perspectival notions of reality. These are the fundamental ordering principles that are implied in thirdness. Chasseguet-Smirgel's uptake of Freud's Oedipal third emphasises the cultural and developmental elements of thirdness which have a specific bearing on knowing external reality. Freudian thirdness is criticised for being phallo-centric (Chodorow, 1978; Irigaray, 1985;) and as not including vital developmental, pre-genital stages of development (Klein, 1984). It is, however, the foundational psychoanalytic model of the third that is revised by subsequent psychoanalytic thinkers.

2.1.2 The Kleinian Third: the depressive position and triangular space

In Gerson's (2004) framework of thirdness, the Kleinian depressive position represents a relational and a developmental third. The depressive position (Klein, 1945) refers to a developmental state where the child is able to relate to external objects as separate from the self, and as consisting of both good and bad elements. In other words the object is perceived more realistically and with a greater sense of ambivalence and guilt (Klein, 1945). Like Freud's version of the superegoic third, Klein's depressive position facilitates a curtailment of primitive aggressive impulses. Hanly (2004) points out that the depressive position that is achieved in Kleinian accounts is in fact an achievement of thirdness because the reality of an

external object is differentiated from internal experiences of that object. This is vital in being able to develop a stable relationship between internal and external reality, and the development of the self-other awareness that this mental accomplishment guarantees. Klein is criticised for her overemphasis on the internal experiences of the child such that environmental factors are obscured (Kernberg, 1994). Post-Kleinians such as Britton (2004) incorporate Freud's Oedipal account into the early pre-genital phases of development that Klein describes in infancy.

Following on from Klein's depressive position, Britton (2004) links the Kleinian third to what he calls triangular space. The depressive position allows for a child to develop an internal representation of the self (one), the self in relation to one other (two) and the self in relation to the Oedipal couple (three). Britton links this to two specific forms of relating. In dyadic relating, the object is experienced directly from a participant perspective. In triadic relating, the child relates to the couple-object from an outsider's perspective. Britton (2004) refers to this outsider's perspective as objective relating; and the insider's perspective as subjective relating. By being able to participate in both subjective and objective perspectives the child achieves triangular space. Like in the Kleinian depressive position, this enhances the capacity to differentiate between internal experiences and external ones. It is also vital for thinking and adopting various cognitive perspectives on reality.

When triangular space is not achieved, perverse (Kernberg, 1992), narcissistic (Morgan, 2007; Ruszczynski, 2007) and borderline (Britton, 2004; Fonagy, 1995) states are observed. These are personality structures often associated with pathological forms of destructiveness and violence. The superego that "develops" in these personality formations incessantly and enviously attacks meaning and reality (Rusbridger, 2004). When these pathological structures occur in patients, functioning is based in the paranoid-schizoid position and the defence of projective identification is used to attack thirdness and triangular space (Britton, 2004; Rusbridger, 2004; Steiner, 1999). Ogden (2004) calls this type of projective identification a "subjugating third". The subjugation of thirdness is a primitive and

destructive attack on the therapist's ability to generate an understanding outside of the emotional realities of the dyad.

2.1.3 Ogden's Third: the relational intersubjectivity

Ogden's third is primarily relational (Gerson, 2004). Ogden's (2004) idea of thirdness relates to a state of awareness that is achieved when the clinician can be "simultaneously within and outside of the unconscious intersubjectivity of the analyst-analysand" (pp. 168–169). The "unconscious intersubjectivity" is what Ogden terms the *analytic third.* The third subjectivity is "the product of a unique dialectic generated by/between the separate subjectivities" (p. 169) of two people, and has its origins in the intersubjective reciprocity between mother and infant, or what Ogden (borrowing from Bion) calls "reverie". Reverie refers to the way in which the mother makes contact with the infant in her mind – the way she takes him in, thinks him and feels him, and returns him back to himself in higher order representational elements (alpha elements). For Ogden, as it is for the intersubjectivity theorists, reverie is a desirable outcome of interpersonal interaction. With regards to therapeutic contact, the concept of the analytic third opens a universe of analytic material in the form of the therapist's ruminations, fantasies, etc. because this mental material is regarded as intersubjectively produced (reverie) – the outcome of two individual subjectivities in unconscious dialogue. What the therapist makes contact with in the form of the analytic object (Green, 2004), or the analytic third (Ogden, 2004) is the patient's very frontier of being, the place where she has come into existence as a meaningful entity for the other. It is for this reason that it is not only words but images, feelings and somatic sensations that can come to represent this contact in the mind of the therapist. This idea is central to the clinical work written in the thesis. The reveries and dream material have formed the basis on which the metaphors organising the formulations have been conceived.

2.1.4 Benjamin's Third

Benjamin (2004) understands thirdness developmentally and relationally. Benjamin's starting premise when theorising the third is that intersubjectivity is pervasive and makes up the privileged communicative and relational pathway by

which we come to know that there are "other minds out there" (Benjamin, 2004b, p. 6). In this way she is similar to Ogden (2004). She states that "to recognise that the object of our feelings, needs, actions and thoughts is actually another subject, an equivalent centre of being, is the real difficulty" (Benjamin, 2004. p 6). The way of achieving this difficult task for Benjamin is the *third.* She regards the third as a "principle, function, or relationship, rather than as a 'thing' in the way that theory or rules of technique are things" (p.7). Benjamin's focus is therefore how thirdness is achieved in relational bi-directionality, in co-construction and sharedness, rather than via rules, technique and superego dictates. The third for Benjamin is created when one surrenders to the relationship (not the other person) in order that the "doer-done-to" dynamics of coercive complementarity do not predominate. If states of complementarity (twoness) do dominate, the result is that no mutual recognition is possible – a state in which thirdness collapses or cannot exist. Contrasted to this twoness is the "potential space of thirdness". Benjamin is drawing heavily from Winnicott's notion of a potential or transitional mental space in which conflict can be "processed, observed, held, mediated or played with" (p. 9).

Benjamin states that the precursors to symbolic forms of thirdness are non-verbal, and are metaphorically resonant with an interactional rhythmicity and musical synchronisation between mother and infant, or what Stern (1985) has called attunement. A vital part of this ability of the mother to facilitate a connection with the infant relies not only on her capacity to have an adult mind (and the advanced forms of symbolic thirdness that are implied), but more especially the ability to respond to the infant's affects and rhythms. This first form of mutual engagement and impact concerns how a mother and baby find a shared rhythm. This form of mutual intersubjective regulation draws upon a "deeper law of reality" (p. 18) than the later forms of thirdness (cultural prohibition, familial separateness etc.). The "deeper law" is inherent in the circadian patterns of sleeping, feeding, bathing and temperamental shifts. It is characterised by its transitional in-between quality in that it emerges between mother and infant and is not imposed. As an aside, this notion is interesting when one examines the highly regimented and forceful routine type sleeping programmes that are available to mothers. When

implemented, neither mother or infant plays a role in finding each other – they are both subject from the start to powerful imposing third.

Benjamin (2004, 1988) is highly critical of Freud's insistence on the rigid gender bi-polarity of thirdness and Oedipal relating, or what she calls "self-with-or-like-mother", (p. 160) and separation, or "self-with-or-like-father" (p. 160). Such rigidity, she argues, results because of a foreclosure of the ambivalence produced from paradoxical identifications and conflicting needs. Thus the moral third, as it manifests in gender, represents an integration of a tendency for relatedness and separation, of self-like-or-with-mother and self-like-or-with-father.

2.1.5 Green's Third

Green (2004) elaborates on the importance of the third in the mind of the mother. His third is developmental and relational (Gerson, 2004). He proposes that the third is not only in the mind of the mother, but is importantly communicated to the infant. Drawing heavily from Bion, he proposes that in the unconscious internalization of a particular experience of the thinking and processing mother, the infant is able to internalize a representation of a mother (a) who is related to another, and (b) who returns transformed and manageable psychic material to the infant. Green links this to the sexuality that passes in the triangular relations between mother-father and mother-infant. In the healthy mother, careful repression is required in order to separate the sexual feelings evoked in the contact between herself and the baby, and herself and the father. This repression for Green is experienced by the infant and is part of the pre-symbolic communication of the fact there are other object relationships that the mother has in her mind. This is a precursor to the psychic distance and separation that is required in order for the development of thought and symbolic representation of internal states.

2.1.6 Fonagy's Third and Winnicott's transitional space: affect regulation, the self and playful pretend

Fonagy and his colleagues who write about mentalisation (e.g. Bouchard, Target, Lecours, Fonagy, Tremblay, Schachter & Stein, 2008; Fonagy, 2015; Fonagy & Bateman, 2013; Twenlow, Fonagy, Sacco, Vernberg, & Malcom, 2011;) do not use the word thirdness in their theoretical language. However, there is a great conceptual overlap with thirdness and mentalisation in what they describe about development and relationship. Mentalisation refers to a capacity to think about and imagine mental states in the self and in others (Fonagy, 2002). It is associated with a greater capacity for affect regulation, symbolic thinking and stable attachment relationships (Fonagy & Bateman, 2008). Mentalisation-based formulation and clinical praxis features prominently in the conceptualisation and treatment of violence (Adshead et al., 2013). The theory that anchors this body of work is attachment. Attachment theory concerns itself with the formative impact of early infant interactions between primary caregivers and the infant (Bowlby, 1969; Ainsworth, 1978). Attachment was developed within scientific and formal empirical paradigms and as such has developed on a different trajectory from psychoanalysis (Fonagy, 2002).

Fonagy and his colleagues, like Klein (1984), Winnicott (1965), Green (2004), Benjamin (2004) and Ogden (2004), draw attention to the earliest interactions between mother and infant in the development of a capacity to know reality. They argue that the omnipotence facilitated by a timeous and readily responsive caretaker, initially creates a "teleological stance" in relation to reality. In other words, the attuned responses of the mother give the infant its first sense of a coordinated, causally suggestive and therefore meaningful internal experience. The rudimentary causality of the infant's internal world that develops is such that sensory-affective states are experienced as ubiquitous and concrete. Fonagy et al. (2004) call this "psychic equivalence" where the feeling state has not yet attained the status of a representation and is experienced as monolithic reality. This relation to reality – a one-in-third relationship in Benjamin's (2004) language – has been implicated in the literature to play a role in various forms of self-injury and violence (Fonagy, 2002).

As the infant develops, this relationship to reality is tempered by the capacity to play. This idea in mentalisation literature is strongly influenced by Winnicott's (1971) developmental ideas on thirdness. Winnicott (1971) suggests that between an awareness of the self (one in the sequence) and an awareness of others as separate entities (two), there is a third or transitional space in which the self-other distinction can develop. In this transitional space the child engages with an awareness of reality that is neither the self, nor the other, but rather something inbetween. Critical to this phase of development is the capacity to play. Play is a relationship to reality in which narcissistic versions of that reality can be gradually mixed with objective reality without it becoming emotionally overwhelming. This developmentally vital capacity to play pre-empts and facilitates a fuller awareness of reality as it is. Winnicott (1971) is different from other analytic thinkers in that he locates thirdness as a precursor to maturity rather than as an outcome of maturity. He also speaks about the third, transitional object. The transitional object is a thing that anchors this inbetween reality before a fuller awareness of reality is developed. These special objects, such as a pacifier, a special toy or a blanket, allow the child to retain aspects of their narcissistic undifferentiated status, while at the same time learning about separateness. The notion that special objects and playful mental configurations are used to mediate difficult realities is an important idea that runs through the thesis.

Fonagy takes up the idea of a developmentally important capacity to play in his notion of "pretend mode" (Fonagy, 2002). Pretend mode represents a relationship to reality in which affects are divorced from reality. Reality can be regarded as though it were of no emotional consequence. Thus, children can engage with disturbing themes such as violence and separation as though it were a game of pretend. Maturity involves being able to integrate psychic equivalence and pretend mode in a dynamic fashion such that reality can be experienced without it becoming too overwhelming. This integrated capacity is called mentalisation. A self who is able to mentalise may be thought of as a "the unitary referent of our self-conscious experiences that is not an entity but an organisation that forms and develops with time" (Minolli & Tricoli, 2004, p. 139).

Hanly (2004) speaks of something similar in the development of a capacity for thirdness when he states that in the emergence of reality testing and subject-object differentiation there is a "rudimentary awareness that images represent but do not duplicate, that they point beyond themselves to the needed, real, need-satisfying object" (p. 276). For him, as with Benjamin, this is a vital developmental moment that leads to more mature forms of thirdness in which the other can be recognised without negating the self, and in which one can evolve an "inner capacity to be educated to reality" (Hanly, 2004. p. 277).

2.1.7 Thirdness: from infancy to Oedipus

Thirdness develops from infancy to Oedipus. In the following section, the main arcs of the developmental third (Gerson, 2004) are described in a broad overview.

In earliest infancy thirdness is brought about by the mother's capacity to contain her infant by recognising her own needs, whilst simultaneously remaining in touch with her infant's needs (Benjamin, 2004; Fonagy et al., 2004; Green, 2004; Winnicott, 1971). An example of this would be the mother being able to tolerate the distress of the baby whilst at the same time being able to hold onto the reality that it will pass. In other words, thirdness in this relational stage is created by the tension between "identificatory oneness and the observing function" (Benjamin, 2004, p.17). Metaphors of this type of thirdness draw on mirroring and reflection (Benjamin, 200b; Green, 2004; Hanly, 2004; Kohut, 1977; Lacan, 1968; Winnicott, 1967) and suggest a developmentally vital gap between what is reflected and the reflector. The baby is contained by the fact that his mother does not dissolve in distress (as with his own experience) yet is able to recognise it and provide him or her with meaning. This gap between the thing and its reflection "constitutes of protosymbolic communication and forms an important basis for symbolic capacities" (Benjamin, 2004. p. 24).

Hanly (2004) points out that the pre-oedipal child relies on his primary caretakers as "surrogate egos to test reality and identify danger" (p. 278). As the infant's

capacity for sensory and affective discrimination develops she is able to take in the different perspectives hailing from the reflections from the primary caretaker. Central to this process is primary identification (Freud, 1921) in which the other (and their perspective) can be taken in as part of the self that in turn provides an alternative commentary on internal experience. As identificatory processes evolve in healthy development an increasingly stable bridge develops between subject and object, between inside and outside, and between various perspectives on experience. This bridge is the third. This form of thirdness is critical for more complex identifications to occur in later stages of development – specifically in Oedipal stages (Freud, 1910) where sexual difference and a capacity for separate relating are consolidated in the personality structure.

All of the processes highlighted by Hanly (2004) and Benjamin (2004) seem to implicate what Bion (1965) refers to as the containing function where the mother takes in the primitive and overwhelming experiences from her infant and transforms them into elements that are psychically manageable and usable. Bion, like Benjamin, links this containing process to the development of a capacity to think and symbolise. The irreducible gap between the felt feeling and its return as a more manageable representation introduces into the mental realm of the infant a capacity for distancing and mediated experience. This is critical in the development of thirdness and ushers in a mode of reality where an experience can be pruned of its affective intensity and dealt with in the register of play and unreality (Fonagy, 2002; Winnicott, 1971). Where psychic equivalence brings with it an inseparable relationship between affects and experiences, "pretend mode" (Fonagy et al., 2004) does the opposite work of excising affect from experience. A predominance of this relationship to reality – a developmental precursor to mature thirdness – produces forms of violence in an adult that are enabled by removing the internal and external reality of affect (e.g. suffering and pain), potentially disinhibiting harmful acts and rendering them emotionally inconsequential. Again this will be discussed in greater detail later in the section on violence.

As with Klein's (1946) bringing together of split notions of the other and internal states in the depressive position, Benjamin (2004) also speaks of a developmental stage when an integration of relational dynamics occurs, resulting in what she calls the "moral third". This relational mode comes about because of the inevitable asymmetry between the mother and the child – and subsequently in any relationship. Britton (2004) highlights the importance of acknowledging inevitable asymmetry and disagreement in relationships, and links the inability to do so to a pathological unidimensional object relational world, i.e. one that is not triangular. Not acknowledging difference and disagreement allows an individual in a dyad to suffocate (in Ogden's language, subjugate) an observational or third stance for the sake of preserving a dyadic, less threatening relationship. Benjamin also notes that asymmetry leads to the breakdown of thirdness into twoness (a state where the transitional or shared quality of the relationship is obliterated). This essential destruction of the transitional space and its subsequent repair in healthy development over time leads to the development of the "moral third". The moral third is so called because it takes recourse to what Benjamin (2009) calls the primordial lawfulness of recognition and predictability. In the moral third there is a meaningful coordination between two dissimilar realities that are acknowledged and recognised by both parties in the dyad, creating an intersubjective, inbetween relational space – the third. It is important to note here that for Benjamin, regression into dyadic relating is an inevitable part of normal interactions. This is so because all understanding for Benjamin is an achievement predicated on negotiating and processing misunderstanding. Pathology occurs when this regressive misunderstanding cannot be negotiated and mutual recognition cannot be restored.

When the ability to tolerate the relating Oedipal couple occurs (Britton, 2004), ontological objectivity (the observational stance on the relationship) and ontological subjectivity (the participatory stance in relation to a parent) (Searle, 1995) are integrated and can coexist, giving the child a capacity to reflect and generate meaning beyond his or her solipsism, and beyond the dyad. Oedipal achievements, guaranteed by the cultural father third, lead to a capacity to internalize a relationship to external reality in the form of the superego.

This section has examined the main arcs of thirdness as described by different theorists in the literature. It has outlined numerous developmental processes related to thirdness that span from infancy to Oedipus. It has also integrated literature on mentalisation, which has been understood as an important aspect of thirdness.

2.2 Violence: current psychoanalytic research

The study of violence and suicide has received significant attention in psychoanalytic literature in the last three decades (Boyle, 2013; Campbell, 2016; Campbell and Enckell, 2005; Cartwright, 2002; Casoni & Brunet, 2007; Fonagy & Target, 1995; Gilligan, 2016; Glasser, 1996, 1998; Goldwater, 2007; Hyatt-Williams, 1996; Morgan & Ruszczynski, 2007; Nissim-Sabbat, 2016; Perelberg, 1999; Welldon, 2015; Welldon, 2009). While a notable increase in psychoanalytic research was observable in the 1990s, subsequent research in the 2000s has tended to focus on social violence in specific groups (Bornstein, 2016; Butler, 2003; Kernberg, 2003; Keval, 2001; Mitchell, 2004; Orlandi, 2002; Piven, 2009; Ramzy, 2007; Twemlow, 2000). There are several major psychoanalytic works that stand out in this period including Cartwright's work on "rage-type" murder (2002); the Forensic Focus Series *A Matter of Security* (Pfäfflin & Adshead, 2004) which examines the relationship between attachment and violence; and the Portman Clinic Series book on violence and the perversions by David Morgan and Stanley (2007); Mizen and Morris' *On aggression and Violence: an analytic approach* (2007); and Yakely's technical treatise *Working with Violence: a contemporary psychoanalytic approach* (2010). Following on from the trends observed towards the end of the 1990's, these works have trained their focus on specific kinds of psychic formations and structures and their relationship to violence. It is in concert with this trajectory that the current review wishes to continue.

The review is divided into five sections. Firstly, the general descriptions of violence will be examined. Secondly, violence will be discussed in terms of attachment,

mentalisation and early traumatic disruption. Thirdly, violence will be covered in relation to internal objects. Fourthly, violence and its relationship to personality psychopathology will be reviewed. Finally, the general contours of violence as it has been reviewed will be listed.

2.2.1 Violence Defined

2.2.1.1 Aggression

As a starting point it is important to distinguish between aggression and violence. The discussion of aggression is controversial in psychoanalysis and subject to considerable debate. Perelberg (1999b) in her extensive review of the area outlines the key contentious issues as:

> a) whether aggression is an autonomous drive or a reaction to anxiety or narcissistic injury; b) whether aggression implies the notion of a death instinct; c) the importance of aggression in the process of separation-individuation. This discussion leads to the distinction between healthy and pathological aggression; d) the connection between aggression and a pattern of 'transmission' in the environment; e) and the connections between concepts of aggression and violence which have only been raised recently. (p. 20)

What is most pertinent for the current work is not the origin of aggression, nor indeed whether it is related to a death instinct, nor its developmental vicissitudes and the factors impacting upon the pathways of its transmission because of the nature of the sample selected for the study. All of the patients in this work are overtly aggressive and have behaviourally enacted destructive forms of violence in response to experiences of relational trauma at critical stages in their development. While this may not be universally true, it is true of the patients in the study. Metapsychological debates about the origin and purpose of aggression in this sense may be distracting from the business of formulation and treatment

(Fonagy, 1999). In addition, recent neuro-affective research is showing that the human brain is wired for aggression, and that this affect can be deployed in any number of ways in combination with the attachment, seeking, fear, panic/loss, play, sexual and care systems (Panksepp, 1998; Solms, 2015; Volavka, 2008). In light of this information, the key psychoanalytic controversies as outlined by Perelberg (1999) do not necessarily point to competing or mutually exclusive theories.

Cartwright (2002) distinguishes violence from aggression in his definition of the violent act as the "actualisation of aggression leading to the destruction or damage of an object" (2002, p. 27). This descriptive definition of violence is useful because it incorporates self-injury and suicide (where the object that is harmed is the self) as well as violence directed towards another. This serves as the primary definition for the thesis. Mizen and Morris (2007) state that while linking violence exclusively to physical object harm is useful in psychoanalytic research, it nevertheless should be a position taken with great caution. The tendency to link violence to actual physical acts can obscure a plethora of intrapsychic factors not directly associated with the violent behaviour (Mizen and Morris, 2007).

2.2.1.2 Types of Violence

Types of violence: Self-Preserving and Sado-Masochistic

Glasser (1998), discussing psychoanalytic definitions of violence, distinguishes between two types. The first type concerns the preservation of the physical and psychological self, in which the violent act is mobilised against what is perceived as threatening in order to negate it. Glasser points out that in a psychological context what is threatening may be "a loss of identity through inner confusion, feelings of disintegration, the domination by an annihilative internal object, a remorseless castigation by a tyrannical, sadistic superego and so on" (p. 888), indicating that something of how the self and the mind are structured, and how the threat is represented and experienced, are vitally important in the understanding of violence. This is critical for the research in that how the mind and the self is

organised and constituted in development is a vital consideration in what produces violence. Limentani (1991) also suggests that what is at play in violence is a threat to self-esteem and integrity. In self-preservatory violence a critical cross-over point is reached where the psychical affect of aggression is no longer limited to the mental realm and "crosses-over" into its physical correlate of violence. In this sense, violence can be thought of as acting out in that physical action replaces thought. Yakeley (2007) points out that while Freud (1914) initially intended acting out to refer to transference in a session, it has come to be more broadly applied to those actions that replace the psychological work of feeling, remembering, representing, symbolising, relating etc. Glasser links this cross-over point to "developmental fixation, the nature of external and internal object relations, the defences, symbolisation, the homeostatic functions of fantasy, [and] economic considerations" (1998, p. 889). Self-preserving violence is characterised by its thoughtless quality and by its dyadic nature, where the object is experienced as annihilating or abandoning, producing powerful affects of anxiety, fear and/or rage. The object is not considered over-and-above its immediately threatening quality.

The second type of violence is what Glasser calls sado-masochistic. In this type of violence ego functioning is intact and the violation is considered. Glasser notes that it is superego syntonic, and thus free from the primitive (existential) anxiety observed in self-preserving violence; what is more, this violence involves a degree of satisfaction and pleasure in its execution. The reactions of the object in this violence are important. Watching the object experience pain, fear, anguish etc. is a vital component of this form of attack. Glasser also points out that this form of violence is strongly related to Oedipal dynamics and as such usually concerns a tyrannical object in reality or in phantasy. Glasser suggests that these expressions of violence are intimately connected with sexual difference and gender identity. This is most apparent in the violence perpetrated by perverts in which the violent act is orchestrated by erotic manifestations of hatred (Stoller, 1986).

It is important to note that both types of violence may be expressed by one individual.

FEATURE	S-P violence	S-M violence
Aim	To negate danger/nullify the object	To preserve the object and make the object suffer
Level of functioning	Primitive	Variable – can be sophisticated
Continuance	Comparatively brief	Usually extended
Nature	Eruptive	Considered
Object-relationship	Dyadic → absent	triadic → present
Developmental	Core complex content	Oedipus complex content
Libido	Absent	Present: pre-genital
Narcissistic vulnerability at primitive levels	Present	Present at every libidinal level
Ego-functioning	Primitive, involving protoego functioning	Present at every libidinal level
Superego relationship	Absent	Present; mainly triadic
Affects:		
Anxiety	Present	Absent
Pleasure	Absent	Present

Table 1: Summary of the prominent differences between self-preserving violence and sado-masochistic violence (Glasser, 1998. p. 896).

Fonagy and Target (1999) and Meloy (1992) also distinguish between self-protective or affective, and sadistic or predatory violence. For Meloy, Fonagy and Target there is a much clearer divide between these two types of violence than there is for Glasser (Cartwright, 2002). Meloy (1998) in his response to Glasser's

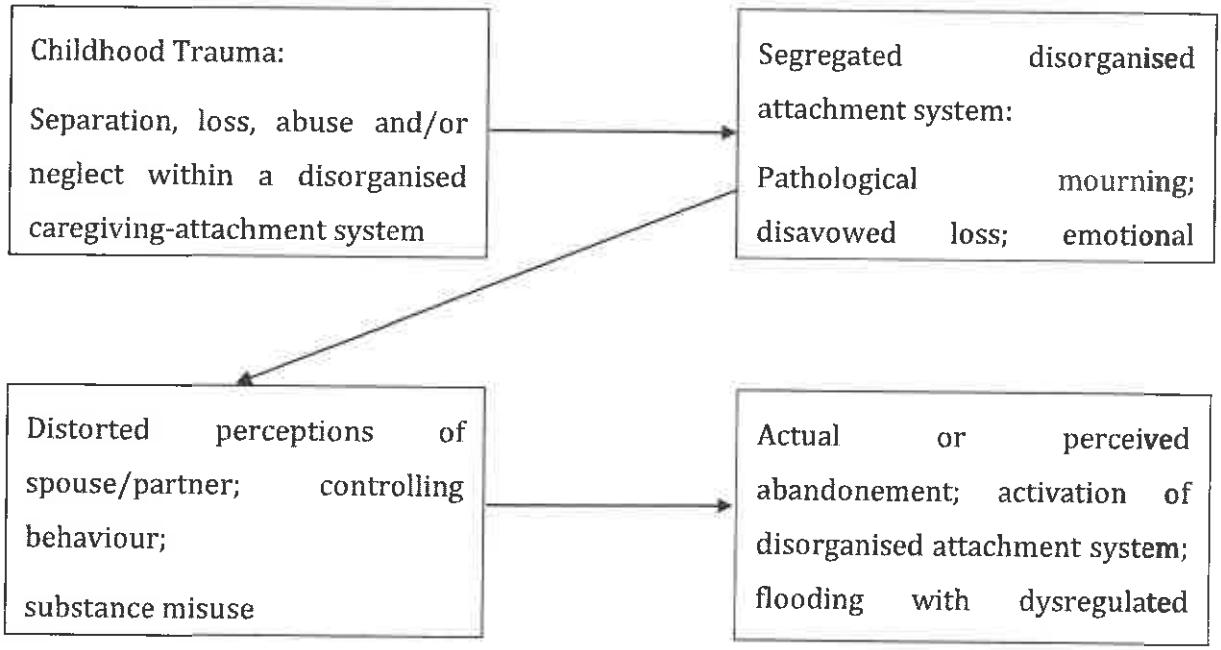
(1998) distinctions on violence vehemently disagrees with his formulation. For Meloy (1998) predatory violence is characterised by its lack of affective determinants, and its practical and functional intention. This type of violence may be thought about as perpetrated by law enforcement agencies or in an exercise of self-defence. The variable interplay and exchange between types of violence in individuals (and even in single acts of violence) observed in the clinical setting, leads to the conclusion that it is better to consider violence along the continuum suggested by Glasser (1998) than the discrete categorisations evident in other definitions. For Glasser, Sado-masochistic violence emerges out of self-preserving forms, having become, in extreme cases of psychopathy, consolidated and embedded within the character.

2.2.2 Violence, Attachment, Trauma and Mentalisation

Early attachment trauma is centrally implicated in symptomatically violent individuals (Biven, 1977; Shengold, 1991; Zulueta, 2006). Fonagy (2004) also implicates problematic early mother-infant relationships as a crucial factor in the development of later violence. Interestingly he notes that early emotional neglect has a stronger causal relationship to violence than either physical or sexual abuse. He states that failures in the early mother-infant relationship, either because of trauma or a problematic attachment, lead to the impoverishment of the capacity for reflective functioning or mentalisation. Crucially for violence, mentalisation allows for an individual to "think about mental states as separate from, yet potentially causing actions" (p. 28). Emerging from this developmental achievement is the capacity to mediate between internal affective states – most critically aggression and fear - and the expression of these in the form of violence (Fonagy, 1993). An inability to mentalise may result in pathological mourning where painful feelings associated to the failed attachment figure are disavowed because they are overwhelming (Bion, 1962; Segal, 1978). This may also result in affect dysregulation where unprocessed emotional material overwhelms or is negated according to the unpredictable and unrepresented ups and downs of relational crisis (Renn, 2004). Affects in these instances are dysregulated because they have acquired no representational coherence owing to the absence of the containing and mirroring functions of the mother (Cartwright, 2002). When these

destructive forms of interaction are patterned or sustained over the course of the first year of life, they become established in the form of a pathological and disorganised *internal working model* (Stern, 1998), or what can be regarded as a set of understandings of the self and expectations of the other (Ross & Pfäfflin, 2004). In the disorganised working model, the relationship to external reality is dominated by more primitive modes of experiencing, clearing the pathway for intensely experienced aggression to translate into violence, especially in the face of an external event that evokes the early relational traumas. This causal pathway is denoted below.

Relationship of childhood trauma to violent offending behaviour in adulthood. (Renn, 2004, p. 133).



This is a useful depiction of the sequence to violence as understood in attachment theory. In this model (Renn, 2004) traumatic experiences in early life produce problematic attachment models. The vital consequence of this trauma is that fundamental emotional states cannot be regulated, impacting upon the individual's ability to process the emotional consequences of the early trauma. This in turn truncates the relationship to others and to reality itself leading to dysfunctional ways of managing it (by being overly controlling or distorting reality with

substances for example). As soon as the pathological attachment system is activated by a perceived abandonment, emotional dysregulation dominates, greatly increasing an individual's propensity to behave violently. This in turn re-traumatises the individual.

2.2.2.1 Early developmental arrests

Fonagy (2004) highlights two critical developmental consequences that are significant in the production of violent symptomology. These two arrests form in relation to what he calls non-contingent mirroring. Non-contingent mirroring refers to primary caretaker responses that do not resonate with the infant's internal emotional states. The first consequence is an inability to understand affective causality (Fonagy, 1991). The characterologically violent individual is unable to meaningfully connect the intentions of the other with his or her emotional state. Owing to this circumstance, the intentionality of others remains concrete. The other's intention is only discernable if it relates directly to the somatic level. For example, the individual can only appreciate the intention of another if it relates to somatic states such as hunger or cold. Should the other reflect upon feeling states, it is incomprehensible. The violent individual has only a rudimentary capacity to appreciate relationships between affective states, actions and the attachment figure. In Fonagy's (2004) parlance, emotional causality functions at the teleological and psychic equivalent level. This means that the individual is unable to regard herself or others as intentional beings and as at the centre of agency and action, unless this action is concretely directed at the physical state. Therefore affect-directed "actions here are experienced as 'agentless'" (Fonagy et al., 2004, p.26). Teleological pre-mentalistic states (Fonagy et al., 2004) refer specifically to the understanding of actions in purely physical terms without taking cognisance of the mental drivers for behaviour. In this mode there is an exclusive exterior focus that requires that external reality change in order to mediate affective states. This state is ubiquitously implied in psychologically motivated violent action. Violent action is by definition teleological because the object is destructively attacked in order to manage affect. Whether the violent act is perpetrated in pretend mode subjectivity or psychic equivalence, teleological pre-mentalistic mechanisms are always at play. As such it is not discussed as

specifically in relation to the pathological third; although it is vital to note that it is always implied.

The teleological stance and psychic equivalence are important in the expression of violence because the individual does not take ownership of violent action because he does not feel as though he is responsible for it, nor does he feel that he is a part of it. A violent individual cannot say for example, "this person has made me angry by behaving in a threatening manner and therefore I feel as though I want to hit him". Instead he experiences the person's intention concretely. In other words he might say, "this person is threatening me and therefore I need to hit him". In the second internal dialogue, the intention of the self and the other is absent. Behaviour is experienced as equivalent to intention. "I am angry" is equivalent to "I will hit you", and "your behaviour is makes me feel threatened" is equivalent to "you have a threatening intention". The "I" and the "you" that feel things are indistinguishable from concrete action directed at the body. Agency and intentionality in this instance are diminished (Lecours & Bouchard, 1997). Violence is experienced as legitimately motivated by a concrete cause.

The second violence-producing developmental consequence in response to faulty emotional mirroring is the internalisation of an "alien experience within the self" (Fonagy et al., 2004. p. 38). This results from taking in the experience of a parent whose response to the infant is incoherent, disorganised and not meaningfully related to the infant's experience. It means taking in hurtful, neglecting and extremely overbearing ideas about the self and relationships. Yakeley and Meloy (2012) when discussing Fonagy's notion of an "alien self" and its relationship to violence describe the dynamic as follows:

If the mother is unable to have a place in her mind for her infant, or feeds back a distorted, damaged image to the child, the child will be unable to develop a representation of his own experience, and instead internalizes the image of the caregiver, a representation that will be experienced as foreign or bad, and will never be fully integrated into his overall schema of self-representations. The

person is then forced to develop an identity around an alien persecutory internal object, or introject, that is unable to think or feel and has to be defended against by violent means (p. 235).

The infant is unable to fight the experience or flee from it and so resorts to the only defence at his disposal, which is to attribute the terrible affect to the object it is associated with. Fonagy (2004) indicates that this leads in later life to a predominantly controlling and manipulative interaction with the object to restore self-coherence and safety. This occurs because the other is perceived as having the negative unpredictable qualities of the individual's internal state. The other is perceived as unpredictable and malign. Asserting omnipotent control over the other is a way to achieve a sense of safety, albeit precarious. Violence is a both a mechanism of control, and a predictable outcome of relating to a perceived unpredictable, hostile other. Fonagy (2004), Kernberg (1982) and Kohut (1977) all indicate that it is deeply disturbing for the self to experience a disjuncture between internal and external experiences. Thus the attribution of internal states to the other (called projective identification in traditional psychoanalytic literature) as evidenced at this level of disturbance is an essential and "self-saving" (Fonagy et al., 2004. p. 39) mechanism that synchronises internal and external experiences of the object.

Although projective identification is self-preserving, it primes the relationships with others to reproduce the traumas experienced in early life in which the self is "brutalised" (Fonagy et al., 2004). The shame and dehumanisation that results is "tantamount to the destruction of the self" (p. 41). This is important to consider in the production of violence that has been categorised as self-preserving (Glasser, 1998). Others are perceived as being constantly threatening. It also highlights why thinking and feeling are experienced as threatening and destructive. This is so because there is a constant threat that the disturbing material that is projected will return creating persecutory anxiety and a need for omnipotent control in relationships (Kernberg, 2003). When shameful and ego destructive feelings are excised from consciousness, subjective experiences of coldness, numbness and deadness proliferate (Fonagy, 2000). Patients who violate themselves or others

often experience this feelingless and thoughtless state as a triumph. This has obvious implications for therapeutic work in that the space itself is regarded as associated with dangerous internal states of shame, terror and rage. Defeating the therapy and the therapist is not only a protection of the self, but a victory in the face of a disturbing other.

2.2.3 Violence and Internal Objects: the dangerous maternal object and the damaged ego

Fonagy (2004) and Renn (2004) describe observable behaviour and attachment related traumas in relation to violence. Although Fonagy (2000, 2004) also details the defence of projective identification in the above model, the subjective structures of the violent individual are largely ignored. A "subjective structure" refers to the metapsychological constructs of the id, the ego and the superego (Freud, 1923) that are consciously experienced in the form of affect (Solms, 2015). In some theoretical frameworks, the ego is primarily constituted of the introjected maternal object (Klein, 1946; Fairbairn , 1941, 1952). Meloy (1992) when discussing violent patients refers to the internal object as an "identity bearing introject" (p. 8) that suffocates the patient and threatens his sense of integrity. The violent act for Meloy (1992) represents an attempt to gain space between the self and the destructive maternal introject. Glasser (1979) describes something similar in the notion of the core complex.

The "Core Complex" is a constellation of infantile anxieties emerging in two incompatible and fraught relational states – merger and separateness. It is so named by Glasser (1979), who noted it as a central feature of the psychodynamics of perverse patients. In these patients he observed that relational intimacy seemed to bring with it the fear of being subsumed into a merger state with a primordial mother-object who would in turn annihilate the patient's sense of self. The defensive retreat from this primary intimacy was also experienced as intolerable by perverse patients who then felt alone, isolated, unloved and ontologically unreachable. This second state only served to stimulate the desire for renewed contact, leading the patient into a cyclical and insoluble dilemma: either face the annihilatory dyad or face the existentially untenable state of oneness (perhaps better described as a state of zeroness or nothingness). Glasser hypothesised that

this complex resulted from a persistence of infantile states of mind that had not evolved because of disturbances in the primary relationship. These two fraught positions are linked to self-preserving and sado-masochist forms of violence (Glasser, 1998).

Perelberg (1999a) extends the notion of the core complex and links it specifically to the expression of violence. Perelberg's conception of violence is that it is an act of self-preservation that is directed towards an engulfing primordial mother. This is echoed by Campbell (1999) who sees a similar dynamic in the suicidal behaviours of his patients where the destructive act is seen as a self-preserving "solution" in the face of annihilatory anxiety resulting from a merger with the mother imago. The father in this instance failed to "stake his claim" on the child (a foreclosure on the processes of *separation*), abandoning her to a damaging symbiosis with the mother, and eviscerating any space for her in his mind. Campbell (1999) notes the inability of the suicidal patient to reflect from a third position in the mind because of the father's failure. He suggests that the father's abandonment appears to be linked to the suicidal act. Bateman (1999) in his discussion of narcissistic personality organisation and violence, appears to come to the same conclusions. He says, "Both suicide and violence become an attempt to regain space between self and object, a space in which thinking may take place, and a place in which a third object can operate allowing emotional subjectivity to intermingle with understanding and objectivity" (p. 122). Shengold (1991), Lefer (1984) and Zuluetta (2006) also draw similar conclusions with regards to violent expression and the destructive maternal object.

2.2.4 Violence and Internal Objects: the dangerous paternal object and the superego

The subjective structure that is implicated in the internalisation of the paternal object is the superego (Freud, 1923). A number of theorists have written about the role of the paternal object and the superego in violence (Bateman, 1999; Britton, 1992; Perelberg, 1999). The consensus amongst these theorists is that the paternal object fails in its objective to separate the damaging fusion between the violent individual and the maternal object (Cartwright, 2002).

Fonagy and Target (1995) highlight another dynamic associated with violence and the paternal object. They argue that hatred and envy directed towards the father is important in the production of violence. This notion is echoed in Perelberg's (1999a) core phantasy. Perelberg's (1999a) notion of a Core phantasy is linked to an Oedipal couple in which coitus is perceived as violent and murderous. This experience is a common developmental phantasy in childhood (see for example Freud's (1918) Wolfman case study) that is created because the powerful aggressive projections onto the couple are perceived as destructive. Instead of relating to an annihilating other as in the core complex (Glasser, 1979), the child is now in relation to an envied and hated sexually identified couple. In the core phantasy the child stands in relation to a brutally excluding couple. Violence is enacted as a destruction of that which is envied and hated. This hatred is directed towards the paternal object who is experienced as a terrifying witness to the patient's shame and degradation (Fonagy and Target, 1995).

2.2.5 Violence and Psychopathology

There is a high correlation between symptomatic violence and personality disorders (Duggan & Howard, 2009; Kernberg, 1992; Yu, Geddes & Faizel, 2012). In more recent meta-analyses of the psychiatric literature on this topic (Howard, 2015), the most common psychological traits underpinning violent symptomology were emotional dysregulation, psychopathy, and delusional ideation. This seems to suggest that affect regulation, exploitative interpersonal dynamics with an emphasis on empathic failure, and an inability to think are the primary drivers that are predictive of violent behaviour (Howard, 2015; Nestor, 2002). This is corroborated in psychoanalytic literature on violence (Bateman, 1999; Glasser, 1998; Hockenberry, 1995; Kernberg, 1967; Kernberg, 1974, 1989a, 1989b, 1991, 2007, 2008; Ogden, 1987). The problem with psychiatric discourse on personality is that it does not examine the internal subjective structures that produce these mental problems beyond what is observable in trait and typological research (Kernberg, 1992; Mizen & Morris, 2015). That being said, it is gratifying to observe the overlap between psychoanalysis and psychiatry in the literature on personality disorder and violence.

2.2.5.1 The Psychoanalytic Axes of Personality Description

For the sake of conceptual clarity I discuss the pathological personality on two axes: its developmental organisation and its typology. I do this in order to show how the pathological personality is linked to violence in the psychoanalytic literature. Choosing this approach comes at a cost. Organising psychoanalytic understandings of the personality is a complex task because no patient seamlessly conforms to diagnostic criteria. There is also the problem that each psychoanalytic school develops its own metapsychological language to describe psychopathology and the personality. Different schools of psychoanalysis may conceive of psychopathology in different ways. Even if the same term is used across schools, this does not mean that it is used in the same way, or that it means the same thing. Conversely, different terms may have significant conceptual or descriptive overlap. Add to this the fact that concepts of psychopathology and personality disturbance have also evolved over time and the difficulties in coherently addressing this area become apparent (Sklar, 2005). It is for this reason that I have chosen to use aspects of the *Psychodynamic Diagnostic Manual* (2006) to organise this section of the review. This manual represents one of the few comprehensive attempts at synthesis when it comes to psychoanalytic conceptions of psychopathology. Other notable attempts are conducted by McWilliams (2011) and Kernberg (1992).

Kernberg's (1992) views of narcissism are considered in this part of the review because of how they pertain to violence. His views are also considered because he adopts an integrative approach to narcissistic psychopathology. He suggests that psychopathy, antisocial personality disorder, sadistic personality disorder and masochistic perversion are all variants of narcissistic psychopathology (Kernberg, 2016). Kernberg (2012) also importantly situates narcissism as a secondary defensive structure that protects the violent patient from his or her borderline organisation. Here Kernberg (2016, 2012, 1992) provides a clear conceptual and diagnostic link between the two conditions that are most often associated with symptomatic violence; those being borderline organisation and the narcissistic personality (Cartwright, 2002; Dutton and Sonkin, 2013; Hasselt and Hersen,

1996). Kernberg's views on the link between borderline organization and masochistic perversion are also reviewed.

2.2.5.2 The developmental-organisational axis of personality psychopathology

There are two axes upon which psychoanalytic theory broadly describes the personality; the level of organisation, and typological (McWilliams, 1994; Kernberg, 1998; Psychodynamic Diagnostic Manual, 2006). The first axis examines the personality in terms of its general capacities. These capacities are listed in the Psychodynamic Diagnostic Manual as follows:

1. To view the self and the other in complex, stable and accurate ways (identity);
2. To maintain intimate, stable, and satisfying relationships (object-relations);
3. To experience self, and perceive in others the full range of age-expected affects (affect-tolerance);
4. To regulate impulses and affects in ways that foster adaptation and satisfaction, with flexibility in using defences or coping strategies (affect-regulation);
5. To function according to a consistent and mature moral sensibility (super-ego integration, ideal self-concept, ego ideal);
6. To appreciate, if not necessarily conform to, conventional notions of what is realistic (reality testing);
7. To respond to stress resourcefully and to recover from painful events without undue difficulty (ego strength and resilience).

(Psychodynamic Diagnostic Manual, 2006. p 22.)

These represent the basic functions and capacities of the healthy personality (Clarkin, Foelsch, Levy, Hull, Delaney & Kernberg, 2004; Greenspan & Shanker, 2004). As these discrete areas of functioning are compromised in the pathological personality, there is an increasing level of severity ranging from neurotic to

borderline. Some theorists (e.g. McWilliams, 1994) locate psychosis as a type of personality organisation in its own right at the extreme end of the severity continuum. This distinction however is a matter of emphasis and psychotic symptomology are equally accounted for at the severe end of borderline functioning (Psychodynamic Diagnostic Manual, 2006). Borderline organisation is indicated when at least five of the functions of the personality (as indicated in the Psychodynamic Diagnostic Manual listing) are compromised.

2.2.5.3 Borderline organisation and violence

Violence is strongly associated with borderline personality organisation (American Psychiatric Association, 2001; Fonagy, Target & Gergely, 2000; Gonzalez, 2016; Howard, 2011; Leichsenring, Kunst & Hoyer, 2003; McMurran & Howard, 2009). Fonagy and colleagues (Fonagy, 2003, 2004; Fonagy, Moran, & Target, 1993; Fonagy & Target, 1995; Fonagy, Steele, Steele, Moran, & Higgit, 1991) suggest that violence arises primarily because of a perceived threat to the self. When a patient with borderline organization is threatened in a relationship (by perceived abandonment or intrusion) the alien self in the mind is activated. The alien self is an internal representation of the primary attachment figure with whom the patient experienced a traumatic early relationship. The details of this process have been discussed earlier in the review (see the *Violence, Attachment, Trauma and Mentalization* section). This floods the patient with feelings of shame and humiliation. These feelings threaten the stability of his or her mind. Bateman and Fonagy (2003) argue that the violent act is an attempt to regain psychic stability and integrity.

2.2.5.4 Borderline organisation and masochistic perversion

Borderline organization by definition implies broad deficits in the functioning of the personality. A significant site of this disturbance is sexuality. There are four main ways in which sexuality is disturbed at the borderline organization. Firstly, there is excessive aggression in pre-Oedipal conflicts in the borderline organization (Kernberg, 1992; Nicolo, 2015; Savvapoulos, Manolopoulos & Beratis, 2011; Stoller, 1985). Primary attachment figures are experienced as dangerous and destructive. Kernberg (1992) points out that sexual partners who are

identified with these terrifying pre-Oedipal objects are responded to as dangerous and destructive. In the case of masochistic perversions this may result in defensive distortions of the sexual engagement in order to master unbearable feelings. Secondly, the sexual object is subject to rapid cycles of idealisation and denigration (Kernberg, 1992). Kernberg suggests that the idealisation occurs in response to an unconscious hatred of the object. Denigrating cycles are phases in which this hatred comes to the fore. These phases are also associated with active expressions of symptomatic violence (Bateman & Fonagy, 2003). Thirdly, because the hated alien object (Fonagy et al., 2004) is identified within the self-structure, annihilatory rage may be mobilised against the self and the patient's own body. Finally, because of the early deficits evidenced in the patient who has a borderline organisation, genital strivings are orchestrated by pre-Oedipal themes such as basic survival, dependency and primitive aggression (Kernberg, 1992). Thus sexuality may become infused with hatred and terror (Welldon, 2011; Stoller, 1985).

2.2.5.5 The typological axis of personality psychopathology

The second axis of personality description is typological. Typology in psychoanalytic diagnosis (PDM, 2006. p. 35) describes:

1. Constitutional or maturational patterns;
2. Introjective or anaclitic orientation;
3. Central tensions or preoccupations;
4. Central affects;
5. Characteristic pathogenic beliefs about the self;
6. Characteristic beliefs about others;
7. Central ways of defending.

In terms of typology, the personality disorders most associated with violence are antisocial personality disorder, narcissistic personality disorder and paranoid personality disorder (Esbec & Echeurua, 2010; Howard, 2015; Stone, 2007). Kernberg (1992) in his comprehensive psychoanalytic treatment of violence, destructiveness and personality pathology, usefully locates the narcissistic

personality disturbance at the root of all of the abovementioned pathological manifestations. He argues that the disorders of antisocial personality, malignant narcissism, the sadistic personality and masochistic perversion are underscored by narcissistic disturbance at a borderline level of organisation (Kernberg, 2016). Kernberg (2016, 2012, 1992) importantly suggests that the narcissistic personality is a secondary defensive structure that protects the patient from the unbearable affects associated with borderline organisation. This is a key finding as it links the borderline organisation to narcissistic typology in clinical conceptions as well as in the literature.

The narcissistic personality will be discussed in terms of the seven typological descriptions listed above (Psychodynamic Diagnostic Manual, 2006). Maturationally, the clinical literature suggests that narcissistic patient appears to have had disruptions in their early attachment history (Psychodynamic Diagnostic Manual, 2006). Their early relationships have been experienced as highly conditional and unfulfilling (Miller, 2002). In narcissistic personalities the ego contains a poorly developed self-concept as a function of internalising these traumatic primary relationships (Morrison, 1989). Hockenberry (1995) points out that narcissitic patients feel "fundamentally inadequate, unworthy or bad" (Hockenberry, 1995, p. 302). This results in a sense of self that is threatened and flawed and requires the mobilisation of powerful defences in order to preserve relational integrity and self coherence (Kohut, 1977; Mitchell, 1988). Their central emotional preoccupation is with the maintenance and enhancement of their self-esteem and self-worth (Kernberg, 2016; PDM, 2006).

Two broad categories of narcissistic types appear to be prevalent in the literature. The first, is the introjective type (Psychodynamic Diagnostic Manual, 2006); also described as hypervigilant (Gabbard, 1989), thin-skinned (Rosenfeld, 1987) and covert (Akhtar, 1989). The second is the anaclitic (PDM, 2006); also described as oblivious (Gabbard, 1989), thick-skinned (Rosenfeld, 1987) and phallic (Reich, 1933). These two types seem to gravitate around two separate defensive poles, one where which the self is protected by aggrandisement (Kernberg, 1984;

Winnicott, 1965) and the other in which the self is protected by masochistic self defeat (Cooper, 1998; Novick & Novick, 1991).

The central affects that occur in the narcissistic typologies are hatred, envy, contempt and shame (Psychodynamic Diagnostic Manual, 2006). For Kernberg (1992) the constituent affect in narcissism is hatred which has become a stable part of the personality. He regards envy as a variant of hatred. Envy arises because any goodness outside the self is resented and destroyed if it cannot be possessed (Kernberg, 2012). Because the narcissistic patient is hostile towards normal dependency, a situation in which the other is acknowledged as possessing desirable qualities, he or she is contemptuous of others (Psychodynamic Diagnostic Manual, 2006). Kernberg (2016) points out that defences against envy and contempt predispose the narcissistic patient to be greedy and exploitative. When narcissistic patients become consciously aware of their limitations, they experience ego-threatening shame (Kernberg, 2016).

The characteristic pathogenic belief about the self centres on an excessive grandiosity (Psychodynamic Diagnostic Manual, 2006). In introjective types this grandiosity is latent (Hockenberry, 1995). Self-esteem is sought by adherently attaching to idealised others, who are ingratiatingly treated although unconsciously envied (Psychodynamic Diagnostic Manual, 2006). In anaclitic types, the grandiose self is manifest (Kernberg, 1992). The grandiose self binds the borderline organisation and allows the narcissistic patient to present as relatively stable (Kernberg, 2016). Narcissistic patients tend to avoid realities that contradict their beliefs about themselves and are periodically prone to periods of terrible insecurity (Kernberg, 2012).

Narcissistic patients relate to others expediently (Psychodynamic Diagnostic Manual, 2006). Kernberg (2012) details how narcissistic patients compulsively seek the admiration of others in order to confirm their fantasies of grandiosity. Introjective types tend to idealise those they unconsciously envy; whereas anaclitic

types are openly aggressive, devaluing and controlling in their relationships (Kernberg, 2016).

2.2.5.6 Narcissistic Typology and Violence

For the narcissistic patient, violence is mobilised in order to expel feelings of shame and deficit (Gilligan, 1997; Hockenberry, 1995). Shame and deficit arise when the grandiose self encounters realities that contradict its imperviousness (Kernberg, 2012). The two types of narcissistic functioning have been drawn together in the following table. This table summarises the typological features and their relationship to violence (Hockenberry, 1995).

Grandiose Narcissistic Style	Underlying themes of narcissistic disturbance	Symbiotic Narcissistic style
Latent: shame is ego-dystonic but unconsciously active	Internalised Shame	Manifest: shame is conscious and ego-syntonic
Manifest: inflated, highly idealised self-image; ego-syntonic	Grandiosity and omnipotence	Latent: grandiosity is ego-dystonic, but unconsciously active
Latent: consciously denies dependency via pseudoautonomy and aggressive control of objects	Insecure self-other relations	Manifest: idealisation and morbid dependence on relationships; others used as self-objects
Manifest: rage is directed towards objects, ego-syntonic	Feelings of anger and rage	Latent: rage is ego-dystonic, projected or passive-aggressively expressed
Manifest: injustice collecting often used as	View of self as victim	Manifest: uses martyr or victim role to deny own

justification for violence, validates grandiosity		aggression, to control others, and to feel "special"
Manifest: engages in deliberate self-destructive behaviours for revenge and control	Masochistic self-defeating tendencies	Manifest: wilfully suffers to keep illusion of control and omnipotence
Manifest: in response to feeling shamed or to restore autonomy	Use of violence	Manifest: in response to feeling abandoned or negated

(Hockenberry, 1995, p. 307)

The first type of configuration is the thick-skinned (Rosenfeld, 1987), hyper-objective (Britton 2004), grandiose narcissist. The grandiose narcissist generally feels aggrieved by how unjustly the world has treated him (ironically this is often not far from the truth in terms of his early development) because of his pronounced sense of self-importance (Meloy, 1992). The narcissist may use this as a justification for violence as well as to bolster a sense of himself as ennobled and powerful. This narcissistic formation clearly manifests as an identification with the aggressor (Freud, 1993). His violence is directed at maintaining self-esteem through the aggressive control and sometimes humiliation of others in order to avoid experiencing any of his unconscious shame. He has consciously over-identified with a pseudo-autonomous position and detests being dependent. This type of narcissistic structure actively seeks out the defilement of others in order to receive pleasure and relational coherence. This is related to the predominant affect of envy (Kernberg, 1989).

The second type is the thin-skinned (Rosenfeld, 1971), hyper-subjective (Britton, 2004), symbiotic narcissist. She is more often violated than violating, symbiotically seeking out an all-powerful idealised object to regulate her self-esteem. In the face

of abandonment unconscious rage and omnipotence may rupture into expression resulting in violence. Bateman (1999) links this form of narcissistic expression with suicidality and self-directed violence. It is also closely linked to the violence observed in the masochistic perversions (Kernberg, 1992).

Cartwright (2002) links explosive rage-type murder to a patient he describes as having a narcissistic exoskeleton. This group of patients appears to fall somewhere between the introjective and anaclitic types described in the table. The self that is constructed to manage underlying borderline dynamics is characterised as empty and distant. When the narcissistic exoskeleton ruptures, explosive violence ensues. Perelberg (2004, 1999) links narcissism and violence to patients who develop a particular form of primal scene phantasy. These narcissistic, violent patients either intrude into, or negate the Oedipal couple in their mind. These forms of phantasy relate to intrusive or aloof manifestations in the transference relationship.

2.2.6 Violence and psychopathology: from infancy to pre-Oedipus

The review on violence and psychopathology has focused primarily on the intra-psychic dimensions of violence and the violent act. These factors are multiple and variable, ranging from the earliest experiences of infancy to early childhood. Unlike the review of thirdness, intra-psychic developmental factors implicated in violence do not extend into the vicissitudes of full phallic and genital development. The implication of this is that symptomatic, recalcitrant forms of violence are deeply imbedded in early developmental sequences. In these sequences the nascent ego is incomplete and the defensive possibilities are limited to primitive evacuation and incorporative psychic mechanisms (Kernberg, 1992; Klein, 1997). These mechanisms are precisely those that lend themselves to destabilizing the distinction between internal and external reality (Kernberg, 1992). Intense, primitive and destabilizing affects are therefore ubiquitous in the paranoid subjective realities of violent patients. Mentalisation literature (Fonagy et al., 2004) makes explicit the link between early stages of development and poor affect regulation. An inability to regulate affect and mentalise reality is a primary factor in the generation of violent symptomology. These intense and unmanageable

feelings are in turn linked to dangerous internal objects that infiltrate internal and external experiences; rendering them permanently threatening. This further intensifies the primitive adaptations violent people need to make, collapsing psychic life into a diminishing cycle of maladaption and psychopathology.

The taxonomical systems that attempt to order personality psychopathology are generally documents that differentiate the disorders on the basis of observable symptoms (see for example the *International Statistical Classification of Diseases and Related Health Problems* as well as *Diagnostic and Statistical Manual of Mental Disorders*). These documents do not address developmental factors in a comprehensive manner; nor do they outline any of the subjective dimensions of personality psychopathology. Psychoanalytic taxonomies of personality disorder on the other hand, delve deeply into the subjective experience of personality disorder, as well as its psychogenesis. These diagnostic systems however, rely heavily on the idiosyncratic metapsychologies of the branches of psychoanalysis from which they hail. McWilliams' (1994) personality taxonomy and the Psychodynamic Diagnostic Manual (2006) are notable exceptions to this, and attempt to bridge different psychoanalytic schools. Even so, these two texts approach the description of the psychopathological personality in entirely different ways. The review has attempted to resolve this problem by approaching violence and the personality from two different vantage points. The first has been to link violence and the personality developmentally. In a continuum of pathological severity, violence is heavily weighted towards borderline and psychotic functioning. Early traumatic impingement and developmental disruption were highlighted as central etiological factors. The problem with this approach is that developmental etiologies underscore and play a role in all personality pathology. There is also the problem that borderline personality dysfunction is a developmental description in psychoanalytic discourse, and a typological description in psychiatric discourse. This leads to serious difficulties when attempting to integrate the literature. And so, a second approach was adopted in the review: the description of personality in terms of its typological characteristics. This approach involved looking at the symptom patterns and observable behaviours associated with different personality types who behave violently. From

this approach anti-social narcissism is most prominently associated with violence. From this approach, psychiatric literature is discussed alongside forensic and psychoanalytic research. The tensions of bringing all these different discourses and approaches together are apparent in the review. As such this section of the review does not map easily onto the personality structures that are described in the thesis. The thesis attempts to address these tensions by foregrounding thirdness as an organizing concept to think about personality and violence. This is the work of the clinical chapters.

2.3 Conclusion

The literature review has been divided into two main sections. The first section has dealt with the psychoanalytic notion of thirdness and the second has reviewed the literature pertaining to violence. In the first section thirdness has been addressed by examining the different theoretical perspectives on thirdness. It concludes with a discussion of thirdness as a developmental construct (Gerson, 2004) with particular emphasis on the modes of subjectivity and affect regulation implied in mentalisation theory (Fonagy et al., 2004). The second section defines violence and examines its relationship to attachment, trauma, internal objects and psychopathology. It concludes by showing the importance of early developmental disruption in the etiology of violence. It also highlights the tensions inherent in the examination of personality psychopathology from both developmental and typological perspectives. The conclusion offers a view that organizing understandings of violence and psychopathology in terms of thirdness may offer an opportunity to circumnavigate some of these tensions and difficulties. The thesis aims to do this by examining clinical material.

The way the thesis attempts to go about the task of organizing understandings of violence and psychopathology is with the notion of the *pathological third*. At first glance, this nomenclature may appear oxymoronic. Thirdness and its multiple developmental, structural and relational underpinnings all imply a sense of coherence and functionality. What then might a pathological third look like in violent patients? What might such a thing be? Violent patients in my experience are shot through with contradiction. Violence is both highly relational and

simultaneously attacking of relationality. It may be chaotic and structured in its enactment. It can be impulsively explosive and yet highly predictable at the same time. It is both meaningful and destructive of meaning. In short violence appears to occupy a hinterland between disorder and order. I hope to argue using the notion of the pathological third that violent patients slouch towards their imagined Bethlehem in an attempt to structure, relate and develop within the confines of a damaged psychic world that is fraught and has lost its centre. In my experience this attempt fails, but it is an attempt nevertheless.

The attempt at relationality, structure and development is perhaps what distinguishes the pathological third from a concept like Steiner's (1993) notion of a *psychic retreat* (although undoubtedly they may cover similar ground). The psychic retreat is an internal constellation of defences and object relations that facilitates a withdrawal from various realities. The psychic retreat encases the patient in a mental structure that forecloses on infantile anxieties as well as the anxieties associated with later development (what Klein (1952) and Steiner (1993) refer to as the depressive position). As in this thesis, Steiner (1993) discusses psychic retreats associated with psychotic, perverse and narcissistic pathology. There are however notable differences between the pathological third and the psychic retreat. Firstly, the pathological third is a construct organised around a theory of affect and its relation to subjectivity. While this is clearly implied in Steiner's edifice, it is not necessarily foregrounded. The pathological third involves a theoretical and clinical description of various non-mentalising, or pre-mentalistic states (Fonagy et al., 2004). Further, the thesis hopes to show that these states may be defensively marshalled in order to manage overwhelming emotional experiences and various aspects of intolerable reality. Secondly, the pathological third describes a state of partial connection, whereas the psychic retreat describes a withdrawal. If the psychic retreat is an island of unreachability, the pathological third represents a limb in the ocean of object relatedness. It is an idiosyncratic, pathological and defensive attempt at connection and interaction; albeit a highly truncated and problematic one. Thus, the term "third" is retained in order to denote this limited, but ubiquitous object-related drive in the patients described. Finally, the pathological third is envisaged and developed in relation to violent

patients specifically. The thesis is not making a general claim about the role of the pathological third in other patient populations as Steiner's work does. Perhaps there may be inferences drawn from the thesis in this regard, but this remains to be researched.

3 RESEARCH METHOD

3.1 The Qualitative Method

The qualitative method is a type of formal enquiry that is used in a wide variety of paradigms and disciplines (Willig & Stainton-Rogers, 2008). It is generally concerned with exploring phenomena in a natural setting (Denzin & Lincoln, 1998) and is directed towards how individuals generate meaning (Patton, 2015). It is most usefully applied to complex social-psychological phenomena that are not easily quantifiable or positivistically examined (Yin, 2010). It can be described as a:

> situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They turn the world into a series of representations...[Q]ualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them. (Denzin & Lincoln, 2005, p. 3).

Qualitative methods are generally underscored by three tenets, those being contextualism, pluralism, and self-reflexivity (Sutton, 1993). Contextualism (Rosnow & Georgoudi, 1986) concerns the acknowledgement that the environment in which the data are collected impacts upon the research endeavor. These environmental factors may include history, culture, language etc. Pluralism

(Frost, 2011; Willemsen et al., 2015) refers to the fact that choosing a specific method and context makes the knowledge claim relative. Interpretations reveal a *position* in relation to the data, rather than claim a monolithic veracity. In this sense, qualitative methods are likely to use existing concepts and ideas to further explore data (Yin, 2010). Qualitative research is not an exhaustive account of the phenomena under scrutiny and represents a particular stance that does not claim to be generalizable (Stake, 1995). Qualitative methods centralise the importance of the reflexivity of the researcher (Denzin & Lincoln, 2005) and regard the researcher's subjectivity as a resource rather than a hindrance (Banister, Burman, Parker, Taylor & Tindal, 1994). Qualitative methods are also reflexive about the act of representing and conveying results, understanding it to be an aspect of the interpretative act (Alvesson & Sköldberg, 2009).

Because of the clinical nature of the investigation conducted in the thesis, the qualitative case study method is used to investigate violent patients who are psychotic, perverse or narcissistic. In particular, the psychotherapy case study method is used because it is psychodynamically informed (Dreher, 2000). This is in keeping with the theoretical orientation of the thesis, as well as the clinical practice informing the treatment of the patients described.

3.1.1 The Case Study Method

Case studies are defined as "intensive analyses or descriptions of a single unit or system bounded by space and time" (Hancock & Algozzine, 2006, p. 11). The case study refers to a written narrative that describes what has occurred during the course of a patient's treatment (Chamberlaine et al., 2004). As a method it is interpretative and exploratory (Fishman, 2005; Willig, 2013). In this study there is an in-depth exploratory examination of certain selected individuals in the therapeutic process (as there would be in normal non-research psychotherapies); as well as attempts to elaborate specific constructs, those being thirdness, violence and the personality.

The clinical case study constitutes the primary vehicle for the communication and interpretation of psychodynamic and psychoanalytic clinical data (Mackay & Poser, 2004; Shepherd, 2004). As such it has exerted extraordinary influence upon the development of theory and practice in the psychodynamic field (Kazdin, 1981). The psychoanalytic case study is a highly complex method as it necessarily involves many forms of qualitative enquiry. It may involve ethnographic, biographic, and phenomenological data as it attempts to examine subjective experience (Chamberlaine et al., 2004). It can be regarded as a method which seeks explanation of an in-depth nature rather than a generatively broad nature (Mertens, 2015). Case study research that is therapy-based is distinctive in that the research endeavour is inextricably bound up with the therapy itself, although not necessarily its outcomes (Shepherd, 2004). The psychoanalytic case study can be regarded as an empirical observation in a natural setting that relates the observed phenomena to the personality of the patient (Meadow, 1984; Yin, 2010), and his or her psychodynamics (Ivey, 2009).

This psychoanalytic case study (Dreher, 2000; Jarvis, 2004; Yin, 2013; Willig, 2013) is aimed at describing, exploring and interpreting the therapeutically-derived narratives of violent patients who have engaged in psychoanalytic psychotherapy with the researcher as their therapist. Because the variables of thirdness and personality formulation are impossible to falsify (Popper, 1963), the emphasis in the thesis is on studying "processes and meanings that are not experimentally examined or measured." (Denzin & Lincoln, 2005, p. 10). Edwards and Ribbens (1998) argue that quantifying human experience in order to satisfy experimental criteria (make predictions about behaviour) is neither desirable nor required in psychoanalytic case study research. For them, scientific quality in case study research is premised on rich, in-depth and detailed data that is contextually collected. This in turn can be used to generate theory and assist in praxis. Qualitative methods, and the psychoanalytic case study in particular, are geared towards the specific and the particular rather than striving for generalisability (Stake, 1995).

Atwood and Stolorow (1993, 1984) identify three characteristics of the psychotherapeutic case study method. Firstly, the data that is acquired is highly idiosyncratic and can only be understood within the context of the patient's life and his own understanding of himself. Secondly, following on from the first characteristic, the primary research object consists in an examination of the life history or "life-historical phenomenon" (p. 28). This is fundamental to psychoanalytic processes and is evident in the genetic meta-psychological principal, namely that early development impacts and is observable in later development. Finally, the method is characterized by its inductive and interpretative stance, arrived at via an immersion in the patient's clinical material. This leads to the provisional identification of meanings that are then critically synthesised into a coherent analysis of the case.

3.1.2 The Phenomenological-hermeneutic case study method

In this study, which explores the psychodynamics of symptomatically violent patients, the psychoanalytic case study method has a phenomenological-hermeneutic emphasis (Greenwood & Loewenthal, 2005). This emphasis allows for the research to respond to various criticisms that have been levelled at the case-study method.

Phenomenological-hermeneutics is not technically distinct from the case-study method. It does however have a different epistemological emphasis with regards to its truth claims. It is located within the philosophical tradition of idealism rather than science (Greenwood & Loewenthal, 2005). This means that there is "an acknowledgement that the world a person observes does exist but that the mind and its ideas are separate from this world" (Greenwood & Loewenthal, 2005, p. 37). In phenomenological-hermeneutics, rigorously scrutinised subjectivity is a primary variable in the consideration of any truth claim (Heidegger, 2010). Phenomenological research offers self-reflexive descriptions of reality rather than objective or scientific reality (Donmoyer, 2000). When the object of scrutiny is another mind, as is the situation in a therapeutic case-study, this approach is of

particular relevance, considering the intersubjective nature of the psychoanalytic interaction (Butler, Flasher & Strupp, 1993; Dreher, 2000).

Case-study methodologies are strongly criticised, even from within psychoanalysis, for their weak reliability and validity (Aron, 2012; da rocha Barros, 2013; Fonagy, 2013). An aspect of the criticism is what Spence (1993) calls "closed texture" (p. 38). The criticism problematizes the presentation of a singular, persuasive account of the data that presents itself as true (Willig & Stainton-Rogers, 2008). Within phenomenological-heuristic approaches this criticism has a limited bearing because the reader is invited to engage with the research claim as an instance of interpretation rather than as a fact (Greenwood & Loewenthal, 2005). In this sense hermeneutic research findings, an exemplified by the case study, are understood to involve two meaning-making processes: the first in the research endeavour itself, as well as in the consumption of that research (Gabbard, Beck & Holms, 2005). In this sense, the thesis is a collection of findings, in a particular set of circumstances that are offered as a description to be taken up, disagreed with, modified and altered in the multiple acts of secondary interpretation and consumption. The thesis does not present itself as an objective truth. As with all phenomenological-hermeneutic approaches, self-reflexivity about socio-cultural location, theoretical orientation (psychoanalysis), and personal history with violence fundamentally inform my interpretation and analysis (Bromley, 1986).

Self-reflexivity is a fundamental tenant of psychoanalytic research and intervention (Butler et al., 1993; Dreher, 2000). The researcher/clinician is engaged in continuous acts of analysing the transference and counter-transference (Joseph, 1985). This is of particular importance for this study. Symptomatically violent individuals are prone to destroying self-reflexive meaning-making processes and shared thinking (Adshead, 2013; Migliozzi, 2016; Widawsky, 2014). The restoration of self-reflexivity and mutual meaning making in the transference was not only a therapeutically valuable act, but a methodological one as well. Sharing creative understandings of the mind in the form of interpretations was a way to check the validity of those understandings as they emerged in sessions. In particular, when patients were able to resonate with, and respond to formulations,

it suggested a good prognostic outcome. In other words, it tended to promote self-reflexivity and engagement on behalf of the patient as well. In this way each of the patients discussed in the thesis were party to generating the meanings evolved in the four clinical chapters. These understandings were also elaborated and considered during the supervision process. This methodological characteristic meant that the findings were heteroglossic in the sense that multiple voices were informing them.

Another serious threat to the validity of the case study method, related to the lack of transparency, is the proliferation of what Spence (1993) calls "argument by authority". By not making clear the psychotherapeutic data leading to a finding, the reader is left to rely on the authority of the therapist that in turn prevents disagreement. While it is acknowledged that patient confidentiality can have a justifiable but negative impact on this type of validity, Spence points out that in many cases reluctance to denote clinical material may in some cases be the therapist wishing to avoid the scrutiny of the professional community.

In this thesis, this threat to validity is addressed by including the clinical material that is relevant for the formulation. Included in the discussion of the clinical material are the explicit subjective impressions of the researcher/clinician. In keeping with the phenomenological-hermeneutic orientation, the four clinical chapters do not claim to represent an exhaustive account of the patient's psychodynamics. Instead there is a self-reflexive attempt to generate a theory, based on the idiosyncratic interactions between the patient and the therapist, using the lens of thirdness. Clinical data was also scrutinised and tracked over the course of the treatments by senior colleagues in supervision.

Further threats to internal validity come from the credibility and the plausibility of the therapeutic endeavour being described. Tuckett (1998) describes credibility as related to the recognisability of the clinical work in that it contains the "basic elements" of what is regarded as acceptable psychodynamic practice. To this end, this thesis includes clinical data that refers to how the unconscious manifests in

the treatment in the form of dreams and transference dynamics. Plausibility refers to the level of consideration that has been given to the clinical data such that conclusions drawn are credible and convincingly argued. This may involve demonstrating that other plausible interpretations have been considered. In this thesis, the clinical chapters are self-consciously generating a focused form of formulation in relation to thirdness. From the outset, the thesis is claiming nothing more than a case-limited and theory-specific reading. The conclusions generated by the clinical chapters are self-consciously selective, and do not negate alternative formulations. The phenomenological-hermeneutic case-study method makes explicit the limited truth-claim of the research outcome.

One of the biggest challenges facing the psychodynamic case study concerns the heavy reliance on the memory of the clinician in data collection and capture (Spence, 1993). Memory as the primary archive constitutes "a shifting and unreliable data base which is not open to public inspection or consensual validation" (p. 41). This opens up numerous methodological difficulties. Firstly, there may be a "tendency to misremember clinical experience in a way that supports received theory, and 2) a tendency to associate memories in a way that agrees with received theory" (p. 42). This fallacy or "illusory correlation" poses a major threat to the research endeavour and every effort should be made to counter its effect.

The thesis addresses these difficulties by drawing on clinical notes that were written after the sessions, as well as notes that were generated in supervision. Many of these notes were written prior to the conceptualization of this research and were thus not influenced by the aims of the research. It was decided that sessions would not be recorded by any video or audio device. Although this compromises the validity of the data, the presence of a recording device would have negatively interfered with the process of psychotherapy, and the relationship between psychotherapist and clinician (Lincoln & Guba, 1985; Stajner-Popovic, 2001; Tuckett, 1993). As the majority of the sample were already in treatment with the researcher, the introduction of recording equipment into the sessions would have been especially problematic. Instead sessions were transcribed from memory

within twenty-four hours of the session taking place. These notes also included thoughts, feelings and associations arising in the researcher's mind during the course of the treatment and during the writing of the notes (Bromley, 1986). These impressions were self-reflexively subjective and represented possible interpretations of the clinical experience. These impressions as well as the memory transcripts were examined in the supervision process for the duration of the treatments.

It has been noted that in the case study method, which usually has a single-subject design, it is problematic to assume that all change occurs because of the therapeutic process (Keisler, 1981). This is noted as a threat to external validity and reliability. The thesis addresses this difficulty by including numerous cases and vignettes across the psychopathological cohorts. The focus of the thesis is not on the therapeutic efficacy of the clinical intervention; rather it is on coherent theory making and formulation. Although the thesis does make some technical recommendations regarding the treatment of violent patients in clinical practice, this is not an explicit aim of the research. The cases described in the thesis are not selected on the basis of a positive therapeutic outcome.

Guba & Lincoln (1989; 1994) highlight measures for determining the "trustworthiness" of case study data that are far more congruent with the epistemological underpinnings of qualitative research. Two of these measures, "credibility" and "transferability" will be discussed.

Credibility is a measure of internal validity. Guba and Lincoln (1994) suggest three strategies for improving the *credibility* of the case study. The first is to spend sufficient time with the patient in order to be able to participate in in-depth and regular direct observation. All of the patients in the study had been in therapy for at least a year and therefore there has been a reasonably lengthy period of observation.

The second suggested bolster for credibility concerns direct communications to the patient (Guba & Lincoln, 1994). In this process the therapist's interpretation or understanding of an event is put to the patient for verification in the form of an interpretation in the session. I have alluded to this process earlier in the method section. This is fundamental in the clinical work described in the thesis. All of the metaphors generated in relation to thirdness have been used in the clinical discussions with violent patients. As I have indicated, the metaphors have been generated because they have had purchase in the formulation of the patient's difficulties. Understandings that have not had clinical utility have been discarded.

The third recommendation for the improvement of credibility is triangulation (Guba & Lincoln, 1994). Triangulation involves other therapists and colleagues examining the data to verify whether or not it supports the understandings based on them.

Specific supervision related to the cases described in the study was also regularly received on a weekly basis by a senior psychodynamic therapist during the course of the clinical work. The findings have also been scrutinised by the researcher's academic supervisor as well as a cohort of senior academic colleagues and peers in the PhD programme within the psychology department (see Long, Eagle, & Stevens, 2015).

The second factor contributing to trustworthiness outlined by Guba and Lincoln (1994) is *transferability*. This measure relates to external validity and reliability and concerns how the findings can be generalised across contexts. With regards to threats of reliability, Yin (2013) states that findings from the qualitative case study are not generalizable to populations but rather contribute to the process of theory building. Theory becomes centrally important to the psychodynamic case study because it becomes the way in which the finding can be contextualized and compared to other findings. Even in a single subject design, the findings can be meaningfully and robustly related to theoretical formations for confirmation, contestation or extension of the theoretical frame. The importance of theory also

then has implications for how research questions are constructed in that they are theory driven (Hollway & Jefferson, 2000). This is certainly the case for this study where the notions of thirdness are examined in the therapeutic context with violence patients with different personality diagnoses. The phenomenological-heuristic orientation of the case-study approach adopted in the thesis also locates the theory-driven formulations within a broader dialogue of other research. The findings do not claim to be monolithically generalizable or transferable beyond the contexts that they are generated and responded to. In this sense, the study findings are not regarded as absolute, but rather the manifestation "of higher-order synthesis in the form of a descriptive picture, patterns or themes, or emerging or substantive theory" (Mertens, 2005. p. 422).

3.2 Research participants

The sampling in the thesis was initially accidental and convenient (Gravetter & Forzano, 2011). The researcher was treating numerous violent patients in a clinical setting before the study was conceived. As the idea of the study emerged, and after a period of attending to the specific psychodynamics of violence out of clinical necessity, various cases were selected as potential case-studies. This stage in the research process involved purposive (Creswell, 2014) sampling. Patient material was selected from a cohort of violent patients that were, or had been, in treatment with the researcher. These patients had to meet the criteria of being symptomatically violent and fall into the three psychopathological cohorts of psychosis, perversion or narcissism. These patients represent the bulk of the patients described in the thesis. Three of the cases were selected as a result of "snowball" sampling (Noy, 2007). These patients are Mr D and Mr A, who were discussed in chapter seven; and C, discussed in chapter four. These patients were referred to the researcher by colleagues who were aware that I was treating and researching violent patients. As far as I know the colleagues who referred Mr D, Mr A and C did not make it explicit that I was conducting research into violence. When I accepted these referrals, I did not anticipate that they would be included in the case studies. It was only after they met the psychopathological criteria, and evidenced material relevant for the research on thirdness that they were selected. Mr D, Mr A and C are the only patients who entered treatment after the study was officially conceived.

Mr J (chapter four and seven), Mr R (chapter four), Mr K (chapter four), L (chapter five), Mr L (chapter six), Mr D (chapter seven) and Mr A (chapter seven) were all treated in medium to long-term adult psychodynamic psychotherapies that ranged from one year to eight years. C (chapter four) was treated in psychodynamic play therapy for a period of seven months. All the patients described in the thesis were no longer in treatment by the time of the final write-up of the thesis.

3.3 Data collection

The highly focused interpretative lens of thirdness in the clinical chapters means that the material is selected on the basis of its relevance to thirdness. This focus is self-reflexive and deliberate. Again, the phenomenological-hermeneutic orientation of the method foregrounds its selective reading of the clinical data in terms of thirdness. The hermeneutic circle (Rodwell, 2015) approach to reading and interpreting the data from sessions will be further elaborated in the data collection and analysis section. All of the primary data interpreted and analysed in the thesis was taken from the psychodynamic clinical encounter with violent patients. This is in keeping with the case study method. The nature of the psychodynamic approach involves a close examination of the relationship between patient and therapist, as well as the narrated content of the sessions (Spence, 1993). Secondary data arose from notes taken in clinical supervision sessions with a senior clinician.

Psychodynamic psychotherapy involves a deep immersion, on behalf of the psychotherapist, into the subjective experience of the patient. At the same time, the therapist attempts to reflect upon this deeply subjective experience from a neutral, objective perspective (Kelly, 1999). Although this objective position is never attainable in a positivistic sense (Bruinsma & Zwanenburg, 1992), it nevertheless provides the basis for psychodynamic, relational knowing (Lyons-Ruth, 1998). The psychotherapist attends to what is concretely observable in the session (e.g. narrative content and body language), what is experienced subjectively for the patient and clinician (affects and relational dynamics), as well as the

manifestations of the unconscious (observed in narrated dream content and free-flowing, unrestricted speech) (Bateman and Holmes, 1995). Further objectivity is sought by writing up notes after the session and seeking out supervision on the case material, usually from a senior psychodynamically orientated colleague (Greenberg, 1994). All cases in described in the thesis were supervised. Notes taken in the supervision sessions were taken as a secondary form of data.

3.4 Data Analysis

Specifically, the analytic approach that is adopted in the study is hermeneutic, a form of close textual reading geared towards understanding lived experience and formalised in the "hermeneutic circle" as a method of enquiry. This method concerned a circular traversing of text (in this case the therapeutic material and interaction) where the movements between understanding the whole of a narrative, and then understanding its constituent parts, ultimately produces a detailed understanding through this dialectical process.

The hermeneutic circle can be broken down into five analytical steps when approaching psychodynamic data (Rodwell, 2015).

1 Phase of immersion.

In this phase all data, including case histories, process notes and supervision notes were read several times during the course of the analytical process. Emerging understandings were noted and modified as understanding changed or new thoughts emerged.

These phases of the research were closely linked to the therapeutic process and a generation of understanding was conducted as the various therapies progressed. Process notes and notes detailing supervision sessions, particularly of difficult sessions and therapies, served as the anchoring material for this phase of thinking.

The most difficult sessions, usually sessions in which thinking and formulation were difficult to achieve, were the orientating data that informed the phase of immersion. These instances are often represented in the thesis in the form of the vignettes denoted. Although these sessions were the access point in the phase of immersion, they were supplemented by less-fraught, more ordinary material as well (in other words, when the transference and countertransference dynamics were not as overwhelming as was the case for crisis sessions). Tentative broad understandings of the clinical material in relation to clinical process were denoted.

2 Phase of unpacking.

During this phase of unpacking the data, a more specific reading of the clinical material connected to thirdness and violence was conducted. Emerging thoughts about these phenomena were advanced and considered in clinical supervision as well the researcher's own personal notes. Novel thoughts about how thirdness was connected to understandings generated in the immersion phase where more comprehensively interrogated. If these understandings were notably distinct, the formulations were adjusted to more accurately reflect the clinical data. These understandings, in turn, were brought to patients in the form of interpretations. The patient's response to the third-related interpretations was carefully monitored and tracked in the therapeutic process and the supervision of this material. For example the researcher in one instance interpreted, "It seems to me that you are using psychiatric understandings as a kind of external mind to protect you from how scared you feel of people in authority" as was the case with Mr J in chapter four. Responses to these interpretations were tracked in terms of how they were taken up and used in the therapeutic process. It is important to note that there were numerous metaphorical understandings of the mind related to thirdness that were discarded by patients because they did not productively match the experience of their own minds in the session. For example, notions of a "parabolic third" in narcissism, a "fetishistic third" in perversion were discarded because patients did not resonate with, or take up, these interpretations.

3 Phase of associating

Linkages of my own exploration of the psychoanalytic literature, creative-fictional literature as well as my intuitive associations to it, were sought in this phase of the analysis. Broad patterns applying across individual patient material were conceived and considered. This was in turn linked to increasingly specific operationalised notions of thirdness in my formulations. The associative connections between patients within a particular psychopathological cohort were developed in this phase.

4 Phase of categorisation

Significant categories of thirdness and violence were lifted from the data and rigorously scrutinised for their veracity in relation to violence and thirdness. This phase involved working through various tensions inherent in the formulatory thinking about violence and thirdness. In this phase in particular, I was faced with bringing together psychoanalytic, psychiatric, mentalization and cognitive approaches to violence in a manner that matched the data in a non-contradictory way. In these instances I was led by what felt most relevant for the patient's experience. For example, in moments of crisis with violent patients, I found it useful to speak directly to the affect regulation aspects of the formulation (as directed by cognitive and mentalization literature) instead of interpreting genetically or transferentially as directed by psychoanalytic formulations. These decisions were in turn shared and discussed with clinical and supervisors.

5 Phase of comparison

The categories and the related material were then compared and contrasted to other categorisations relevant to a particular patient, but also to other patients in the study. I began to think more generally about what the differences and similarities were across psychopathological cohorts in relation to thirdness. This

served as a refining process of the various formulations, but also as a means to generating a cross-patient comparison. Differences and similarities pertaining to violence and thirdness were identified at this stage, and informing the research conclusions. These comparisons are discussed in chapter seven.

3.5 Ethical considerations

3.5.1 Patient confidentiality

Patient confidentiality is a cornerstone of psychotherapeutic practice. Confidentiality is however at odds with an equally important priority within psychodynamic psychotherapy, which is to share clinical information so that the field as a whole can advance. In the thesis I have chosen a combination of informed consent and patient disguise (Furlong, 2006) to protect the confidentiality of the patients described. I will discuss the instances where informed consent was utilised and then I will discuss how patient information was disguised.

3.5.2 Informed consent

The Health Professions Council of South Africa's research guidelines direct the researcher to "seek the consent of patients to disclose information wherever possible" (HPCSA booklet 11, 2007, p3). The proposed study has obtained informed consent from two of the research participants. In both instances, the participant constituted a single case study used to demonstrate the formulations offered. As such their material and their histories were discussed in detail. This necessitated an informed consent approach. As directed, these participants have signed a consent form (appendix 1) outlining the appropriate details of the study (HPCSA, booklet 10). Participation was thus voluntary, willing, informed and consenting. Participants were informed that were able to withdraw from the study at any point. In these two cases, the therapy was concluding by the time the study was conceived and therefore consent was given retrospectively. These patients were offered additional therapeutic contact in order to provide a space in which

possible repercussions of being asked to be involved in the study could be negotiated.

In all the above cases I am satisfied that I have satisfied the criteria specified for informed consent as specified by Homan (1991). All the relevant details about the study and possible ramifications for being involved in the study have been discussed with the research participants. I am satisfied that these patients have understood the information that I have shared with them. In this regard I did not approach either patient whilst in the grips of any judgment-compromising condition. I have also spelled out that should there be a change of heart regarding participation, that this would be respected. I have also explained that there is a limit to this consent withdrawal in that I will not be able to do so once the thesis has been submitted or aspects of their material published. Lastly, I am not able to separate the consent that has been given from the dynamics of being involved in the therapeutic relationship, but I understand this to be unavoidable.

3.5.3 Patient disguise

For six of the patients described in the thesis, it was decided that thick disguise (Furlong, 2006) would be utilized to protect patient confidentiality. There were three reasons why informed consent was not considered in these cases. Firstly, they were included as one of a number of cases discussed in the research. Accordingly, highly selective vignettes were taken from their material in order to demonstrate the formulations offered. Their personal histories were not examined in detail. Secondly, these patients were no longer in treatment at the time that their material was written-up. As all of these patients presented with serious psychotic, perverse and narcissistic disturbance, it was decided that an unsolicited contact post-treatment could have a potentially unpredictable and possibly negative effect. This was a difficult decision that was not taken lightly. Although the principle of informed consent is an ethical paragon, it stands relative to the principle of *primum non nocere* or 'above all do no harm' (Stajner-Popovic, 2001). Because of the factors outlined, a general policy of informed consent was not considered appropriate in these instances. The researcher, along with others in the field

(Gabbard, 2000; Goldberg, 1997) acknowledge the inherent tensions in these ethical considerations.

In these cases, it was decided that thick patient disguise would be used to protect patient confidentiality (Furlong, 2006; Gabbard, 2000). Gabbard (2000) outlines five strategies for the protection of patient information in the writing-up of case studies. Of these strategies I have utilised thick disguise and the process approach.

Thick disguise refers to the changing of identifiable details in order to obscure the patient's identity. Patients have not been identified in the thesis in order to assist with the thickening of the disguise. A disguise is considered as thick when only the therapist and the patient could recognise the patient's identity from the text. Gabbard (2000) suggests that use of thick disguise should be judicious and carefully conceived so as not to interfere with the main argument. Judicious thick-disguise has been used in the proposed study. The patients are identified by an arbitrarily assigned letter, and their identifying details (that are not germane to the discussion) have been changed. Dream material and process description has not been altered.

The process approach (Gabbard, 2000) to writing case material is drawn from The Committee on Scientific Activities of the American Psychoanalytic Association's guidelines for the improvement of scientific and ethical concerns in clinical writing (Klumpner & Frank, 1991). This approach relies on selecting elemental vignettes of the overall process which demonstrate the argument, but which require very little identifying information about the patient.

I have submitted this study to the Human Research Ethics Committee of the University of the Witwatersrand for ethical clearance in this regard. The certificate is appended (appendix 2).

3.6 Research Questions

The research aims to address the following research questions:

1. How can psychotic, perverse and narcissistic patients who are violent be formulated using the notion of thirdness?
2. What role does thirdness play in the mind and therapeutic process of the psychotic, perverse and narcissistic patient who is violent?
3. What is the relationship between thirdness and violence in psychotic, perverse and narcissistic patient cohorts?

4 THE PROSTHETIC THIRD IN VIOLENT, PSYCHOTIC, MALE PATIENTS[1]

4.1 Introduction

The chapter introduces the 'prosthetic third', a complex clinical phenomenon evident in work with psychotic, violent patients. The prosthetic third describes the semiotic object, a self-contained pocket of meaning manifest as a story, song or game which is used by the patient as an artificial ego. The semiotic object is also used to deny, control and ameliorate intolerable aspects of reality, the most clinically salient being the reality of the thinking-other in the therapeutic encounter. The chapter provides clinical examples of the prosthetic third and concludes with some thoughts on the relationship between the prosthetic third and violence.

[1] A version of this chapter has been previously published in *Psychoanalytic Psychotherapy in South Africa* (van der Walt, 2011).

The way in which *prosthetic* is used in this chapter is well described in a short story by Edgar Allan Poe called *The Man that was Used Up* (2009). In this narrative the grandiose and socially impressive Brigadier General, known for his battle prowess, is revealed to consist of a grotesque collection of prostheses. In his true state, he is "a large and exceedingly odd-looking bundle of something" (Poe, 2009, p. 5931), in essence a fragmented and unorganised corporeal entity. Each of the prosthetic pieces signifies and stands in for a horrific act of violence perpetrated against him in the wars he has fought. The terrified narrator, who has accidentally witnessed the macabre assembly of the Brigadier General, comes to the conclusion that he is a man 'used up'. In other words, what remains in the form of his prosthetic self is more dead than alive. What is more, this fact is deceptively obscure in the initial contact the narrator has had with him.

Similarly, the patients described in this chapter cut a deceptive coherence, even if that coherence is ceded through the destructive and defensive acts that often place them at the anxious centre of many social interactions. In the initial phases of listening I was often impressed by how these boys and men had survived their 'battle-ridden' lives. As these impressions increasingly contradicted my experience in the therapy, I began to realise, like the terrified narrator in the story, that the patients before me were not as they initially seemed. They were in fact a collection of mental prostheses, poised on the point of collapse and indignantly clinging to a psychic life in which they could not genuinely think about themselves, their experience, nor relate to others.

All of the patients described in this chapter are both violent and psychotic. By violent I mean that they have actualized their aggression such that it has led "to the destruction or damage of an object" (Cartwright, 2002, p. 27). Furthermore, this violence has become an established part of how they relate to certain others. The diagnosis of psychosis indicates a personality which lacks the ego capacity to meaningfully organise, experience and interpret reality (Freud, 1924).

The primary aim of the chapter is to introduce what I have called the prosthetic third – something that I have found in my clinical work with violent, psychotic patients. The prosthetic third describes two related clinical phenomena.

The first phenomenon is seen in the way in which my patients use particular objects, and the second is observable in the destructive way my patients treat me in the act of using these objects. The objects are particular because they are semiotic systems that generate meaning. Let me elaborate on this. A cup, for example, may participate in a patient's psychic economy in various ways, and via the patient's associations we could follow the trail of displacements and substitutions, metaphors and metonyms, and with some luck arrive at its psychological relevance and meaning. The cup, in and of itself, does not generate meaning beyond how it operates in the mind of the patient and its practical function. Contrast this to the semiotic object – a story for example – which could participate in the psychic economy of the patient in the same way as I have just described, but is also able to generate meaning systemically using the devices of narrative, plot, character, genre and so on to construct a self-contained, meaningful, linguistic reality. This structured and meaningful reality is necessary because it provides the order and coherence that the patient is unable to provide for himself internally. The semiotic object is used by the patient as an artificial mind – hence the term prosthetic – an adjunct or addendum to the ego's functioning that makes up for what is damaged and lacking. The main function of the prosthetic third is to create an ordered artificial reality; a manufactured account of the self, the other and the external world.

The second clinical phenomenon observed when the prosthetic third is at play concerns how the patients use the semiotic object against the therapist in a manner that is destructive. Because the function of the prosthetic third is in part to replace certain realities that are intolerable, it stands to reason that the therapist, who tries to introduce this painful knowledge, is treated forcefully and uncompromisingly. The patient responds by trying to negate, deny and omnipotently control aspects of the therapeutic interaction. The reality of a thinking-other in the form of the therapist is one that poses significant dangers for

my violent, psychotic patients. In particular it threatens their fragile prosthetic engagement with the world.

4.2 Thirdness and knowing reality

Why have I called the prosthetic third a prosthetic *third* and not a prosthetic mind? To my mind, the body of psychoanalytic literature concerned with *thirdness* addresses how a person comes to know reality. This includes the reality of the self, the reality of others and the realities of the external world. It also describes the myriad of developmental processes and mechanisms that result in a capacity to functionally manage these different types of realities. The prosthetic third, then, is what the patient uses to try and know reality in the absence of the capacity to do so.

Thirdness is a difficult concept to trace in psychoanalytic literature. It is pervasively implied and utilized (Green, 2004), and taken up differently by numerous authors and schools of thought within psychoanalysis (Benjamin, 2004; Britton, 2004; Green, 2004; Ogden, 2004). Gerson (2004) highlights three different ways in which the third is conceptualised in psychoanalytic literature. He draws a distinction between the relational third, the cultural third and the developmental third. These three areas represent the broad strokes of how the contact with reality is orchestrated and developed.

The relational third describes how a person comes to know the psychic reality of self and other via the mechanism of the intersubjective relationship. The relational third is for Gerson the idiosyncratic unconscious of the relationship between two people, not unlike Green's analytic object (1975), Odgen's intersubjective analytic third (2004) and Benjamin's (2004) third-in-one intersubjective encounter. While there are different emphases on the nature of the intersubjective contact, all authors commonly regard relational aspects of thirdness as that which is mentally produced when two people make contact, and which in turn can be used by either party in the relationship to know and experience reality.

The cultural third in turn describes the processes and objects necessary to know a social world, with its rules, hierarchies and institutions. The function of the cultural third is to facilitate an introduction to a reality that exists outside of the dyadic relationship between two others. As such it refers to a person, symbol or institution that shapes the relational dynamics between two others – a guarantor or referee-type entity keeping and enforcing social rules. The exemplar of this type of thirdness can be seen in the Oedipus complex (Freud, 1910; Lacan, 1977) where a third entity (the father) intervenes in the relationship between the mother and the child, ultimately producing a situation where the child internalizes prohibitions and identifications vital for pro-social maturation. It is also observable in psychotherapeutic supervision, particularly training supervision. In this case the supervisor secures and oversees the rules of therapeutic engagement as well as facilitating a third perspective on the interactions between patient and training therapist with a view to promoting both parties' development. For the supervisee this facilitates (if the supervision is successful) the development of thirdness, also named the "internal supervisor" (Casement, 1985), the observing ego function (Aron, 2000), or the internal analytic working model (Zwiebel, 2004).

The developmental third denotes how the different types of reality come to be known over time. In developmental thirdness there is a continuum that ranges from primitive ways of knowing reality in early stages of development to more advanced and complex knowledge of reality in later adult life. In other words, the developmental third is achieved when states of infantile dependence and solipsism (one in the developmental series) make way for dyadic relating where the need for the other is narcissistically delineated (Minolli & Tricoli, 2004) (two) which in turn evolves into a self-reflexive state in which meaningful separateness from a recognized other is achieved (Gerson, 2004). From this vantage point a stable, complex and dynamic capacity to appreciate and engage with the reality of self, others and the outside cultural world has been achieved.

The patients described in the chapter have not acquired a capacity for thirdness. Ways of knowing cultural reality and relational reality are not present. For the patients described below, difficulties in capacities for thirdness are, without

exception, underscored by severe developmental deficits. The prosthetic third is a replacement of reality which is achieved via the use of the semiotic object. The prosthetic third denotes both the defensive orchestrations against what is perceived as terrifying and *meaningless* as well as an attempt to create something functional, albeit artificial, with which to engage with, and be in, reality. Each of the four patients described below cobbled together their own specific semiotic object – discourse for one, music for another, a game for the third patient and an autobiographical text for the fourth – in order to prosthetically replace reality.

4.3 Discourse as a prosthetic third

Mr J's first session is a decidedly tense affair. As I am sharing my first thought with Mr J he interrupts me by asking me what I know about his specific psychiatric disorder. He then goes on to speak about his illness in a manner which is patronizing and makes me feel stupid and annoyed. I am annoyed because it feels as though I am the patient, and I feel stupid because a lot of the psychiatric discourse and pharmacological research he is talking about I do not know or understand. He concludes his tirade by saying that he monitors and administers his own medication and even goes so far as to recommend some readings so that I can understand him better.

My understanding of this fragment of Mr J's first session is that he is responding defensively to his awareness of me as a thinking-other. His response is in the form of the prosthetic third, his use of psychiatric discourse. The use of the prosthetic third operates in a number of ways to nullify the reality of the thinking-therapist. Firstly, Mr J's introduction of the discourse of psychiatry into the session comes in the form of an interruption, an imposing semiotic act. In this way he communicates that he is replacing something from me with something else of his own making.

Secondly, Mr J speaks as both the agent of the discourse (the knowledgeable psychiatrist administering his own medication) and the object (the psychiatric patient). He could avoid the realities of the thinking-other by becoming a

caricature, or approximation, of a mental health professional. By achieving a mechanistic mastery of the discourse, Mr J could replace the therapist's thoughts by 'thinking' and 'treating' himself. I am reminded here of Escher's (1948) print, 'Drawing Hands' which depicts two hands that sketch themselves into being. The discursive illusion achieved by Mr J is that he is everything to himself, and his invitation to me was to participate as an uninvolved witness. My counter-transference reactions alerted me to the fact that I was being excluded in a hostile manner from mutual engagement.

Thirdly, using the discourse of psychiatry also had the effect of lending Mr J a coherence that he did not otherwise have. This effect relied on the social status and history of the discourse of psychiatry. Parker (1992) describes that discourse is a vehicle for the expression of power because it constructs a truth claim which in part relies on how it connects to what is regarded as true in a historical and social frame. Thus psychiatry, which is associated with the discourse of medical science, has a privileged truth claim (in certain contexts) and therefore lends power to those who speak it. Coherence comes about because there is a shared *recognition* of the history and power of the discourse.

In order to further illustrate this point I will refer again to the *The Man that was Used Up*, which demonstrates this type of discursive power. In the narrative there is repetitive and rote description of the General's prowess by virtually all of the characters. This has the effect of elevating the truth status of what they describe as it becomes clear that there is social consensus about what is 'known' of the General. This social consensus relies a great deal on the way the characters relate to the wars that the General has fought and the bearing these have had on their own national identities. The discursive subtext of the narrative is that the General is valued because he is an agent for the promotion of a valued idea and identity. As such it is the nationalist agenda of the characters that is discursively underscored in the repetitive, mechanical and idealizing descriptions of the General, who acts as an exemplar of this truth. Such rote repetitions abounded in the descriptions of Mr J by colleagues and other health professionals. "He is such a typical so-and- so on this or that Axis", they would say, producing a repetitive psychiatric 'truth' about

the patient which became cumulatively compelling with each utterance. The fact that Mr J could speak of himself in the same terms as his mental health 'audience' conferred a great deal of discursive authority upon him in the form of a shared psychiatric 'truth'.

Finally, Mr J's use of the discourse of psychiatry allowed him to produce a type of pseudo-mentalising in which his affect could be coherently managed but not directly experienced. Mentalisation refers to a capacity to be aware of and represent the reality of mental states in the self and subsequently to be aware of these states in others (Fonagy & Target, 1999). Mr J's excruciating helplessness as a psychiatrically ill man was calmly explained within the ambit of the discourse of psychiatry. His feelings of impotence and powerlessness as a psychotherapeutic patient were circumnavigated when he provided the therapist with clinical supervision. Also, his rage and hatred of the therapist's capacity to think were interrupted and substituted by presenting himself as the agent of his own treatment. Via the use of the prosthetic third, then, Mr J found an artificial intellectual tool to 'think' his feelings but not meaningfully experience them. Fonagy et al. (2004) refer to this type of relationship to affect as 'pretend mode' where thought excises affect and imposes an artificial logic upon the experience of self and other. In this way Mr J, via the use of the prosthetic third, can tolerate the therapeutic encounter.

Mr J relies on the recognizable, coherent and structured truth claim inherent in the highly organized discourse of psychiatry. He uses it prosthetically, borrowing these organizing properties to prop up his own faulty capacities to engage with reality. An aspect of this process allows him to disavow disturbing affective states and instead to participate in the therapy as an expert on himself. What is sacrificed in the use of the prosthetic third is the relational third, a connection to the reality of a thinking-feeling other who could potentially help him.

4.4 Music as a prosthetic third

Mr R arrives in his session and is noticeably manic. He speaks incoherently and jumps around the room doing exercises. I feel that Mr R is in a great deal of pain

and cannot tolerate thinking about his feelings. I share with him my thought that he does not want to think about something painful. Mr R responds by sitting down in his chair and playing some gentle jazz music on his cell phone. When I try and speak to Mr R about what he may be attempting to do with the soothing music, he turns up the volume and drowns out my voice. I feel simultaneously disturbed, helpless and moved when watching Mr R sway and rock to the strains of the music. His eyes are closed.

In the vignette Mr R uses music as a prosthetic third in two ways. Firstly, he uses it to respond to a thinking-therapist. This is seen in how he responds to my comment about what I thought he might be doing in his manic behaviour. While he seems to have been able to use the comment in some way by becoming less manic and finding a way to regulate his affect using music, he simultaneously turns away from the therapeutic contact in an act of sonic isolation. Mr R underscores his wish that I should not exist as a thinking-other by turning up the volume of the music to drown out my voice and secure his solipsism.

My reverie in this moment of the vignette was a disturbing image of a disembodied voice belonging to a dead woman. I understood this powerful image as communicating something about the hollow presence of an unthinking mother. This was an inference I drew from his history and recent therapeutic material. This reverie indexes with great clarity the second function of the music which was to regulate Mr R's affect through the use of the music as a substitute for a maternal function. This was achieved through voice (a woman singing in the song), rhythm (the regular percussive signature of the song), cadence (melodic phrasing and inflection), melody (the organization of single notes into a satisfying sequence) and finally arrangement (the organization of all of the elements of the song in a coherent whole that has an emotional impact).

This form of affect-regulation is resonant with what Benjamin (2004) calls the *third-in-one dynamic* in the mother-infant dyad. A vital part of this ability of the mother to facilitate a connection with the infant relies not only on her capacity to

have an adult mind (and the advanced forms of symbolic thirdness that are implied), but more especially the ability to respond to the infant's affects and rhythms. This first form of mutual engagement and impact concerns how a mother and baby find a shared rhythm. Such mutual intersubjective regulation draws upon a "deeper law of reality" (p. 18). The 'deeper law' is inherent in the circadian patterns of sleeping, feeding and bathing, and is characterised by its gradual emergence between mother and infant.

The rhythmic mirroring qualities of this developmental phase occurring from the earliest moments of life are akin to the holding function of the mother-infant dyad referred to by Winnicott (1965). In this relational modality interaction is synchronised to the 'deeper laws' (to use Benjamin's language) of space and time, where the inside sensory affective states of the infant find an outside relational correlate in the coordinated responses of the mother. The rhythmic synchronisation of infant and mother introduces the basic orientation to reality, where the basic contours of an inside space and an outside space begin to emerge for the infant in the register of rhythmic coordination and accommodation, or what Stern (1985) has called attunement.

This function appears not to have been present for Mr R in his psychohistory, nor present in the form of a remembered internal object. The prosthetic third approximates this function. The absent mother and her soothing functions are artificially created through music. The music also serves to drown out the therapist's disturbing presence.

4.5 A game as a prosthetic third

In C's first session he makes virtually no contact with me or the playroom. He wanders around aimlessly, randomly touching things and picking up this toy, then that one. Towards the end of the session he eventually settles on playing with the toy soldiers by arranging them in strange geometrical shapes. This arranging and rearranging has a hypnotic effect. I imagine that this is a secret language,

understandable only to himself. When I emerge from my hypnotic state at the end of the session I feel lonely and out of touch with C.

In a subsequent session C sits on his own and begins his strange geometric constructions using the soldiers. These are angular and arranged with obsessional precision along the corners of the carpet. I feel somnolent and drugged. There is an elaborate and indecipherable sequence of moving this soldier and that, including other toys as well. I try to speak, but he stops me and says that I am only allowed to speak when 'the bazooka guy fits in like this' (he demonstrates another elaborate pattern). I can't follow and I think this probably means I'm doomed to silence for the rest of the session. I'm shifting uncomfortably and trying to stay awake. I try and say something and again he interrupts me. He tells me that the bazooka guy now has to go on a special mission 'otherwise he will be killed'. Again he shows me the pattern which I cannot make sense of. I think that it is probably better to 'die' and I lie down on the carpet – eye-level with the shapes. I feel better and I notice that things have become less intense in the room.

I believe that C's highly organized and self-referential game serves as a prosthetic third in these sessions. In the first session this game serves to bar the therapist access to C's mind by foreclosing on thinking and contact. This is communicated by the fact that the game is played in solipsistic isolation, and also through the hypnotic effect experienced in the counter-transference. This alteration of consciousness, I think, results from C's destructive intention to prevent the potential thoughtfulness of the thinking-other. My associations to his game as a secret language known only to him suggest something of its organized, orchestrated and exclusory quality. This is also connoted in the obsessive attention to detail that characterizes how the soldiers are organized.

In the subsequent therapy session the prosthetic third serves a similar function, except in this instance, the therapist is now involved. Initially the therapist attempts to speak and then he is shown the game's unfathomable rules. The game is still a self-referential world but now its rules and roles are imposed upon the

therapist. In this therapeutic sequence, I believe that the 'bazooka guy' is a reference to the therapist, who is warned about stepping out of line (by speaking and thinking). The connotations carried by the 'bazooka guy' communicates something of the thinking-other's phallic (the shape) and explosive (the weapon) dangerousness. The therapist is required to 'fit in' and be subject to a set of highly complex and obscure rules that are unknowable. This has the effect of negating the therapist. The profound negation of the therapist's own capacities is evident in his somnolence and his thoughtlessness. In the logic of C's game, to speak and think is a prospect that is subject to homicidal rage as denoted in the chilling threat of death for the unwilling soldier. Counterpoised against the deathly fate awaiting the thinking-speaking therapist is the 'special mission' which functions as an invitation to participate on the patient's special terms.

The game seems to function as an imposition onto the undesirable aspects of reality rather than an apprehension of it. This is achieved because its rules are forced upon the therapist, preventing him from thinking by demanding his submission. When the therapist concedes, there is a feeling of relief suggesting that the reality of the thinking-other has been nullified in the minds of both C and the therapist.

4.6 Writing an autobiographical text as a prosthetic third

Mr K used writing as a prosthetic third; the act of writing his autobiography was the semiotic object through which he gained meaning, coherence and self-narrating certainty. He used the prosthetic third to organize his experience and his identity. Talking about his manuscript was central to how he conducted his therapy sessions. He would bring his written pages to the therapy and go through them in great detail. The text was described by Mr K as an autobiography, and yet it had a contrived and often blatantly inaccurate bearing upon his life. Many of the intolerable realities about himself and the world were distorted. If I pointed this out, Mr K would chastise me and tell me that I knew nothing about the writing process, nor did I appreciate what his readers required of him. In one of the most disturbing examples of these distortions, it emerged that Mr K did not have an

understanding about some basic anatomical differences between the male and female genitals. When I enquired about what his understanding of the anatomical differences between the sexes was, he became anxious and subsequently deleted this section of the book, saying that 'it did not read well'.

This prosthetic third also came with a particularly virulent form of violation, achieved by the particular way he used his manuscript to turn the therapy into a terrifying count-down to his own demise. Mr K had developed a timeline for himself and the therapy, at the end of which he required that his novel be published by a renowned publishing house. Should his work not be accepted for publication, he stated that he would kill himself. He gave himself (and the therapy) one year. As the 'deadline' (his word) approached I became increasingly tortured and anxious. I felt an enormous amount of pressure to exact a therapeutic breakthrough to head off his suicide. Equally, I found myself entering into this delusional contract by wishing he would be published as though this were somehow the final solution. On more than one occasion I listened to his material as though I were an editor reviewing a storyline. By the time we had arrived at the last session prior to the deadline (and no publishing house acceptance letters were forthcoming) I was beside myself with desperation. Mr K, by contrast, was calm and superior in the knowledge that he knew how it was all going to end. Eventually I told Mr K that I would have to institute procedures to admit him into hospital. To this he replied that he would give us another six months. For Mr K, the function of the countdown (itself a form of prosthetic third imposing itself on the therapy) was to communicate something about the distressing helplessness he felt in relation to an unchangeable and deathly other that was coming to annihilate him.

Mr K used his autobiography to invent a particular version of himself and his reality. This reality was distorted and excluded certain basic anatomical facts. When the therapist pointed this out, these elements were erased and removed from the therapeutic dialogue. The 'autobiography' as a prosthetic third served to distort and replace the relational reality of the therapeutic encounter, as well as the cultural and anatomical realities of gender and sexual difference. The suicidal countdown, also an imposing prosthetic reality, served similar functions,

those being to replace and control the therapist, and to contrive a highly idiosyncratic, rule-bound system of meaning that replaced the thinking and reflective functions of psychotherapy.

4.7 Discussion

With regards to the clinical material discussed, the prosthetic third may serve at least three functions:

1) It furnishes the ego with a structure that is coherent and recognizable to the self and to others. This was clearly demonstrated in Mr J's clinical material where his use of discourse lent him recognisability and structure.
2) It approximates the mental functions that are required by the ego in order to interface with, and tolerate, reality. The artificial mind offered by the prosthetic third may, for example, help regulate affect, which is required to disembed the individual from primitive experiences of emotion so that contact with reality can be maintained without being overwhelmed. Mr R's use of the song and Mr K's telling revisions of his manuscript are clear examples of managing and regulating disturbing feelings.
3) The prosthetic third also mediates an experience of reality such that intolerable or undesirable elements can be replaced or edited out of awareness. Like a symptom that functions to disguise certain unacceptable realities, the prosthetic third creates tolerable realities. The semiotic object invents a false 'reality', one which is used to forcefully replace rather than negotiate what is experienced as intolerable. C's game, which forcefully imposed a highly particular version of reality onto the reality of the session, is a good example of this.

I would like to further discuss the relational dynamics observed in the clinical material. These dynamics involved forcefully controlling and negating the therapist. In particular, my patients consistently found it difficult to tolerate a thinking therapist. It was as though my thoughts were experienced as envied and

hated by-products of what one of my patients referred to with considerable disgust as 'whatever happens in there', pointing in my general direction as he said this. Thinking in general is experienced as a repugnant reality. Furthermore, there appears to be the added insult that the therapist's thoughts index a reality that is not shared, comprehensible or desired. As if this quagmire were not complex enough, there is the added dilemma of *forming or having* thoughts about any of these thinking actualities, which is to a large degree what psychotherapy attempts to do.

Britton (2004) addresses these difficulties directly, in a manner that I find helpful in the consideration of the prosthetic third, in a notion which he describes as triangular space. The work of the post-Kleinians on the relationship between Oedipal development and the depressive position places emphasis on the capacity for symbolization and thought (Bion, 1954, 1957), the capacity to tolerate meaning (Britton, 2004), and the desire for knowledge (Segal, 1989). Britton directly addresses the notion of the 'third' in Oedipal development. If the child is able to internalize the creative parental couple in the depressive position, an internal and delimiting triangular space is created, essential for the emergence of meaning in mental life. This is achieved because separate realities and experiences are tolerated in triangular mental space. Thus the child can be a participant in the intense dyadic interactions with mother (and later with father), but can also be an observer of a relationship between the parental couple. In other words, when the ability to tolerate the relating Oedipal couple occurs, it enables the child a capacity to reflect and generate meaning beyond his or her solipsism, and beyond the dyad. Thus Britton says that:

> If the link between the parents is perceived in love and hate can be tolerated in the child's mind, it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant. A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage being observed. This provides us with a capacity for seeing ourselves in interaction with others

> and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves (Britton, 1989, p. 89).

When the third position is achieved it enables more mature forms of thinking and relating in which various epistemological perspectives can be assumed. It also serves to disembed an individual from primitive affect (such as annihilatory anxiety, rage and terror) in such a manner that the vitality of the contact with others can be maintained (Straker, 2010).

For all of my patients, being in the observing position of the Oedipal couple was a painful and overwhelming experience. The parental couples of the four patients described were violent towards one another, towards my patients and towards others. Britton (2004) points out that even in normal development there is, for a time, a regressive attack on the meaningful nature of the parents' contact with each other and on the very ability to take an observational position. If this regressive tendency to attack an observational stance is not resolved because of a failure to internalize a good object (which makes separateness and hence the awareness of other objects bearable) these individuals go on to attack this capacity in others later in life. I certainly believe this to be the case for the patients described in the chapter. Like with the patients described by Britton (1989), Feldman (1989), O'Shaughnessy (1989), Rusbridger (2004) and Steiner (1993; 1999) my patients feel persecuted by the thinking, creative and observational stance taken by the clinician, who is concretely identified with the hated Oedipal other. They respond with the prosthetic third which in turn protects them from the hated stance taken by the therapist and the terrible feelings that are associated with it. The prosthetic third also serves as an aggressive assault on what is experienced as destructive and dangerous to the integrity of the self.

I would like to conclude by considering the prosthetic third and violence. To the best of my knowledge the violent expressions of my patients were greatly reduced when the prosthetic third was in operation. In contrast, in moments when the prosthetic third was forcefully and relentlessly challenged outside of the therapy

context, violence ensued. This may suggest some type of ameliorative function of the prosthetic third in the actualization of violence. This tentative position finds some support in the fact that despite my feeling terrified, threatened, thoughtless and corrupted at points in the psychotherapeutic process, i.e. subject to the aggressive properties of the prosthetic third, no violence or physical attacks were enacted by the patients. Unlike situations that did produce violence, the prosthetic third remained relatively intact. This has led me to ruminate on the possible function of the prosthetic third when it comes to acts of violence: there might be a functional difference between *violation* (a destructively imposed meaning upon the other which preserves the relationship albeit in a greatly diminished form) and *violence* (an attempt to decimate the other). This is of particular interest because it suggests a relationship between these two forms of destructiveness in which one may serve as a prophylaxis against the other.

5 THE AUTOGENIC THIRD: NARCISSISM AND THE VIOLENT ACT

5.1 Introduction

The chapter describes how in some narcissistic pathology, acts of violence are caused when certain psychosexual realities contradict the patient's autogenic phantasy. The autogenic phantasy is one in which the patient believes himself to be participant in his own conception, obscuring the reality of a procreative couple that precedes him. This autogenic phantasy is defensively constructed in order to prevent the mourning that accompanies an awareness of others as separate and significant. When the autogenic phantasy operates, the narcissist distances himself from affects and experiences them as though they were of no consequence. In situations when the autogenic phantasy collapses, affects are experienced concretely and rage and envy are violently enacted. This produces a violent act in which the patient seeks to eliminate the triangular reality that threatens him. A clinical example will elucidate this sequence to violence.

The relationship of narcissism to violence is well recognized in the psychoanalytic literature, and has inspired key thinkers to try to untangle why some narcissistic individuals are so intractably and rancorously violent (e.g. Bateman, 1998; Kernberg, 2004; Perelberg, 2004). Perhaps this question continues to preoccupy clinical discussion precisely because, as Kernberg (1992) has described in relation to what he terms malignant narcissism, violent narcissists tend to be both particularly destructive and particularly difficult to treat. This chapter draws upon clinical experience in order to offer one possible explanation for the relationship between narcissism and the violent act, as well as for the intractability of narcissistic violence. Rather than offering an entirely new theory (of which there are many), it is proposed that thinking about narcissism and the violent act through a dual prism of thirdness inspired by writers such as Britton (2004) and affect regulation (e.g. Fonagy, 2002) offers a perspective of the sequence of violence and the underlying phantasy it may be preserving.

In my work with violent patients who are narcissistic, I have noticed a consistent sequence that has led to violent action. This chapter aims to document this sequence and provide one possible account for its existence and function. The sequence will be described in four stages. These stages seem to characterise both the transference dynamics and the patient's general descriptions of interactions outside of the consulting room. In each stage, I argue, a particular relationship to thirdness and to affect regulation is sustained, and movement to a subsequent stage is prompted by a change in these two qualities. The first stage is characterised by the patient being aloof and exploitative. In this stage the patient is dismissive of his objects and uses them in a pleasure-seeking and selfish manner. He is generally self-assured and his mood is stable. He is unperturbed. In the second stage, something threatens him and he responds by becoming threatening. The threat is related to an experience that uproots and challenges a conviction that the patient has about himself. The nature of this threat is generally related to his sexual life. In this chapter the threat to the autogenic phantasy is of particular focus. Here the patient is belligerent and coercive. He is aggressive and forcefully demands a submission. The threat of violence is an essential element of this stage. If the threat of violence does not achieve the submission it seeks, it precipitates an

internal crisis for the patient. Subjectively the crisis is experienced by the patient as an annihilation - a frightening threat to his sense of reality. In this terribly unsafe and fraught emotional state, violence ensues. This violence is chaotic, desperate and directed towards that which threatens him. Its aim is to void the offending sexual reality that threatens him. In most instances, the patient then returns to stage one of the sequence. In some cases, usually deep into the therapeutic process, the patient progresses from stage three and enters a state of abject depression. In this stage he may be deeply mournful and suicidally preoccupied. Here the violence, should it occur, is self-directed. Guilty feelings gradually enter into the material of the patient in this phase.

Stage 1: Aloof and dismissive – selfish use of objects, unperturbed presentation.
Stage 2: Threatened and threatening – threat of violence, demands submission.
Stage 3: Rageful, disorganised and violent – internal emotional crisis dealt with through violence.
Stage 4: Mournful, depressed and suicidal – guilt enters into the material.

Table One: Sequence to violence

What is the function of the sequence, and what are the unconscious meanings that underscore it? I suggest that the function of the sequence is *affect regulation*. As the threat to the patient escalates, so too does his unpleasurable affective arousal. If the state of negative arousal becomes too intense, he fears he will lose a coherent sense of himself. This is an unbearable state. With each progressive escalation of the threat, different forms of destructiveness are employed to remedy it. His threatening behaviour and his violence attempt to restore the aloof and unperturbed mental state. In stage four the affects cannot be regulated and overwhelm the patient for extended periods of time.

Narcissitic patients find it difficult to think about feelings, or what Fonagy (2002) calls mentalization. The narcissistic patient who is violent adopts a prementalistic

stance to affects (Bateman & Fonagy, 2004). Feelings cannot be thought about and integrated into a schema for interpreting the world, the self or others. The first of the prementalistic states that characterises the narcissistic patient is pretend mode (Fonagy, 2002). In pretend mode, the emotional significance of others and the self is cognitively abstract. The imaginative work of attributing emotional significance to other minds is suspended, resulting in a situation where things are "pretend". Developmentally, this is a vital mental ability as it allows for disturbing affects to be sufficiently distanced to preserve the stability of the emotional economy and ultimately, the self. In the sequence pretend mode defines the relationship to affect in stage one when the patient is aloof and unperturbed. The second of the prementalistic stances is psychic equivalence (Fonagy, 2002). Here, affect is unregulated and volatile. It is experienced as though it were equivalent to external reality. In psychic equivalence disturbing feelings concretely threaten the psychic integrity of the narcissistic patient. This relation to affect is observable in stages two, three and four. The third affect-regulation stance that is characteristic of violent narcissistic patients is teleological (Fonagy, 2002). In this stance, emotional remedy is sought physically and concretely. Only action that has a physical impact is perceived to be effective in altering the emotional states in the self and others. This stance is where violence is enacted in stages two, three and four.

Stage 1: Aloof and dismissive – pretend mode
Stage 2: Threatened and threatening – psychic equivalence
Stage 3: Rageful, disorganised and violent – teleological mode, psychic equivalence
Stage 4: Mournful, depressed and suicidal – teleological mode, psychic equivalence

Table 2: Sequence to violence and prementalistic affect orientations

I argue in the chapter that the unconscious meaning of the sequence is related to what I have called the ***autogenic third***. In this unconscious conviction the patient

believes that he is self-made. He fundamentally negates the fact that he is a product of a procreative act between two others. The narcissistic, violent patient cannot tolerate a triangular reality in which two others preceded him, and created him. It is when the autogenic third is contradicted or challenged that violence ensues.

This is well demonstrated in Sophocles' play "Oedipus the King", which elucidates the emotional sequence to violence. Oedipus narcissistically negates his triangular psychosexual reality through violence, hubris and denial. He lives under the influence of an unconscious autogenic phantasy in the play and his unconscious story is that he is his own father. Perelberg (1999) describes the "core phantasy" of the violent patient as having precisely these unconscious dimensions. What is of particular importance here, is how this unconscious conviction plays itself out in the enactment of violence, and what function the violence plays in the defensive regulation of the psychic economy of the narcissistic patient. The relationship between Oedipus' narcissistic hubris and the violent act is clearly demonstrated in the play, and a similar emotional sequence that leads to violent action is recognisable in many of the instances of violence which I have clinically analysed in narcissistic patients. A good example of this is the sequence of narration towards the end of the play when Oedipus hears the painful truth of his past and realises that he is his mother's son and her lover, and that he murdered his father. In Perelberg's theoretical formulation, Oedipus' core phantasy has been uprooted and shown to be false. This is deeply disturbing for the protagonist and ushers in an emotional crisis in which the order of triangular reality is revealed. There is a procreative act that produces him, one that he did not play a role in. In response to this imposition of triangular reality, he flies into a homicidal rage and aims to murder his mother, Jocasta. The role of this murderous act may be viewed as a violent attempt to negate the reality that vexes him, what Bion (2013) calls an attack on "K", the knowing that disturbs his phantasy. This act is a violent negation to restore his core phantasy convictions and his emotional composure. He finds his mother dead and treats her body tenderly, the libidinal overtones of which suggest a restoration of his core phantasy reality (Barratt personal communication, 2013). Then, Oedipus engages in an act of self-mutilation for which he claims the ultimate narcissistic agency: "It was Apollo, friends, Apollo that brought this bitter

bitterness, my sorrows to completion. But the hand that struck me was none but my own. Why should I see whose vision showed me nothing sweet to see?". Oedipus, it seems, steals back his omnipotent power in his self-directed violence. Apollo, the sun and healer god, may have shown Oedipus his paternal triangular reality, but Oedipus negates this in a restoration of narcissistic omnipotence by blinding himself. Steiner (1985) describes Oedipus' act as "turning a blind eye" in a paper of the same name.

In order to demonstrate the operation of the autogenic third in violent, narcissistic patients I will review relevant aspects of the literature. I will then discuss these ideas in relation to a clinical case.

5.2 Narcissism: mapping the theoretical terrain

Narcissism as a concept can be thought of as consisting of three broad ideas in psychoanalytic literature. Firstly, narcissism can be thought of developmentally. In developmental narcissism, infantile and childhood minds are fundamentally preoccupied with the self, prior to be being outwardly concerned with others. Narcissism in this sense describes the human subject's primal self-investment in the initial stages of development. This idea is established in Freud's 1914 paper *On Narcissism*. He calls this idea primary narcissism or auto-eroticism (Freud, 1914). For Freud, an awareness of others develops out of primary narcissism in later stages of development. Although Balint (1965) and Klein (1946) dispute the notion that there is no concept of others in the beginning of life, and Kohut (1971) disagrees with the view that object-interest develops out of self-interest, the notion that the self is a primary preoccupation in early development holds firmly throughout psychoanalytic literature.

The second notion of narcissism could be described as responsive or reactive. This form of narcissism occurs in response to something being lost. There is an attempt by the human subject to make up for the loss by pursuing things (ideals or situations for example) that will compensate for that loss. Freud (1914) describes

this as secondary narcissism. In response to the loss of love, Freud argues that the young child develops an idea of what is most desirable for the parent, and then seeks to personify this ideal. He calls this the ego-ideal. Although he does not describe it fully in this early paper (Freud, 1914), Freud also alludes to the conscience that works in tandem with the ego-ideal in order to achieve this. In *The Ego and the Id* (Freud, 1923) this conscience is called the superego. The superego is an internalisation of pro-social prohibitions that govern the pursuit of pleasure. This psychic agency also plays a role in the achievement of acceptance and the pleasure of positive regard – a state that is actively sought to compensate for earlier narcissistic losses. Winnicott (1971), Bion (1959), Kohut (1971) and Lacan (1977) all address the notion of early narcissistic losses and deprivations that drive a need for compensation in later life. Although a reactive or compensatory narcissism is regarded as a normal part of development, excessive loss and deprivation produce a third kind of narcissism, that is, defensive narcissism.

Defensive narcissism, or clinical narcissistic pathology, is a difficult concept to trace in the literature. There are several reasons for this. Firstly, from the beginning of psychoanalytic thinking on narcissism, normal narcissism and pathological narcissism have been discussed side-by-side. The thinking about normal narcissism has largely been hewn from psychopathology. Secondly, because of the centrality of the clinical problem of narcissism in psychoanalytic practice, fundamental meta-psychological revisions have occurred in response to it. Each of these revisions has led to different psychoanalytic schools being formed. Thus object-relations, ego psychology, self-psychology and Lacanian psychoanalysis all take up the problem of narcissism differently. Thirdly, Freud's (1920) late (and controversial) introduction of the death drive into psychoanalytic thought has created significant divisions in how to account for aggression and destructiveness in narcissistic pathology. Few psychoanalytic thinkers have attempted a synthesis of the main findings of psychoanalysis in addressing narcissistic pathology. Britton (2003), Kernberg (1992) and McWilliams (2011) are notable exceptions to this. The particular track of narcissism as a defensive clinical pathology that is relevant for this chapter relates to thirdness and affect regulation. In this regard I will examine Britton's notion of triangular space and its

relationship to clinical forms of thick- and thin-skinned narcissism (Rosenfeld, 1971, 1987). I will attempt to link these theoretical formulations to affect regulation and mentalization (Fonagy et al., 2004) before turning to the clinical material.

5.3 Triangular space: Thinking about reality of couples in narcissism

Triangular space (Britton, 1989, 2004) refers to a mental situation in which a child is able to engage with the reality of a procreative, sexual couple that comes together without him, and which has produced him. It is triangular because it involves three parties - each member of the couple and the child - and contained within it are two relational configurations that are only possible with these three parties. The first relational position is *participatory*, a position where the child relates to one of the two parties in a dyad. The second is *observational*, and in this stance the child looks on as two others relate without him. Developmentally, the participatory dyad precedes the observational triad. As the child develops cognitively, so too does his capacity to know more than the self-other dyad. This development ushers in a great deal of fear, anxiety, jealously and envious rage. Britton describes this as follows:

> The initial recognition of the parents' sexual relationship involves relinquishing the idea of sole and permanent possession of the mother and leads to a profound sense of loss which, if not tolerated, may become a sense of persecution. Later, the Oedipal encounter also involves recognition of the difference between the relationship between the parents as distinct from the relationship between parent and child: the parents' relationship is genital and procreative; the parent child relationship is not. This recognition produces a sense of loss and envy, which, if not tolerated, may become a sense of grievance or self-denigration. (Britton, 1989, pp. 84-85)

The developmental dilemma, if not adequately negotiated, creates an emotional web which snares the child into various pathological formations characteristic of what Klein (1946) refers to as the paranoid-schizoid position. In this position,

defensive deformations of the Oedipal phantasy stand in place of the triangular situation (Britton, 1989). I observed a version of this kind of phantasy in the discussion of Sophacles' Oedipus.

Britton (2004) links the two positions of triangular space to Rosenfeld's (1971) descriptions of clinical narcissism. Rosenfeld (1971) describes the thick-skinned narcissist who is aloof and cannot meaningfully engage in relationships with others. Britton suggests that this thick-skinned form of narcissism is informed by the pathological adherence to the observing position. Triangular space is negated by disregarding the reality of others, and a resound refusal to relate to the couple as significant. The other form of narcissism that Rosenfeld describes is the thin-skinned type. The thin-skinned narcissist is intrusive and refuses to be excluded in any way from the minds of others. In the thin-skinned stance, the patient pathologically adheres to the participatory position (Britton, 2004). Triangular space is negated because others cannot be seen as separate from the self. Both of these psychopathological positions are accompanied by an Oedipal distortion or illusion.

The autogenic third may be one particular form of the Oedipal distortion that Britton (1989) describes. Autogenic Oedipal illusions – in which the child does not relinquish his exclusive claim on the primary object – involve a defensive adherence to one of the two positions made possible in a genuine triangular configuration: either the child clings to a participatory position, as is the case with thin-skinned narcissism (Rosenfeld, 1971); or he ignores the significance of others completely, as with thick-skinned narcissism (Britton, 2000, 2004; Rosenfeld, 1971). In the participatory position, reality outside of the "me and you" dyad is ignored. When this "outside reality" impresses itself upon the thin- skinned individual, there is an attempt to incorporate it into the subjective realm as a persecutory version of "that which belongs to you and I". For the thin-skinned patient, there is no objective reality that does not belong to the dyad; objectivity is subjectivised. Britton (2004) refers to this as the hyper-subjective position and in this position, thinking about reality is distorted. The significance of others is either subsumed and omnipotently controlled with adherent attachment (Rosenfeld,

1971), or the other is regarded as insignificant and treated in an aloof manner (Rosenfeld, 1987). I suggest that this theory is useful when linked to an understanding of affects.

5.4 A link to affects: a theoretical contribution to the understanding of the violent sequence

What I hope to offer in the chapter is a bringing together of notions of triangular space and prementalistic affect regulation. I suggest, following Britton, Rosenfeld and Perelberg, that thick-skinned manifestations of narcissism are underscored by an autogenic phantasy in which the reality of others is negated. I also suggest that this particular type of negation of triangular space is consistent with pretend mode affect orientation. As the autogenic phantasy is challenged by procreative reality of others, there is a surge of envious and aggressive affects that are experienced in psychic equivalence. This also signals a move from the observational and hyper-objective narcissistic stance, to the participatory hyper-subjective stance described by Britton (2004) and Bateman (1998). The function of the aggression and envy is to destroy or modify the reality of a procreative couple in order to restore pretend mode and the integrity of the autogenic phantasy. When this fails, teleological affect orientation seeks to concretely change the reality of the procreative couple through violence. I have opted to use the term autogenic phantasy, instead of Perelberg's (1999) core phantasy, in order to suggest denote the integration of prementalistic affect regulation orientations with unconscious distortions of Oedipal thirdness.

The chapter now turns to the clinical case. I will then unpack Mr L's sequence to violence. The sequence will be discussed in terms of the autogenic third.

5.5 Clinical case: Mr L

Mr L was a violent man in his late twenties. He used to get into fights regularly and during the course of our treatment, he was arrested several times for road rage clashes in which he would assault other drivers or damage their vehicles. He always reported these events with a great deal of moral superiority, understanding

himself to be justified in his actions. In his role as a reservist police officer, Mr L also perpetrated a series of violent acts, a source of great pride for him.

I met Mr L when I was doing a series of lectures for a local college. He phoned me to set up an appointment, saying that he liked the look of me. The "me" in question was a young, newly qualified psychotherapist lecturing psychoanalytic group dynamics to a largely older, mistrustful audience of a Master in Business Administration course. The group was generally suspicious and dismissive of psychoanalytic principles, and I am certain that my presentation was somewhat nervous and tentative. It did not escape my notice that a tentative, nervous psychotherapist might well have been what was appealing to Mr L. From the outset, Mr L engaged me with the patronising ease of someone in control. In the first session – as was characteristic of most of our sessions – he did not allow much space for my thoughts or questions. He told me about two serious conflicts he was experiencing with two older men in his life. The first was his father, who he described as violent, controlling, and dismissive. The narration was constantly tempered by reassurances from Mr L that his primary concern was for his father's health. He was worried that his father might die from the stress arising from the conflict. The second conflict he reported was with one of his father's business rivals, a man who was precisely the same as his father. Unlike with his father, Mr L had no concern for the well-being of this man. I was struck by the graphically violent, homicidal fantasies and daydreams Mr L expressed.

From the outset of the therapy, he let me know that my role was as a passive observer of his mental contents. He would present his thoughts calmly, as though he were unpacking a cluttered drawer, then organise them according to his own logic, and then leave. Sometimes this would take the whole session, and sometimes this would take 10 minutes. He was in no way interested in what I thought or had to say, and yet I had the feeling that this function was of vital importance to him. Mr L always paid for his session as soon as he was finished, and if he had organised his own thoughts in a manner that he found satisfying, he would "tip" me by paying extra. He would laugh at my attempts to refuse this money and would say that I could give it away if I felt strongly enough about it. I had a number of different

reveries about being used in this way. At times I felt like a toilet for his shit, at other times I felt like he was using me as a prostitute. In a particularly deadening session, I imagined myself as a scuffed-up wooden table upon which he was leaving a series of circular coffee stains. I also experienced shortness of breath in the sessions with him, a terrible somatic reverie of being crushed. On the rare occasions when Mr L felt vulnerable, he would bring his gun to the sessions and leave it on the table next to where he sat.

I would like to describe a session in which he reports an act of violence. In the violent act described, he beat up his girlfriend's ex-boyfriend. His girlfriend was a sex worker whom he had met at a strip club. After a few months of dating, Mr L would drive her around to her appointments with clients who had solicited her for sex. I was surprised by his complete lack of jealousy or rivalry in this regard.

Mr L arrives on time for his session and as he sits down, he complains about the lack of security in my office. I wonder aloud if he is feeling unsafe. He laughs and shakes his head, saying that it is me who should be feeling unsafe. He tells me he has had an action-filled couple of weeks (there had been a break for several weeks). He had driven F around the whole of Friday night and got her home at about 4am. They were both exhausted and had fallen asleep. At about 8am, there had been a loud knock at the door. It was F's agitated ex-boyfriend demanding the belongings he had left at her house. Mr L reports that he calmed the man down. He had pitied this man, who he saw as pathetic. F had insulted him and told him to get out. F's ex- boyfriend had then tried to attack her. Mr L had prevented this by restraining him. Mr L laughs uproariously when he describes how the man had slipped and fallen in the lounge. I notice that I am taking sadistic pleasure in thinking about how this man fell. Mr L and I relish this man's humiliation. After the ex-boyfriend had left, Mr L noticed that F was crying. He asked her about it and she told Mr L that she had fallen pregnant by her ex-boyfriend and that she had to have an abortion. At this point in the narration, I feel Mr L's mood change. He is now furious and he is clenching and unclenching his fists and his jaw. I feel afraid. He tells me how he screamed at F for being such a cunt. I am shocked by his savagery. I am feeling confused and I am struggling to think. Up until this point he

seems to have been unperturbed. He broke up with F and left. He says it was at that moment that he had decided to physically assault this man. He found the man and assaulted him. He describes how kicking this man in the dick gave him a hard-on. I am not sure if he means this literally or figuratively. I am struck by the homoerotic nature of his utterance. After narrating the assault, Mr L feels calm and feels like something has been restored. I feel sick and robbed of any thoughts. My mind is gone. Mr L has regained his composure and is peeling off notes to pay me.

5.6 Discussion

5.6.1 The autogenic third – a negated and intruded-upon Oedipal couple

Mr L appeared to have had the conviction that F's sexual activities with other men held no consequence for him. He was even supportive of her in her career. In the session, it was not her sexual activity that maddened Mr L but the realisation that F could be reproductive with other men and become pregnant. This triggered a vexing psychic crisis causing a surge of rage. Mr L's rage can be understood to be in response to the reproductive potential of his girlfriend and her ex-boyfriend. Only after he received this news did he experience L's ex-boyfriend as being provocative and insulting.

In this vignette, I believe that Mr L's reactions are informed by two opposing relationships to the sexual couple of his phantasy. In the first instance, the significance of the sexual couple is ignored. It is of no conscious consequence. In the second instance, when the procreative potential of the couple is made known to Mr L, he intrudes violently into it. His intrusion into the couple is twofold. Firstly there is an emotionally destructive and demeaning negation of F. He enviously rages against her, calling her a "cunt" and breaking up with her. She is reduced to her basest essence in Mr L's mind – nothing more than a genital hole. She is expelled and killed off in his mind. During the course of the therapy, F was never mentioned again. The second intrusion is directed at the ex-boyfriend. This physically violent act takes on homoerotic overtones as he simultaneously negates

and replaces the phallic essence of his vanquished rival. It "makes him hard" to destroy the genitals of the ex-boyfriend.

Although the material in this vignette has been selected because of its relationship to a violent act, many other instances of autogenic content characterised his psychotherapy. Mr L constantly described himself as a "self-made man", and consistently foregrounded how he had "pulled himself up by his own bootstraps". This was an organising motif of his identity. He was extremely hostile to his female sibling and was dismissive of his nephew – both being representations of a procreative act. He regarded himself as the "mother and father" of his adored pets. When at a later stage in the treatment he impregnated his girlfriend, he took obsessive control over "his" pregnancy. His girlfriend was regarded as inconsequential to his own decision to have a baby. The dynamics of autogenesis also extended to the therapeutic relationship. In the vignette I am a subjugated psychotherapist. I join Mr L in his violent version of events as an excited witness to his cruelty; or I am a terrified mental prostitute who he uses and pays. In the material I am not separate and I cannot think. I also play a vital role in Mr L's regulation of his affect. I suggest that my subjugation, as well as the violent subjugation of F and her ex-boyfriend, serve an important function in the regulation of Mr L's affective impunity and the maintenance of his autogenic phantasy. This is observable in the sequence to the violent act.

5.7 A sequence to violence: the autogenic third and pathological affect regulation

Mr L's telling of this incident demonstrates a highly condensed version of stages one to three of the sequence to violence. This sequence is observable in the transference- counter-transference ebbs and flows, as well as in the content of his story.

Stage 1: Aloof and dismissive – selfish use of objects, unperturbed presentation.
Stage 2: Threatened and threatening – threat of violence, demands submission.

Stage 3: Rageful, disorganised and violent – internal emotional crisis dealt with through violence.
Stage 4: Mournful, depressed and suicidal – guilt enters into the material.

5.7.1 Stage 1

Mr L is aloof and dismissive in his contact with me. The break in our therapy sessions is unacknowledged and any possibility that there is something unsafe in the room is pushed away into me, so that I feel unsafe. There is a negation of the therapeutic relationship and its importance. This aloofness and distance is echoed in the story Mr L tells. He drives his girlfriend around to her clients. There appears to be no acknowledgement of the sexual implications of her sex work, nor is there any sense that he is aware of, or concerned about, the men he is driving her to see. Neither I, nor his sexual rivals exist in any significant form. When the 'other man' does eventually enter the story in the form of F's ex- boyfriend, he is regarded as pathetic and an object of shameful ridicule. So too the impotent psychotherapist, who can only participate as a perverse observer, enjoying the humiliation of this pathetic man. I am a pliant extension of Mr L's sadism.

In this stage of the sequence, Mr L is in a thick-skinned position. His stance is hyper-objective and ignorant of the procreative couple. Affect is pretend, or non-consequential. In this mode cruelty is amusing.

5.7.2 Stage 2

Stage 2 is prompted by a rupture of Mr L's grandiose superior position. This rupture occurs because Mr L becomes aware of the reproductive potential of F and her ex-boyfriend. This is extremely threatening for Mr L. He screams at F and berates her, threatens and denigrates her. No matter what the abusive denigration of F achieves, it cannot take away the threatening reality of what she has disclosed. He cruelly breaks up with her knowing how deeply this will hurt her (F was a borderline person who fundamentally feared abandonment). As stage 2 is described in Mr L's story, so too is it enacted in the consulting room. Mr L's

aloofness dissipates as he becomes agitated telling me this story. Like F, I feel threatened. The atmosphere between us feels violently threatening.

In this stage of the sequence, Mr L has moved from a thick-skinned position to a thin-skinned one. This hyper-subjective stance is characterised by an intrusive interaction with the female party of the creative couple. I am identified with the denigrated woman in the transference. If she is dismissed as a genital hole, I am similarly dismissed as being psychotherapeutically vacant. Affect is experienced in the mode of psychic equivalence – there is no difference between Mr L's internal rage and his vexing reality. His reality is dominated by a threatened autogenic phantasy and he responds by forcibly intruding into it so that it can be coercively restored.

5.7.3 Stage 3

Violence ensues as Mr L attempts to destroy the reality that vexes him. This is a genital assault. An important detail for Mr L is that it makes him "hard" to direct an attack against the penis of the other man. As he destroys the phallic and reproductive potential of his rival, it seems that he symbolically takes the rival's essence: diminishing the rival feels analogous to an enhancement of the self. Mr L's rival is destroyed, and I am also destroyed as a thinking therapist. I am frightened, I feel my potency has been attacked and I cannot think.

In the enactment of violence Mr L is still in the thin-skinned, hyper-subjective position. Affect is negotiated in the psychic equivalent and teleological mode. Affect is psychically equivalent because the feelings associated with the collapsing autogenic phantasy dominate. Rage and envious spoiling define emotion reality. This emotional reality is concretely expressed through physical, violent action as affect states are managed in the teleological mode. Violence is the remedy for restoring the autogenic phantasy on the canvas of external reality.

5.7.4 Return to Stage 1

Once the violence has been enacted, in Mr L's life and also in the therapy session, Mr L returns to his aloof state. He pays me like a prostitute. He is once again in control and dismissive as the session ends. The thick-skinned position and pretend mode affect regulation is restored.

5.7.5 Stage 4

Stage four in the sequence emerged after many years of work with Mr L. There was an important shift for Mr L in the course of the treatment as his core phantasy became more conscious. The restoration of the autogenic third became increasingly tempered with suicidal depression as he began to experience more despair. He could not shake the feelings of having hurt someone else, nor could he recover from the ubiquitous nature of triangular reality. The defensive separation of pretend and psychic equivalence began to dissolve. Ultimately, these suicidal feelings saw the treatment end as he entered into a psychiatric facility in order to manage his unbearable mourning. I understand this to be an attempt to secure an ultimate victory over reality. It represented a self- banishment from the therapy, a self-imposed exile and a self-blinding.

The circular and self-sustaining nature of stages one to three above offer some indication of why it is so difficult to move to stage four, which holds a more mature relationship to thirdness and to affect, but is also characterised by overwhelming guilt, pain and paralysis. When pondering why violent narcissists tend to be so recidivist and intractable, an awareness of the alternative – the overwhelming pain of facing triangular reality and their own culpability in denying it – goes some way towards offering an answer.

5.8 Conclusion: A sequence to violence

This chapter has explored the question of the relationship between narcissism and violence by suggesting a specific sequence of violence in which a narcissist's autogenic phantasy and defensive aloofness are disrupted, resulting in violence. Thirdness is denied by the narcissistic patient. It is denied relationally,

psychosexually, cognitively and affectively. I have used the character of Oedipus to convey a narcissistic patient's relationship to violence. I have described an unconscious conviction of being an intrusive participant in the primal scene, in concert with Perelberg's formulation of the core phantasy. I have linked this to narcissistic relational styles described by Britton and Rosenfeld. I have also integrated these relational styles to a defensive separation of pretend and psychic equivalence modes of affect regulation, following Fonagy (2002). I suggest in the chapter that violence is a pathological solution that restores the autogenic third and negates triangular reality. I also suggest that a negation of genital triangular reality, and the overwhelming affects that accompany this reality, are central in the enactment of violence. The understanding of the sequence of violence in narcissism; and its unconscious and affect regulation dimensions may offer the clinician a conceptual and technical map in this overwhelming work. In my experience, affect regulation and its management is critical for successful treatment, especially in the initial stages of therapeutic work. Although the analysis of unconscious autogenic phantasies is critical in getting to stage four of the sequence, it cannot be addressed without first negotiating the terrifying, and annihilatory emotional experiences of its undoing.

6 TRI-BAR MENTAL STRUCTURE IN MASOCHISTIC PERVERSION[2]

6.1 Introduction

This chapter introduces the concept of a Tri-bar third in relation to a perverse, masochistic patient. Using the visual metaphor of the Penrose Triangle, a series of theoretical and clinical observations exemplified by case material are discussed in relation to a) the patient's symptom structure, b) the transference and countertransference, and c) the patient's management of affect. The masochist's symptomatic oscillations between mindless bodily symptoms on the one hand, and rigid cognitions and relational deadness on the other, are understood as two different defensive strategies to save the masochist from knowing about a terrifying object in her mind. Although this annihilating object threatens her very

[2] A version of this chapter was published in the *Psychoanalytic Psychotherapy in South Africa* (van der Walt & Long, 2013)

ego integrity, the chapter argues that she seeks to maintain a relationship with this object in the compulsion to repeat her infantile trauma. This desperate state of affairs is echoed in the therapeutic relationship, which also flips between the mindlessly visceral and cognitively dead. These two irreconcilable states are maintained in the perverse relationship via the use of deception and illusion, which in turn obscures the horrifying emotional reality of the annihilating object. The chapter then discusses the way in which the split in the pervert's symptoms and her relationships may relate to two different ways of organising her affects: in pretend mode and psychic equivalence. The chapter concludes that Tri-bar structure, although resulting from severe developmental arrest, also serves a defensive function that protects the masochist from full awareness of her persecutory emotional world.

This chapter aims to document some observations concerning the diagnostic and treatment difficulties experienced with perverse patients. The chapter will argue that masochistic patients experience a core anxiety in which merger with the object and separation from the object are simultaneously desired and feared. In order to resolve this core complex (Glasser, 1998) patients alternate between two subjective states. On the one hand, violence is enacted in order to produce sensation-laden bodily symptoms offering a perverse connection with the object. On the other hand, an intellectualised and rigid deadness prohibits genuine relational contact. These two subjective states come together in an illusory apex of self-deception, which ironically maintains both core complex anxieties and the subjective states designed to alleviate these anxieties.

In order to capture this dynamic, the metaphor of the Tri-bar visual illusion will be employed as a way of organising the clinical eccentricities of violent perverse patients. The Tri-bar triangle, also known as the Penrose Triangle (Penrose & Penrose, 1958), is an optical illusion in which the triangle's apex is mathematically impossible but visually achieved. The achievement of the apex is 'possible' because of the onlooker's perspective. Looking at the Tri-bar triangle is a de-realising experience because the gestalt juxtaposes perceptual and rational capacities antithetically. This causes an endless slippage between two mutually exclusive

experiences of the same thing. The image can never settle in the mind of the onlooker – it is always incomplete and unresolved because thinking and perceiving are set against each other. Either the object is seen or it is understood, never both simultaneously. In relating to this object there is an experiential dynamism which I describe as an intimate alienation: as compelling as the Tri-bar third is, the observer cannot ever be fully reconciled with it. It is this irreconcilability that suggests it as an apt metaphor to describe the symptom structure, as well as the transference dynamics, of masochistic patients.

The chapter begins with consideration of some of the themes emerging from the vast psychoanalytic literature on masochism and perversion, with the aim of relating these themes to the conceptualisation of a Tri-bar mental space offered in this chapter. A clinical case study is then presented which illustrates how the metaphor of the Tri-bar triangle offers a formulation of the patient's symptom structure. Implications for transference and countertransference, and for the organisation of affect, are then explored.

6.2 The concept of perversion

Much like the experience of viewing the Tri-bar triangle – and, I argue in this chapter, the experience of being in touch with a perverse patient – reading the vast literature on perversion can sometimes feel like searching for a shape that never quite materialises. Since the drive approach to understanding perversion developed by Freud (1905; 1910; 1919; 1924a; 1924b; 1927), there has been a great deal of psychoanalytic interest in understanding the perversions (Eshel, 2005). Noting how the concept has substantially changed over time, Stein (2005, p. 775) ventures only so far as to define perversion as "a complex notion that resists simple definition and eludes stabilisation". Significantly, though, the continued theoretical development of perversion may be "the latest frontier in psychoanalysis" (Fogel & Myers, 1991 in Stein, 2005, p. 776). A full exploration of the shape of existing psychoanalytic literature on perversion is beyond the focus of this chapter; instead, specific themes are explored because of their relevance to the formulation offered here. Specifically, I wish to examine perversion as it relates to

sexuality and hostility, object relatedness, and the psychodynamics of the perverse symptom.

6.2.1 Perversion and sexuality

Beginning with *Three Essays on the Theory of Sexuality* (1905), Freud proposed that perverse sexuality is a developmental norm whereby component drives, coalescing around the erogenous zones of the body, are eventually organised, under the forces of repression, into a coherent expression of genitally-led heterosexuality. Aberrations in adult sexuality are understood by Freud as deviations in the partial drive (from the genital to the oral or the anal) and deviations from the heterosexual object. Thus perversion in adulthood is an untransformed and recalcitrant version of infantile sexuality. In the *Three Essays* Freud makes the point that "To begin with, sexual activity attaches itself to the functions serving the purpose of self-preservation, and does not become independent of them until later" (Freud, 1905, p. 181). This offers a particularly valuable idea when considering the traumatogenic origins of the severe perversions: right from the developmental outset, sexuality is linked to self-preservation and survival.

In 1919 Freud turned his attention to the perversion of masochism, in particular addressing the question of how pain and punishment could be implicated in the pleasure-seeking impetus of sexuality. Using the Oedipus complex (1910) and its vicissitudes, Freud understood that punishment is recruited for the purposes of alleviating the guilt experienced by the daughter for her forbidden sexual wishes. The chapter also introduced the idea that perversions may serve a defensive function. Freud (1924b) took up the question of masochism again in 1924, this time implicating the death drive as the source of masochism. This is an important addition in the theoretical terrain of the perversions because the derivatives of the death drive (such as aggression, hostility and hatred), so prominent in the clinical manifestation of masochism, had no longer to be accounted for in the libidinal economy exclusively (Deutsch, 1932; Glover, 1933; Stoller, 1986). As Caper (1999) states, perversion can be best understood as a hijacking of sexuality by aggression, or in Stoller's (1986) terms, an erotic form of hatred.

In later work Freud (1927; 1938) introduced the idea that certain perversions involved a splitting of the ego in order to deny a traumatic sexual reality. Although referring to fetishism and not masochism, the partial detachment of the ego from disturbing aspects of reality via the defence of disavowal and ego-splitting is a crucial idea for the metaphor informing this chapter. For Freud this mechanism was seen in relation to the Oedipus complex and castration anxiety, representing the pervert's triumphant defence against the anxieties produced by sexual difference. This idea has been fruitfully taken up in other conceptualisations of perversion, most notably by Chasseguet-Smirgel (1985) and Stoller (1986). Splitting of the ego as a defence in perversion is also described by Welldon (2011). Splitting of the ego through dividing the mental apparatus is a defensive operation related to managing something unbearable. It is as though the masochistic patient has duplicated and altered the other mental picture of her torment in order to remember or forget as required for psychic survival. Wurmser (2003) makes a similar point with regards to the splitting of the ego in the character perversions. He states that it is an archaic defence which is the "phenomenological outcome of denial and the setting up of a countervailing pseudo-reality" (p. 229). The predominance of this defence produces a "radical doubleness of self and object representations" (Wurmser, 2003, p. 229). For Wurmser (2003), the defence is orchestrated in relation to an archaic superego resulting from the internalisation of early infantile trauma.

6.2.2 Perversion and the disturbing object of infancy

Departing from drive perspectives, a number of theorists have turned to infantile trauma as an explanation for perversion (Eshel, 2005). Klein (1946), for example, saw the ego-destructive mechanisms in perversion as relating to earlier phases of development, implicating orality and the psychotic processes of infancy. Glover (1933), who drew directly from Klein, made this point specifically in relation to the perversions. Object relations theorists extended understandings of perversion and masochism by exploring the link made by the perverse symptom between the operations of the internal world and the objects that inhabit it. The approaches of

Glasser (1979; 1986; 1996; 1998), Khan (1969;1979), Socarides (1974) and Welldon (1988; 2011) are of particular relevance to this chapter.

Glasser (1979; 1986; 1996; 1998) locates the mechanism of identification – or, more accurately, a lack thereof – as central to the understanding of the perversions. He defines identification as "the process in which the subject modifies the self-representation in such a way as to be the same as one or more representations of the object" (Glasser, 1986, p. 11). For Glasser, the perverse psyche emerges because the pervert cannot identify with his primary objects. The reason for this is that the earliest bodily relationship and its accompanying affects are unbearable because the mother overstimulated, intruded upon and/or deprived her child. The child had an affective and bodily experience of her as annihilatory and destructive. The infant's response to this problem, and the mental structure that results, is described by Glasser in the form of the "core complex" (Glasser, 1979). He describes the core complex as a deep seated and pervasive longing for the most intense and intimate closeness to the object, amounting to a complete "merging" or union. It is as if the pervert has a memory of primary identification and is trying to regain it. Not only total gratification and safety from abandonment or rejection is longed for; also desired is a secure containment of his intense, primitive rage and the consequent dangers of disintegration of self and the destruction of the object (Glasser, 1979, p. 163). In the face of the traumatic experience with the primary caretaker, the infant responds with an aggressive negation of her, a state that Glasser describes as a "narcissistic withdrawal" (Glasser, 1986, p. 9). This withdrawal stimulates terrible isolation, fear and abandonment since the object is also essential for survival. This renews the wish for contact and produces the cyclical and insoluble dilemma of the core complex.

Although Socarides (1974) utilises a different theoretical framework to conceptualise the perversions of sadism and masochism, he too locates the anxieties feeding into the perversions as coming from the earliest developmental stages of life. Similarly, his "nuclear complex" involves the oscillations between the dread of merger and the desire for it. He regards masochism as a 'submissive

enactment of the dreaded destruction and engulfment at the hands of a 'cruel mother" (Socarides, 1974, p. 186). McDougall (1995) also focuses on the earliest infantile trauma in the aetiology of the perversions. Her emphasis, as is the case with Greenacre (1953), is on the psychotic fear of bodily disintegration the infant experiences in traumatic separation.

Khan (1969) similarly understands the perversions as occurring because of a fundamental maternal/environmental failure in infancy: 'Thus dependency becomes translated into compelling the object to adapt. Neither absorption in the relationship nor pleasurable satisfaction is possible. Intrapsychic and developmental conflicts are transmuted into ego-interests" (Khan, 1979, p. 52). In other words the ego's fundamental work becomes tied up with trying to negotiate a self-other configuration that is dangerous and damaging. Because of these serious problems in the primary relationship, the infant internalises a dissociated primary object in the form of what he terms a "collated internal object" (Khan, 1969). This experience of self, which is inextricably bound to infantile auto-eroticism and the body-ego, can only be regained through specific perverted sexual acts in which the patient continually searches for "a relationship in which dissatisfaction, anxiety, sadness and loss can be experienced and psychically assimilated by the ego" (Khan, 1979, p. 53).

What links all of these understandings of early infantile impingements is the intensity and irreconcilability of trauma-produced affects (Fonagy, Gergely, Jurist & Target, 2004; Schore, 1997). Wurmser (2003) argues that these intense affects are not simply experienced but have a profound influence on the structure of the perverse psyche. Firstly, the ego is split or fragmented as irreconcilable affects and ideas are separated. Secondly, the superego is pathologically impacted. Wurmser (2003) argues that the shame-based, guilt-ridden and pain-saturated aspects of self become the precursors for an archaically destructive superego. Garza-Guerrero (1981) and Kernberg (1992) offer similar accounts of the aetiology of a perverse archaic superego.

These explications imply an important link between the disturbing internal object and structural understandings of perversion: the disturbing internal object imagos of early trauma continue to serve directing, prohibiting and punitive functions. The primitive superego present in the severe masochistic perversions directs the patient in accordance with a culture of violence; a superego morality in which violation is veracity and torment is the truth. Two important implications can be extrapolated for the structural account of masochistic perversion offered in this chapter. Firstly, the *superego* is involved in directive mental functions, the most important of which is to control overwhelming affect floods which are experienced as superego-dystonic (Wurmser, 2003). The pervert's superego does this by orchestrating several defences including sexualisation, dissociation and the defensive use of aggression. Secondly, the superego, based on the disturbing object, links to at least two separate facets of the fragmented *ego*, producing different kinds of mental phenomena including distinct forms of symptomatic expression. It is to the psychodynamics of the perverse symptom that attention now turns.

6.2.3 The psychodynamics of the perverse symptom

In *Alienation in Perversions,* Khan (1979) identifies seven ways in which the pervert acts out symptomatically. Here Khan is using a greatly expanded version of Freud's (1914) definition, which Khan relates exclusively to the analytic process. He suggests that acting out serves the following functions for the pervert. Firstly, it allows the ego to maintain an executive function by displacing and externalising the intrapsychic conflict so as to achieve mastery in external reality. Secondly, acting out neutralises shame and guilt through the involvement of another object, whilst the sexual excitement associated with the action diminishes depression and psychic pain. Thirdly, imaginative excitement ameliorates the deadness of the internal world. This deadness comes about because excessively utilised archaic defences are relied upon to protect against excessive instinctual affects (sadism and aggression). Fourthly, the reparative and libidinal aspects of sexual acting out provide an opportunity to repair relations with an actual object, thereby partially mediating the impoverished and deprived nature of the internal object. Fifthly, by temporarily escaping his constrictive internal world through acting out,

the pervert rescues the ego from collapse and psychotic decomposition. Sixthly, the pervert who acts out sexually is able to partially bind and neutralise the intense, archaic sadistic and aggressive impulses. Finally, acting out functions as the pervert's rudimentary attempt to communicate with a non- receptive other who is not separate from the self.

Welldon (1988; 2011), like Khan (1969), underscores dissociation in the production of the perversions. She prefers the term encapsulation rather than dissociation, describing it as the defining mechanism that the pervert uses to manage a ubiquitous mortal anxiety. This mortal anxiety she describes as "the dreaded black hole of depression hiding away suicidal ideations or just plain suicide" (Welldon, 2011, p. 28). In addition to encapsulation, Welldon understands perversion to be defined by several factors. These are compulsion and repetition in the perverse sexual act; the use of the body for perverse action; part-object and dehumanising ways of relating to the other; the emotional interference of hatred in the sexual relationship; sexualisation which replaces a capacity to think; a fixated and restricted sexual repertoire; hostility; extreme fears of being trapped or engulfed; a need for omnipotent control; deception; risk-taking; and an inability to mourn (Welldon, 2011).

Of all of these factors I wish to highlight deception for the purposes of this chapter. Welldon regards deception as *the* defining feature of perversion and understands divisions of the psyche as the cause of the deception: "Perversion implies a private lie that tantalises, allures, and teases in an agonising way. In my opinion, deception is not only at the core of perversion but it is also its distinguishing feature" (Welldon, 2011, p. 35). She accounts for the deception structurally, indicating that the pervert's ego is constantly under pressure from the id to engage in sexual acting out. Eventually the ego is corrupted and the overwhelming sexual urge becomes partially ego-syntonic in order to relieve the unbearable anxiety which is subsequently acted out. Hostile sexual anxiety is dispelled and the sexual impulse once again becomes ego-dystonic, ushering in guilt, shame and depression. The hostility that is released is related to vengeful feelings for an early trauma in the mother-child relationship. This trauma, for Welldon (2011), is specifically related

to gender humiliation. Welldon (1988) also highlights the differences between the male and female perversions, showing that women and girls tend to act out against themselves (and their children who are experienced as part of the self), directing their violence against the humiliating pre-oedipal mother who is experienced as being in possession of the pervert's body and mind as well as her feelings. The body and the baby are treated as dehumanised part- objects.

Glasser (1986) describes a defensive sequence that accompanies the intense and unbearable affects of the core complex. This defensive sequence, consisting of aggression and sexualisation, plays a constitutive role in later symptom formation. In response to the anxiety stimulated by the core complex, the infant responds with defensive aggression, the aim of which is to negate the annihilating experience. This primary defence, however, only serves to heighten anxiety because the object is needed for survival. The next defensive operation that is marshalled in response to losing the object is to sexualise the aggression, which transforms it into sadism. The function of sadism is to hurt, violate and omnipotently control the object. Thus the object is retained albeit under violent conditions. Masochism is understood here as the defensive sexualisation of aggression when the infant is in a state of narcissistic withdrawal. Because the infant is isolated, she directs the sexually transformed impulse against herself; a situation that Glasser refers to as "masochistic invitation" (1986, p. 9). Kernberg (1992) also refers to the defensive sexualisation of aggression in perversion.

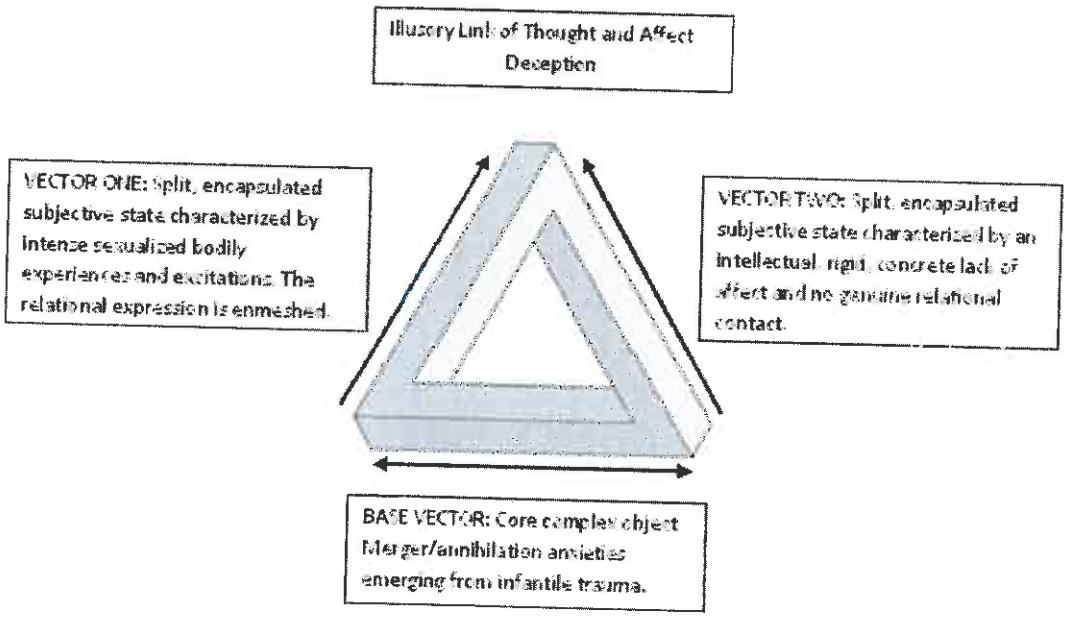
6.2.4 Perversion as a concept

Despite differences between the theoretical contributions explored above, I would like to draw out three convergent themes. First, perversion can be understood as a survival strategy that negotiates early infantile trauma related to a problematic mother-infant relationship. The contours of this relational problem involve oscillations between a wish for merger with the primary object and a dread that the object will annihilate the integrity of the nascent ego. The disturbing object is also the basis for the archaic superego that continues to play a directive role in the psychic economy of the pervert's mind. Second, the main defensive operations that

inform the development of the perversions are the sexualisation of aggression and hostility, the splitting of the affectively overwhelming self-experience into irreconcilable parts, and the disavowal and encapsulation of these contradictory mental states within the structure of the self. Third, the infantile, pre-symbolic and bodily nature of the pervert's disturbance results in an expression of the psychic dilemmas in concrete, fixated, repetitive and compulsive actions. Speaking, symbolising, thinking and feeling are antithetical to the pervert's symptomatic intention. The pervert must remain malevolently mindless.

6.3 The Tri-bar metaphor: Symptom structure

Each of these themes inform the structure of the Tri-bar as a metaphor for understanding perverse masochistic patients. I offer a visual representation of the Tri-bar metaphor (see below) in order to foreground the interactions between the different proposed elements. The base Vector represents the insoluble emotional dilemma with a destructive object/superego, in which both merger and separateness are equally terrifying and desired. I retain Glasser's (1979) term "core complex" to describe this vector. Vectors One and Two represent the pervert's response to the core complex anxieties. They represent two split, encapsulated and dissociated subjective states that bear the hallmarks of intense, somatic enmeshment on the one hand (Vector One) and, conversely, rigidity and lack of affect (Vector Two). The illusory apex is intended to convey the pervert's deeply embedded tendency to compulsively deceive the other for the sake of her survival. This deception forecloses upon the capacity to relate and communicate symbolically



The Tri-bar illusion offers one way of understanding the symptom structure of masochistic perverse patients, as well as the sometimes insoluble transference and countertransference dynamics evoked. Each will be explored in relation to the case of L. I have chosen as the starting point the pervert's symptom structure in order to highlight that the perverse symptom is the privileged way in which the patient communicates her emotional dilemmas. I will consider a case vignette of a violent and perverse patient treated by the first author, a patient whose 'body-dreams' (Khan, 1979) took the Tri-bar form. Khan's (1979) formulation of perversions expresses something of the experience of this patient:

Perversions are more akin to dreaming than neurotic symptom-formation. The technique of intimacy is the vehicle to this type of dreaming and acting out is its preferential mechanism of psychic functioning. The ego of the pervert acts out his dream and involves the other person in its actualization. It is possible to argue that if the pervert dramatizes and actually fulfils his body-dreams with a real person, he also cannot wake out of them (Khan, 1979, p. 30).

L, a woman in her mid-twenties, was referred to therapy because she was abusing alcohol. It quickly emerged that her emotional difficulties were tied up with a set of volatile and intense relationships with her mother and her four female siblings, who she experienced as unsympathetic to her feelings of boredom, loneliness and isolation. She felt harshly rejected by the women in her family who refused to entertain her wish to return home from her university residence. In L's mind, as in the sessions, it was difficult to tell her female relatives apart. 'Mother' was easily confused with 'sister' and in her linguistic slips she sometimes called her mother by her own name. Her idealised father had divorced L's mother when L was an infant and had remarried and started another family. He had very little contact with L. She felt abandoned by him, but idealised him nevertheless and fiercely protected him from the vitriolic commentary of her mother and siblings.

Drinking excessive amounts of alcohol functioned as a way of dealing with overwhelming and unbearable feelings of isolation and loneliness when she was away from her female relatives, and the tormenting experience of her own rage when at home with them. L would drink until she lost consciousness. Her loss of consciousness was frequently accompanied by destructive sexual acts with men. She would describe in great detail the damage done to her bruised, bleeding and brutalised body. My countertransference to these descriptions was powerfully visceral and I felt nauseous and revolted. The unknowable quality of the sexual trauma she experienced when unconscious also fuelled my own fantasies of how sinister and perversely violent these abusive interactions were. Early in the therapy there was always a question for L and me as to whether these acts had been rape or not. As the therapy progressed it became clearer that these acts were indeed sexual assaults which she perversely orchestrated against herself. In the days after these sexual assaults, L would descend into a profoundly dissociated state. She responded to these states by cutting her arms in order to 'feel herself' and bring herself 'back to reality'. My attempts to explore these disturbing sexual events and her cutting were largely futile, with L being unable to think about these events beyond the fact that they were somehow related to how trapped she felt.

In other sessions L would present buoyantly, accounting for herself and her life through astrology. She would speak about her star sign and that she was being subject to this or that astrological force. In these sessions she was emotionally distant and subtly dismissive of the therapeutic process. Previous difficulties were accounted for in astrological terms, or via explanations which focused on the 'normal' stressors of student life. I felt great frustration and anger in these sessions, and I often struggled to curtail my derisive and dismissive emotional reactions. Reflecting her emotional distance or interpreting the defensive/evasive quality of the process made very little impact.

Two dreams typified her internal emotional dilemmas. The first was a nightmare in which L was a circle that endlessly fell into another (a dream capturing the Tri-bar quality of one reality falling endlessly into another). This was a terrifying dream for L and made her afraid to sleep. When I interpreted that the dream seemed to be pointing to some kind of emotional dilemma with another, L responded by digging her nails into her arm. The second was about a puppy which was locked outside of a house, where it was dark and terrifying. The puppy would scratch on the door to come inside. Eventually, frightened, tired and lonely, the puppy was let inside only to be thrashed by an evil woman.

I will discuss each of the elements of L's case material that I regard to be constituent of the Tri-bar symptom structure.

6.3.1 Base Vector: The desired and dreaded other of the core complex

The Base Vector connotes the fundamental emotional dilemma concerning a violent and inescapable relationship to an internal object. This internal object is also the basis of the pervert's archaic superego. This object, represented in L's dreams as an engulfing circle and an evil woman thrashing a helpless puppy-self, seemed to be made up of a set of frightening, hurtful and enraging experiences with her mother, and subsequently her female siblings. The lack of object differentiation between her female relatives, and between her mother and herself

(as evidenced in the linguistic slips in which she confused her mother with herself), also underscores this inescapable enmeshment. The infantile nature of her core complex dilemma is well illustrated by L's presenting concern, her alcohol abuse. L would describe drinking as much as she could, as quickly as possible so that she could become unconscious. She described this process as 'getting fucked' and becoming 'motherless'. This experience involved 'forcing the shit down' her throat and feeling like she was ingesting 'poison' and 'razor blades'. The noxious and violent quality of the taking-in experience as well as the condensation of oral, anal and phallic introjective metaphors is striking. This recalls Chasseguet-Smirgel's (1985) notions of perversion, in which she describes how the perverse patient 'faecalises' her object relations, and how anal themes (omnipotent control and negation of difference) tend to contaminate oral and genital activities. The act of becoming inebriated appeared for L to reproduce an experience of taking in something dangerous and poisonous into the body through the mouth – objects and experiences that in other circumstances would be urgently voided from the body and mind for fear of the damage they could do. This process of 'getting fucked' was consistently precipitated by an overwhelming emotional experience with her mother and female siblings, either because they were agonisingly absent and abandoning, or because they were painfully present and intrusive.

In the face of the core complex dilemma, that being the violent inescapability of the object, L seemed to split, dissociate and encapsulate her subjective experiences into two distinct formations. The first, linked to Vector One, involved a violent reproduction of the experience of the core complex relationship in her body, culminating in a cessation of consciousness and awareness (through binge drinking or cutting). The second, linked to Vector Two, concerned a distancing of herself from any meaningful emotional contact with herself and with others.

6.3.2 Vector One: Sensation-laden bodily symptom

Vector One of the Tri-bar represents one of the symptomatic paths out of the dilemmas of the core complex. Clinical experience leads me to believe that it is achieved by ablating the emotional experience of the core-complex such that it is

reproduced as a sensation-laden bodily experience in which there is no conscious knowledge of the object relation it implies. In the case of the masochist this may involve symptomatic sexual behaviour that is predominated by some form of masochistic destructiveness. In other perverse patients (as with L), this vector can also take other forms of somatised destructiveness such as self-mutilation and substance abuse. These communications are characterised by their thoughtless, compulsive and repetitive quality, the relief they bring to patients, and by their split-off and separate existence from other parts of the patient's life and mind.

In the case of L, Vector One symptoms include her binge drinking, the destructive masochistic sexual acts accompanying her loss of consciousness and her cutting. The relationship between the core complex anxieties and self-harm is well illustrated as L responds to the interpretation about the circle dream by moving away from thoughtfulness via self-inflicted pain – digging her nails into her arm. Likewise, her binge-drinking seems to follow the same sequence: momentary awareness of core complex anxieties translates into self-harm. This sequence turns awareness of core complex anxieties into a somatic form of the distress that can remain unknowable, or consciously unthinkable to L. A relationship to the distress is maintained in the form of a bodily sensation; however, the knowledge of the core complex relationship that produces this mental distress is lost. Mental anguish is defensively transmuted into bodily sensation. Perhaps in this way the relationship to the tyrannical mental object can be maintained by not allowing it to exist in the realm of the mental: by splitting off and denying its mental representation through an obliteration of its emotional linkages.

There is a constellation of Vector One type symptoms that occur around L's sexual assaults. Firstly, there is the orchestrated sexual assault itself. Then there are the two reactions to the sexual assaults. One of these is how L uses her body in the discussion of her physical damage in the sessions after her sexual assaults. The other is observable in her self-mutilation when dissociated after the sexual assaults. The sexual assaults themselves were the most disturbing feature of L's therapy. They were disturbing not only because there were terrifying acts of violence that she subjected herself to, but also because they were repetitive and

recalcitrant to any form of meaning-making process that therapy had to offer. L would describe choosing particular locations for the purposes of getting drunk. L was aware that these contexts were unsafe and known for their 'date-rape' risk. She would frequently return to the same places where sexual assaults had previously occurred and would be consciously aware that she was getting drunk with men who had, or would, rape her. Putting herself in harm's way by becoming inebriated ('getting fucked'), and then becoming unconscious and literally 'fucked', were the defining features of a core complex enactment with a violently intrusive and dangerous other that she could not bear to be conscious of. Yet at the same time she forcefully and repetitively maintained her relationship with this object through the sensation-laden, bodily, sensory symptom.

As L was unconscious during these assaults, her contact with these disturbing experiences was read from her body. L's body, post the assaults, was one which bled and had bruises, was infected, one which was used and completely disregarded by the other. These sickening narrations produced nauseating and unbearable somatic countertransferences, including, in moments, a distressing sexual arousal. I felt as though I were being identified with L's rapists via the damaged body being narrated to me. A frightening pastiche of revulsion, hatred, anger and intimate sexual contact permeated these sessions, making it difficult to distinguish between what was helpful and therapeutic, and what was perverse and corrupt. It was virtually impossible to think meaningfully about L and the countertransference dynamics until after the session. L's somatic communication of her emotional dilemma with a terribly abusive object was communicated directly to my body without my being able to link my sensations to thoughts.

Perhaps the pinnacle of L's attempts at a symptomatic solution to the core complex problem lies in obliteration of her consciousness. As a solution to the threat of sadistic annihilation, it seems to achieve reconciliation with the abusive object (necessary for emotional survival); while at the same time absolutely severing contact with the object. Like the Tri-bar, this solution operates because it savagely splits the bodily/perceptual/sensational contact with the object from the cognitive/conscious contact with the object. These illusory contacts safeguard the

necessary ever-shifting illusion of contact and preserve L from the full realisation of the treachery of her mental state. This partial or illusory contact with the object can never be realised without exposing the patient to the full treachery of her mental state.

6.3.3 Vector Two: Communicating self through affectless cognition

The second symptom vector is a highly rigid and intellectual mode of expression. In this mode of self-representation the patient communicates an account of her experience that necessarily excludes genuine thoughtfulness or any affect. As with the first vector, these symptoms are concrete, recalcitrant and compulsive. L's terrifyingly destructive turns were alternated by lengthy periods in which she would make no emotional contact at all. Cutting off from the emotional contact in periods of grave difficulty was initially experienced as a relief by both L and me. Initially welcome, these periods would become tedious and produce considerable frustration in the countertransference. At these times she distanced herself from the horror of her destructive sexual life, her alcoholism and her self-mutilation by regarding these behaviours as a consequence of normal university stressors. 'Normal' university stressors require normal intervention' she would say when I challenged her reading of her destructive behaviour.

A specific example of L's Vector Two symptom concerned her use of astrology as a cognitive orientation to her life. Initially, the astrology reminded me of a 'prosthetic third' (van der Walt, 2011) in the sense that she was taking a complex semiotic system and using it to shape her experience and her interactions. Her use of astrology, however, was superficial and 'chatty' as opposed to detailed and structured, as would be the case in the prosthetic third. Her star sign was Pisces and she would get daily updates from different internet sites offering her astrological predictions. From these, she would infer meaning regarding her previous destructive episodes. The deadliness of the Vector One symptom was counterpoised by the deadliness of this or that moon or planet – a terrifyingly remote force that could violently impinge upon her. Despite the frightening resonance of these forces with the core complex experience, L narrated these

without feeling. She would constantly tell me various astrological 'truths' about herself, all completely resistant to emotional exploration. Her responses to my thoughts would usually be dismissive and passive and she would insist that things would unfurl 'according to the stars'. The other potentially significant astrological fact that L would constantly invoke was the dyadic nature of her Piscean condition. She would often refer to the Piscean icon of two interwoven fish heading in different directions. This appeared to me to depict something of the condition of being torn between two different directions, an image which deeply resonates with the Tri-bar dilemma. When I shared this interpretation with L she regarded me with piteous disdain and reflected that I knew nothing about astrology.

These periods with L were frustrating. L would often refer to me as 'not knowing', 'reading too much into things' and being 'overly sensitive'. I experienced L as hard, cut-off and cruel in these moments. In these Vector Two type interactions, as with the Vector One type, I felt powerless to say anything that would make meaningful contact with L, or to change our compulsively concrete way of interacting. Despite there being no discernible emotional contact, any discussions of ending the therapy, or me taking a holiday break, would evoke pronounced levels of anxiety. I understand this to indicate that despite the feeling that there was no real emotional exchange in the Vector Two forms of interaction, our interaction nonetheless served a vitally important function. This function seems to involve a relational dynamic in which L could be looked at and engaged with from an emotional distance – a relationship in form, but without consummated interactional content.

6.4 Transference and countertransference

Powerful and sometimes conflicting transference and countertransference states thus characterised my work with L. In recent literature on perversion, the transference and countertransference relationship is stressed as the primary vehicle by which perversion can be conceptualised and treated (e.g. Eshel, 2005; Etchegoyen, 1978; Jiminez, 1993; 2004; Ogden, 1996; Stein, 2005).

Etchegoyen (1978) was one of the first authors to address the notion of a perverse transference directly. He regarded the transference as consisting of a narcissistic type of object relationship in which the patient attempts to negate the separateness between herself and the clinician in order to create a symbiotic unity. Secondly, he describes how the patient alternates between evoking overwhelming excitations, on the one hand, and deadened exclusory boredom on the other. Finally, he points out that these operations are linked to the splitting of the ego and, following Meltzer (1973), closely associated with infantile dissociative defences. Owing to the early infantile nature of the pervert's psychic disturbance, the relational mechanism utilised by the patient in perverse clinical encounters is that of projective identification. Projective identification can be understood as a mechanism whereby the ego splits off "intolerable experiences by dividing itself, and locating parts of the self in external objects" (Hinshelwood, 2005, p. 1338). As a function of this defence, the clinician is interpolated in ways that are pre-symbolic, somatic and characterised by the 'compulsively enacted desire for ritualised trauma' (Eshel, 2005, p. 1070).

There are two discernable transference-countertransference patterns in my work with L. The first involves a symbiotic perverse excitement, associated with Vector One symptoms; the second, a dismissive and frustrating deadness, associated with Vector Two symptoms.

6.4.1 Symbiotic perverse excitation

Reactions of symbiotic perverse excitation were primarily related to Vector One symptoms in which I was sickeningly aroused by the way L narrated the bodily violations. In the analytic encounter I was flooded with an array of fantasies about what had happened to L. My fantasies always involved a gang of violent, marauding rapists who brutally misused L's lifeless and limp body. My own sexual arousal in some of these fantasies was a distressing somatic component in which I felt implicated as one of her rapists; uncontrollably excited by my sadistic assertion of power over L. Simultaneously I would feel great shame and an overwhelming wish to abruptly end our contact. I often imagined myself screaming for L to stop

torturing me. When these moments passed I would fiercely ablate the terrible experience by resolving never to think or speak about it. I would continue the session as though nothing had happened; pretending that what was going on was just an ordinary exchange between a clinician and a patient. I became false and wooden in my demeanour.

I believe that what I was experiencing in these times was the projectively identified experience of being symbiotically related to an annihilating, torturing other. A number of features are salient. Firstly, my fantasies of a marauding gang of rapists perhaps arose from L's attempt to communicate an experience of being assaulted from everywhere and intruded upon in every orifice. The omnipotent power of the gang is sharply juxtaposed against the absolute weakness of L, an all-powerful object in relation to a helpless baby. I am reminded here of L's puppy dream in which the puppy is thrashed by the evil woman. Secondly the sexualisation of the countertransference turns what should have been empathic distress, and an aggressive wish to protect L, into sadistic, voyeuristic excitation. This is in keeping with Glasser's (1979) and Jiminez's (1993; 2004) observations about the use of violent eroticisation as a relational defence that maintains the proximity to the object. Thirdly, my wish to stop the engagement identifies me in the position of the helpless self who screams for the torture to end. The desperate need to end the contact, I believe, is related to L's ultimate solution of rendering herself unconscious in relation to the object. Finally, my pretence that an ordinary exchange was underway in the session may suggest my own countertransferential pull towards self- deception. This self-deception, resulting in the intentional splitting of my subjective reality (what Welldon (2011) calls encapsulation), communicates the essence of L's perverse relationship to her trauma: one part that knows, and one part that wilfully hides this knowledge. As Welldon (2011) says, the right hand knows what the left hand is doing in the perverse psyche. This deception is connoted in the Tri-bar's illusory apex.

The projectively identified experience also communicates L's internal structure in relation to her infantile trauma. A violent sadistic 'gang' constellation in her ego (Steiner, 1993) mercilessly torments a helpless violated part of her. Steiner's

notion of the inter-relatedness between various pathological organisations in the psyche suggests that there is a perverse cooperation between aspects of the self, generated in order to survive trauma. It is possible to read L's digging her nails into her arm as a regressive attack on any potential understanding of her mental state. In other words, the annihilating gang threatens L's helpless baby if the perverse status quo is disrupted. This status-quo, although a pathological psychic retreat (Steiner, 1993), is a last ditch attempt to save the pervert's mind from psychotic decompensation, morbid despair (Welldon, 2011) and psychic deadness (Ogden, 1996).

In structural language, I believe Steiner is referring to the experience of a violently imposing superego which defends against unmanageable affects by imposing brutal negations upon the ego (Wurmser, 2003). In the archaic superego of the masochist, violence and aggression are the legitimate solutions to the shame and threat of having no control.

6.4.2 Deadness

Feelings of frustration, lifelessness and deadness appeared to accompany Vector Two symptoms. The affectless and cold quality of the relationship in these moments is denoted in the dream of two circles falling into each other. The depiction, which I believe to be suggestive of a dangerously fused state between L and her mother, is sanitised of its affective intensity and presents as an illusory geometric calm. Like my false calm and my deadened wooden presentation post the perverse symbiosis described above, the geometric calmness is an illusion. Thus L described herself as just a 'normal student' suffering from 'normal stressors' or accounts for her problems through astrology.

Despite there being no authenticity in this relational position, I would sometimes find myself feigning interest or forcing myself to find intellectual meaning in her utterances. I experienced the distance from L in my somatic reactions. I would feel enormously hungry after sessions, I would not be able to sit comfortably in

my chair, and I would feel very cold. As my frustration mounted, my wish was to interpret aggressively or threaten L with termination of the treatment. It may be the case that I was projectively identifying with the experience of being abandoned, uncomfortable, cold and hungry. Closely aligned with these somatic identifications was the wilful deception undertaken by L and I as we tried to 'act' as though therapy was meaningful and intellectually interesting.

6.5 Discussion: Affects and mentalisation

L's violence, her symptomatic acts, and her transference dynamics, all seem to hinge on the mental problem of unbearably overwhelming affects: firstly, in the experience of unnameable, foreboding experiences with threatening primary objects, and secondly, in relation to an archaic superego which orchestrates aggressive negations of the affected ego in order to return a sense of control of her mental life. Wurmser (2003), referring to the work of Krystal (1988), says of repetitive, severe infantile trauma that "it leads to the standstill, usually partial, of affective development: the differentiation, verbalisation and desomatisation of the emotions are blocked" (p. 226). For L, feelings cannot be distinguished, spoken about, or even separated from her body. L's feelings are by definition dysregulated and unthinkable. Fonagy et al. (2004) understand affect regulation to be "a process of crafting mental states in accordance with a sense of agency" (p. 436). An ability to regulate affects is a component of a general capacity to think about feelings, or what he and others term mentalisation (Fonagy et al., 2004). This capacity is related to one's own mind as well as the ability to imagine the minds and intentions of others (Fonagy et al., 2004). It is also implied in the ability to distinguish between inside mental states and the highly complex relationship of those states to external reality (Fonagy & Target, 1996).

Failure to mentalise results from poor affective mirroring in the primary caretaking relationship (Fonagy, 2001), leaving the child with poorly conceived, inaccurate representations of herself and others. In addition, the highly charged, unmodified emotional content inherent in the traumatically impinged-upon mind is often dispelled through violent action because affect is used instrumentally

rather than expressively or communicatively (Fonagy, 2001). This is clearly the case with L, whose symptomatic presentation typifies that of a borderline, non-mentalising patient. In particular, her symptomatic and transferential dynamics align with two separate ways of organising subjectivity: pretend mode and psychic equivalence (Fonagy et al., 2004). Psychic equivalence is characterised by mind-world isomorphism is which negative affects are experienced as dangerous things that pose a threat to the integrity of the self (Allen, Fonagy & Bateman, 2008). In this state negative affect becomes utterly unbearable and the mind is experienced as intolerable. I believe that this relationship to affects is typified by L's perverse expression in her bodily Vector One symptoms as well as by the perversely stimulating counter-transference dynamics. It may be argued that the disturbing and intolerable affects aroused in relation to a dangerous internal persecutor, experienced in psychic equivalence, resulted in the expression of that affect concretely, somatically and instrumentally.

Pretend mode refers to an organisation of subjective experience in which there is a decoupling between inner reality and outer reality such that the one is experienced as having no bearing upon the other (Bateman & Fonagy, 2006). In this mode, patients like L experience a sense of profound emptiness and subjective deadness. I would argue that this way of organising affectivity was dominant in L's Vector Two symptoms and in her empty, affectless transference. Thinking about her feelings and herself in the pretend mode may well be described as 'pseudo-mentalisation' (Fonagy et al., 2004).

In order to be able to think about feelings in the self and in others, the processes of pretend mode and psychic equivalence must be linked (Bateman & Fonagy, 2006). This allows a person to experience emotion without being overwhelmed by it, but at the same time be able to experience the affective state as meaningfully linked to the world and a sense of personal agency (Fonagy et al., 2004). In L's case, it appears that she was unable to link these modes of experience. What is more, her material is suggestive of a distinct severing of these functions such that they occupied different realms of the mind, or different parts of the split ego. In this regard I offer an additional reason a patient like L might split her ego: it may also

be a way of defending against the full affective knowledge of the disturbing experience within. In this assertion I am moving in a slightly different direction to a more traditional understanding of mentalisation. I suggest that in addition to there being a developmental arrest, a split psyche with unintegrated modes of organising experience may serve as a defence against the disturbing object of the core complex. It may also be a way of retaining the object by only ever knowing about it in truncated affective snapshots: a disturbing mindless body encounter, or an emotionless, empty cognitive encounter, never both simultaneously. To integrate these subjective modes of the object would usher in a more complete mentalisation of the disturbing experience of the core-complex object, resulting in a catastrophic emotional unravelling.

6.6 Conclusion

In this chapter I have suggested that the mind that beholds the disturbing internal core-complex object is severed into two different subjectivities, a split in the ego. This is done in order that the disturbing object can only be known in pieces, fragments masquerading as an illusory three-dimensional whole object. Two separate minds each relate to the disturbing core-complex superego in different ways: a Tri- bar mind. It has been argued that the Tri-bar mind emerges because of severe, traumatogenic developmental arrests, in which the disturbing core complex object is paramount in the mental life of the pervert. This object remains in the mind of the masochistic pervert as an archaic superego that functions malevolently, producing terrifying overwhelming affects that the patient has to manage. The developmental arrests also produce two distinct and unintegrated mechanisms for dealing with this affect, those being psychic equivalence and pretend mode. Keeping these modes of managing affect and organising subjectivity separate may also serve defensive functions against those overwhelming affects. Psychic equivalence produces a sensation-laden bodily expression of the affect (Vector One); and pretend mode produces an affectless, concretely cognitive negation of affect (Vector Two). The affective currents of the psychic equivalence and the pretend modes were also described in relation to the transference and countertransference. In one mode the transference and countertransference

feelings were perversely stimulating and bodily, in the other, dead and relationally distant. Thus, the Tri-bar split of the mind includes a stark split in the two strategies for managing torturous affect. It is this split that maintains the Tri-bar dilemma, simultaneously dead and alive, perversely related to both a sensation-laden body and a deadened mind. This chapter has offered a model for understanding this simultaneity of the experience of perverse masochism in the hopes that the therapist, confronted with apparently irreconcilable opposites, may link what the patient cannot, and thereby have some way to hold the totality of experience in mind.

7 DISCUSSION: THE PATHOLOGICAL THIRD, VIOLENCE AND REALITY: PSYCHOLOGICAL PATHWAYS TO VIOLENCE IN PSYCHOSIS, NARCISSISM AND PERVERSION

7.1 Introduction

The chapter describes violence and its relationship to pathological third formations in psychotic, narcissistic and perverse patients. The pathological third is a defensive formation of the compromised psyche that distorts the patient's relationship to reality in order to make it emotionally bearable. In psychotic and narcissistic patients who are violent, the pathological third truncates a disturbing relationship to the reality of the self and others. When the pathological third operates unperturbed, it defensively regulates affect by consciously rendering it of

no consequence. When the pathological third is disrupted, disturbing and unmanageable affects arise and threaten the ego with annihilation. Violence then ensues in order to protect the ego and restore the pathological third. In perversion, violence produces and maintains the pathological third. Here, the pathological third is characterised by a split in the ego producing two different forms of violence and subjectivity. One is cognitively rigid and emotionally dead; the other is intensely somatic and thoughtless. Affect is regulated by keeping these two violent subjectivities separate. The chapter illustrates the pathological third and its relationship to violence using clinical material. Some technical observations and tentative suggestions about work with violent patients are offered.

It could be said that violence is deeply relational and yet simultaneously attacking of relationality to the point of destruction. This paradox, in my experience, is the jagged rhythm to which violence moves. This chapter explores the question of the paradoxical relationality of violence from the perspective of thirdness. The relationship between violence and thirdness has been underexplored in the psychoanalytic literature. Specifically, the chapter draws on the work presented in the thesis to suggest that thirdness operates in very particular ways for psychotic, perverse and narcissistic patients. Case material is presented to argue that, at least in some cases, different kinds of pathological thirds are created by psychotic, narcissistic and perverse patients who present with violence. These pathological thirds serve as a way of managing overwhelming feelings associated with making relational contact with the self and the other. The relationship to the self and the other is psychopathologically disturbed, and needs to be truncated. For psychotic and narcissistic patients, it is suggested, the disruption of the pathological third evokes a different relationship to reality, and violence ensues. In other words, the disruption of a pathological third produces violence. For perverse patients, where violence is more pervasively linked to sadomasochistic ways of relating, the reverse can be observed: violence produces and maintains the pathological third. The chapter also aims to bring together understandings of thirdness and of mentalization theory. Sontag (2003, p. 118) has observed that "nobody can think and hit someone at the same time". Violence coincides with a failure to mentalize. This link has been most fruitfully explored in relation to borderline pathology

(Bateman, 2003; Fonagy et al, 2004; Fonagy, 1995); here it is extended to other kinds of pathology. I argue that a pathological relation to thirdness, linked to violence, goes hand in hand with a pathological relationship to reality. The aim of the chapter is to propose a possible relationship between thirdness, violence, relationship and mental reality. The focus is on the formulation of this relationship, but some implications for therapeutic engagement are also proposed.

7.2 Thirdness, reality and violence

Thirdness is a difficult concept in the literature because it is an abstraction, denoting not only the sequence of one, two and three; but also the qualities of whatever constitutes these designations. In psychoanalysis, each school of thought accounts for the one, two and three differently, and this muddies the water. This is not a new problem for psychoanalysis. There have been notable attempts to address this theoretical quagmire (see Hanly, 2004; Green, 2004; Gerson, 2004). But overwhelmingly psychoanalytic schools embrace thirdness for their own purpose. I will outline the major theoretical schools and their relation to thirdness before I define what thirdness means for the chapter.

Freudian notions of the third engage the triangular by speaking of Oedipus and the socializing function of paternal prohibition (Freud, 1910, 1924) involving the father, the mother and the phallic stage child. States of autoerotisism (one) (Freud, 1914), give way to dyadic relating (two), which in turn emerge into Oedipal thirdness. The sequence of three for Freud is "me", "mother" and "father". Object relational accounts of thirdness bring the triangular relations of thirdness into the internal emotional world of the infant. For Klein (1952), the infant is always in a state of dyadic relations with its primitive internal objects. Thirdness involves a capacity to apprehend an external reality (and the whole objects therein), whilst at the same time maintaining a link to the internal objects. Three here is "me", "my internal objects" and "you". Britton (2004) follows in the object relations tradition of thirdness and casts the players of Oedipus as internal objects. The reality of two external others that can come together in exclusion of the self is internalized as a

cognitive capacity to adopt two different and essential subjective relations to the self. Thirdness for Britton is described as an internal triangular space that allows both observing and participatory relations with the self. These positions are correlations of the external object relations in which the child can relate to the oedipal couple by observing them interact with each other, and participate with each member of the couple in a dyadic relation.

Hailing from the independent school of psychoanalysis in Britain, Winnicott's (1971) notions of thirdness involve a progressive subjective journey out of monadism into an awareness of external others. For Winnicott, there is an intermediary subjective position between the self, and an awareness of an other, called transitional space. The transitional third space is an intersubjective realm in which there is a blur between what is self and what is other. Three for Winnicott is "me", "part-you and part-me", and "you". This theoretical advance lays fertile ground for intersubjective notions of thirdness developed by Ogden (2004) and Benjamin (2004), as well as the relational psychoanalysts such as Mitchell and Greenberg (1983).

This idea of intersubjective thirdness is also adopted by attachment-based schools of psychoanalytic thought (Stern, 2004; Fonagy et al., 2004). The focus in these theoretical schools is on a close-grained examination of the processes between mother and infant that progressively introduce the reality of others and the self. Fonagy (2002) importantly links attachment, developmental intersubjectivity and affects to the development of a self that can emotionally engage with reality. Three in these systems of thought is "me", "you" and an "emotionally-valenced reality". In post-structural psychoanalytic schools (see for example Lacan (1977) and Zizek (1993)) thirdness is language and meaning itself. In these theoretical frames, subjectivity and objectivity are the effects of being alienated in language. Intersubjectivity itself is a property of the human subject being alienated and animated in language.

I am in agreement with Gerson (2004) who highlights three broad strokes of the meaning of thirdness in the literature: namely the developmental third, the cultural third and the relational third. Developmental thirdness designates the multitude of subjective processes that ultimately produce a mind that can integrate subjective and objective perspectives in a multi-dimensional appreciation of reality (Gerson, 2004). The relational third refers to that which is created subjectively and intersubjectively between two minds. Relational thirdness and developmental thirdness are inevitably discussed synonymously in the literature. Intersubjective developmentalists such as Lacan (1977), Ogden (2004), Benjamin (2004), Green (2004), Winnicott (1971), Stern (1985) and Fonagy (2002) all describe how the human subject comes into being in relation to another mind. These developmental processes hinge on a relationship to a third entity or mental position outside of the immediate experience of the caretaker-child dyad. Finally the cultural third refers to entities or positions conferred by social roles and institutions that anchor a set of rules which govern the interactions of human subjects in relation to each other. Examples of these are Freud's Oedipal father (1910), or the internalized supervisor (Zwiebal, 2004).

My own understanding of thirdness could be best described as relational and developmental. As a psychoanalytic psychotherapist, intersubjective knowing and its impact on the prognostic progression of a patient is an integral part of my clinical work. Intersubjective knowing is also the primary mechanism on which diagnostic and technical decisions are made. The "third mind" created between a patient and myself serves as a rich source of relational knowing. Violent patients are particularly vexed by relationship and intersubjective encounters. Thirdness, or relational contact that involves a contact between two minds, is therefore of particular significance and importance. Establishing a shared relational contact, or what Benjamin (2004) calls a state of mutual recognition is a primary therapeutic goal. For the violent patient this is diagnostically difficult. Psychotic, perverse and narcissistic patients who are violent, by definition contort and attempt to negate a third shared space. Their own developmental deficits are primary agents of the contorted or pathological third space. It is also the case that the therapist is brought in to participate in a foreclosure of a healthy thirdness. Healthy thirdness

can be understood as the capacity to be aware of, and to relate to the self and the other without becoming emotionally overwhelmed. It is a mental vantage point from which reality can be organized. In very basic terms it describes how the human subject gets from the internal world to the external world of the other, and back again, without dissolving in terror or violently destroying the threat of reality.

In my attempt to operationalize thirdness for the chapter, I would like to link it specifically to the mental work of affect regulation as this plays such a central role in violence. Fonagy et al. (2002) link the capacity to regulate affects to what they call mentalization. Mentalisation refers to a capacity to be aware of and represent mental states in the self and subsequently be aware of these states in others (Fonagy & Target, 1999). Importantly its absence has been centrally linked to violence and self-harming behaviour. Similarly, thirdness can be understood as an awareness of an other, or an awareness of a third 'something' produced by two people. Ultimately, the third position is internalized as a reflective function (Fonagy, 2002), a thinking triangular space (Britton, 2004), an observing ego function (Aron, 2000), or the internal analytic working model (Zwiebel, 2004). In these instances reality can be engaged with from subjective and objective perspectives, based on a stable reflective ego mechanism that contains an organised conception of the self. The mind can be imagined and thought about, as can the minds of others. Affects can be regulated and contained.

Clarkin, Gabbard and Fonagy (2010) link the structural integrity of the mind to developmental notions of mentalization. They point out that the less differentiated the ego constellations are, the more pathological the individual is likely to be. This in turn has implications for the patient's likelihood of taking recourse to more primitive defences, including resorting to violence. In more pathological ego constellations, the subjective experience of affects is persecutory and ego threatening. Feelings are experienced as though they are concretely real. In the mentalization literature this state is described as "psychic equivalence" (Fonagy, 2002). In this state feelings are experienced as concrete reality because there is an inability to distinguish between internal subjectivity and external reality. This

subjective state is contrasted to "pretend mode" (Fonagy, 2002) in which reality has little or no emotional consequence. In this subjective state playing with reality becomes possible because it has limited affective valence. In a developed capacity for mentalization, psychic equivalence and pretend modes are integrated and function together so that a person can know about internal and external reality in an emotionally responsive way without becoming overwhelmed. This relies on the ability to move dynamically between these two subjective states in response to various realities.

I suggest that physically destructive behaviour is associated with states of mind in which either psychic equivalence or pretend mode dominate, to the exclusion of the other. In the clinical material to follow I wish to discuss how violence is associated with non-mentalising subjective states linked to a pathological third. The three pathological thirds explored in the discussion have been presented in previous chapters. They are specifically described in relation to the eruption of violence. A brief outline of each pathological third and their relation to the distortion of reality and violence, is offered before case material is presented.

The first is the *prosthetic third*, linked to psychotic functioning. The prosthetic third is a semiotic object (discourse, music or complex games for example) that coheres and regulates the fragmented ego of the psychotic patient. Psychotic functioning is concrete; so too is the pathological third. The prosthetic third is used in this instance, much like a prosthetic limb, to concretely regulate affect and to create an illusory sense of thirdness in order to shore up coherence. The case of Mr K below shows that when his prosthetic third is ruptured – when the concrete object is challenged by thoughtfulness – violence ensues.

The second pathological third, termed the *autogenic third*, is linked to narcissism. Narcissism turns on the belief that the self is centrally special. This can be extended to a belief of being self-made or self-produced. It has been argued that narcissistic patients may create a pathological third around this autogenic phantasy, in which the narcissistic patient believes himself to have been a

participant in his own conception. This intrusive phantasy allows the narcissist to deny the reality of a procreative couple that precedes him. Affect is regulated by remaining relationally aloof and consciously ignorant of the separateness and significance of others. When the phantasy is challenged or shattered, violence may erupt.

Finally, the *Tri-bar third* is proposed in perversion. Glasser (1979) describes the masochist's ego as split in response to a terrifying superego, or core-complex object. This object cannot be destroyed, nor can it be survived, leaving the pervert with an almost irresolvable dilemma. Hostility and dependency are the affective poles between which the pervert oscillates uncontrollably. I have proposed that each of these poles produces a pathological third. In order to self-regulate and manage the core-complex object the pervert splits his experience into two separate subjectivities. One subjectivity, a somatic, sensually saturated and mindless state, retains a connection to the object through bodily sensations. In this subjectivity, affect is psychically equivalent. Violence is sexualized and sensational. The other subjectivity, a rigid and dead cognitive state, retains a connection to the object through emotionless and empty thinking. Affect here is unreal. Each of these subjectivities produce a pathological third that is maintained by violence – of a somatic, bodily kind or of a dead, emotionless kind. In the case of perversion, violence is produced by the pathological third rather than produced by the rupture of the pathological third. This makes violence core to the experience of thirdness in perversion.

The case material presented to illustrate each of these dynamics is partial. The cases are presented as vignettes offered to illustrate the operation of thirdness in relation to violence. Much about these three patients is therefore necessarily excluded from discussion. Although the dynamics described below may not fit all violent psychotic, narcissistic and perverse patients, I have observed these configurations with other patients and offer the analysis below as a way of thinking about how the disruption or maintenance of a pathological third may result in violence.

7.3 Case 1: Mr K – Psychosis and the prosthetic third

Mr K was referred to me because a colleague of his had noticed some bizarre behaviour and had encouraged Mr K to enter into psychotherapy. It soon became clear that Mr K was prone to regular episodes of violence. In my first meeting with Mr K I was struck by how scared he was. In order to create a sense of emotional safety, Mr K had constructed strict routines and created certain special objects in order to keep his overwhelming terror at bay. He was obsessionally attached to these routines and objects, and would experience psychotic breakdowns and episodes of violence if his obsessional order was disrupted.

One of his special objects will be described to illustrate how a prosthetic third can be concretely used to cohere mental reality (see also chapter four where Mr K is also discussed). Mr K worked obsessionally on an autobiographical manuscript in which he would organise his experience and consolidate his identity. I was struck by how he borrowed from the semiotic coherence of language and self-narration to furnish himself with meaning and identity. He used his autobiography as an external mind or prosthetic third to manage reality. He used his sessions to read himself to me. I was the mental editor to his emotional life. When narrating himself he was mostly calm and emotionally detached.

Sometimes this calm would be disrupted and it was in these moments that the catalysts of his violence could be more clearly seen. In one session, whilst reading the "relationships" section of his manuscript, I became confused about his understanding of homosexuality. He described himself as having homosexual feelings for a woman. When I reflected on this aspect of his narrative, wondering if he identified himself as a woman, and invited him to reflect with me, he became very frightened, and consequently very menacing and threatening towards me. It seemed that I had invited myself into his prosthetic third and asked him to think, and that this was intolerable for him. He was convinced that I had sexual feelings for him and that if he did not give in to me, I would rape him. Mr K had moved from

a state of pretend mode into a state of psychic equivalence. In this subjective state Mr K experienced my question and his subsequent transference as a dangerous and penetrating reality. In response to this perceived threat Mr K threatened to report me to the authorities and demanded that I hand him his file. He was very menacing and said that he would destroy my career. I felt frightened, enraged and intruded upon. All my attempts at exploring these feelings as a reaction to what had transpired in the session failed and only served to escalate the emotional temperature. Eventually in desperation I asked Mr K to explain to me how he would write up his experience of the session in his autobiography. He did so and in the process calmed down to the point of saying that what had happened was a misunderstanding.

7.3.1 The prosthetic third and violence

Mr K was a man whose ego was in tatters. His primary affective relation to the world and to others was terror as he lived under the constant threat of annihilation. His experience of any therapeutic reflexivity that did not immediately match his own was persecutory. An alternative reflective function ushered in a severe internal threat - something ego-destructive, a malicious foreign body whose destabilising presence required urgent life-preserving aggression to be mobilised. In the vignette, a question about sexuality and gender produced a terrifying internal experience: a psychic reality in the form of a dangerous and foreign thought, which threatened the integrity of Mr K's understanding of himself. The noxious and threatening quality of the experience was then projected onto me in the form of a psychotic delusion. In this delusion Mr K believed that I would force myself into him; a personification of the dangerous reality I introduced. In order to restore a sense of safety, Mr K had to get me to back down, shut-up and stop thinking. Had I not done so, I believe that violence would have ensued, as was the case in his numerous psychotic and violent outbursts at home. Mr K's calm was restored only when he was able to cohere his self-experience in the organising narrative of his autobiography. In this way, the prosthetic third was reinstated and I – the potentially non-pathological third inviting mentalisation – was relegated

back to safety. This autobiography served as a semiotic system in which he could write his own experience of the session.

The prosthetic third is a complex semiotic system or organised structure of symbols that the psychotic patient uses as an alternative ego formation. For Mr K this structure was his autobiography. In chapter four I have described how psychotic patients have used music, symbolic games and psychiatric discourses as prosthetic thirds to regulate affect and manage disturbing reality. These concrete objects serve as an external mind and are able to lift the psychotic patient out of their psychic equivalence into a mental state of pretend mode reflection. This also has the effect of reducing terrifying affect. When the prosthetic object is disrupted so too is the reflective and affect regulation capacity of the psychotic patient. When I disrupted the autobiography of Mr K, he responded in a threatening and aggressive manner. This aggression was being mobilised in order to preserve the integrity of the prosthetic third. In other areas of Mr K's life, others around him were not able to respond to the warning to back away communicated by Mr K's aggression. In these instances, it seemed that his prosthetic third collapsed and violence was enacted.

7.4 Case 2: Mr A – Narcissism and the autogenic third

Mr A was a man in his early twenties and was referred by a psychiatrist for "anger issues". He had a history of violent encounters with others, and his romantic relationships were characterized by rageful fights followed by intense reconciliation. Mr A presented as a highly strung agitated individual whose psycho-somatic presence crackled with manic energy. His legs bounced, his fingers tapped, his shifting never ceased for more than a few minutes. I always felt nervous and imposed upon in sessions. Mr A felt unstable and volatile. After our first session he had seen me take up my notebook to write down my impressions of our meeting. He immediately challenged me about this and demanded that I not take any notes on his sessions. Startled I suggested we take this up in our next session. He refused to leave and insisted that he would like to check my notebook

the following week to see if I had kept my word. He was aggressive and intrusive and I felt rattled. The following session I braced myself for more of this onslaught. To my surprise he did not raise it until I did so some half-way through our time. Instead he was disinterested and disconnected. He dismissed it saying he did not care to think about it and that I should do what I wish. Throughout the therapy, I constantly felt uncertain as to whom I should expect in the room: the remote and unconnected patient, or the intrusive and controlling one.

The primary content of Mr A's sessions concerned his relationship with his mother and his girlfriend. The two relationships were enmeshed. Both women idealised him. He was extremely possessive and jealous of both women. He had had violently conflictual relationships with the various men his mother had been sexually involved with, resulting in him being sent to boarding school several times in his adolescence. When it came to his girlfriend he could not tolerate any other man in her life or her mind. He would regularly rage at her for some or other misdemeanor she had perpetrated with other men, real or imagined. They would fight vociferously and then come together in a sensual cocoon of eating, sleeping, stroking and having sex for prolonged periods. These were blissful and precarious times, always poised for an imminent collapse with the intrusion of another hated man. These sensual cocoons were supplemented by drug and alcohol binges. Mr A was a manic pursuer of pleasure and as such was a prolific drug and alcohol misuser. He had been in and out of rehab several times.

In Mr A's first session he told me about two incidents of violence. In the first incident, Mr A described being beaten up outside a nightclub by two men. He described how they had used knuckle-dusters and chains, and how sadistic they had been in their protracted assault. The violence he described was graphic - a spectacle of pain and suffering. His narration felt staged, inauthentic and incomplete. Many months later I learned that his account had failed to include any of his own culpability. Importantly, it had also excluded the important detail that Mr A had precipitated the altercation after the man had interceded in a fight between Mr A and his girlfriend. The spat had begun a month prior to the incident

because the perpetrator had threatened Mr A after witnessing him in a jealous fight with his girlfriend. Although there had been no physical violence at this point, Mr A was so incensed that he had sought out the man's address and begun vandalising his property. All of these details had been neatly excised in his initial account.

The second incident was reported in fuller detail and in a manner that felt sincere. The incident had begun at a restaurant. Mr A and his girlfriend were having another fight. A man sitting at the adjacent table had asked Mr A to stop shouting and swearing. Mr A had then threatened this man with physical violence, at which point the restaurant had called the shopping centre security to deal with Mr A. The situation rapidly escalated and Mr A assaulted the security officer attending to the incident. As Mr A was telling me about this, he became agitated and manic. I noticed that his mouth was dry in response to his adrenaline surge. He was in a state of psycho-motor agitation. Mr A described how he had become like a "machine": he felt no pain and he experienced himself as invincible. In the session his memory and his sensual descriptions were heightened. He ran through and broke the restaurant window, and jumped down a storey in the shopping centre in an attempt to evade the security officers. Eventually after the police had been brought in, Mr A was wrestled to the ground by a number of officers, assaulted and then arrested.

7.4.1 The autogenic third and violence

The autogenic third is a concept that combines Perelberg's (1999) description of the violent narcissist's core phantasy of being present at his own conception, Rosenfeld's (1971) ideas of thin-skinned and thick-skinned narcissism, Britton's (2004a; 2004b) elaboration of these ideas in terms of triangular space, and Fonagy's (2002) theories on affect regulation.

The core phantasy of the violent patient according to Perelberg (1999) concerns an unconscious conviction about being present at conception. Rosenfeld (1964)

distinguishes between thick-skinned narcissists who cannot form relationships in the transference and thin-skinned narcissists who cannot tolerate anything but intense relating. In both cases, the nature of the relationship to the therapist forecloses on being able to think, interpret or understand. Perelberg (2004) and Britton (2004a) note similar transference dynamics with narcissistic patients. Britton (2004b) links these narcissistic styles of relating to *triangular space.* He establishes a link between being able to tolerate the external reality of others coming together in a creative, reproductive way, and the capacity to think. If the reality of being in a separate relational stance to others interacting in the world cannot be tolerated, the narcissistic patient enviously destroys this triangular reality in his mind. In the case of thick-skinned narcissism, the patient predominantly takes up a stance of refusal in relation to any manifestation of that triangular reality by remaining relationally disengaged. This severely hampers his capacity to think and engage in meaningful relationship to certain aspects of reality in which he is aware of himself as being excluded. In thin-skinned narcissism, the patient relates intrusively, preventing thinking and separateness.

With violent patients who are narcissistic, my experience has been that both thin- and thick-skinned orientations to the therapist manifest. Bateman (1999) notes a similar dynamic. Perhaps this is because these violent patients generally manifest with a borderline personality organization (McWilliams, 1994) and so the personality is less stable. Certainly it is the case that both thick-skinned and thin-skinned styles of relating are built on similar psychodynamics: that of preventing triangular space. The thick-skinned patient sustains his dyadic object relational world internally, whereas the thin-skinned patient does so in the external relationship. When the internal dyadic fantasy is unperturbed, thick-skinned aloofness predominates. When the fantasy is disrupted, thin-skinned intrusiveness manifests.

The narcissist feels himself to be at the pivotal centre of all reality and action. His mental arithmetic calculates accordingly. Cognition, affect regulation and relationship all assume this dyadic logic in which a triangular reality is negated. In

previous work I have called this dynamic the autogenic third (chapter five) because the patient, in phantasy, produces a pathological third which maintains his centrality and self-production, thereby allowing him to avoid relational thirdness. In instances where the autogenic third is compromised by reality, affects become dysregulated and envy, hatred and aggression arise to threaten the ego. Violence ensues when these affects are mobilized to restore the autogenic third and the precarious safety it offers. Affects are managed through the defensive maintenance of pretend mode in thick-skinned aloofness. In thin-skinned positions, affects are dispelled and enacted through a violent imposition on external reality in an attempt to restore the dyadic phantasy.

There is a clear sequence in the two incidents described by Mr A: a passionate and jealous fight with his girlfriend (involving the threat of a sexual rival); then, a patriarchal other who intervenes to oppose Mr A's aggression against his girlfriend; and finally, a violent act against the third who dares to intervene. As a post-script to the sequence I might add a highly selective retelling of the events, which hides Mr A's culpability and disguises the role of his rage as a catalyst.

In this sequence, Mr A's sense of being the only man in relation to a woman seems to be destabilized. The woman is a source of id-linked pleasure and sensual idealization. He is the only beneficiary of this pleasure. This includes the pleasure of bullying his girlfriend into acquiescence and forcefully demanding that she declare her absolute allegiance. He responds angrily and violently to any entity that interrupts his pleasure. Any interfering man is responded to as a threat. The purpose of his violent response is to ward off the dangers to his autogenic third – to obliterate the actual third that challenges his autogenic cocoon. The quality of the threatening response is an important feature of the sequence. There is intense pleasure linked with this kind of violence. I observed this when Mr A was telling me about the violent action - an ecstatic agitation, a prelude to thanatic orgasm, perhaps as addictive as any of the substances Mr A misused.

When Mr A negated triangular reality, he was able to disconnect from others and use them as objects to pleasure himself. The sensual cocoons with his girlfriend and the aloof disconnection in some of his sessions attest to this thick-skinned state. In both cases the rival third had been banished through violence. In our first session Mr A managed to scare and intimidate me by demanding that I cease my note-taking (a concrete indication of me communicating with myself and my thoughts). Once this was achieved in the mind of Mr A, he no longer had the need to engage with me, and so he felt no need for confrontation in the second session. The retelling of his episodes of violence bore the same manipulation of reality. The retold violence was constructed incompletely. His subjugation, culpability, fear, pain and injury were muted. He was a "machine". However, in the second narration of violence, the perturbing influence of the patriarchal other is closer to his awareness. In this instance his body betrays the emotional impact of the retelling. His displays psycho-motor agitation and his mouth is dry. It is perhaps for this reason that, in the transference, Mr A intrudes into my mind by demanding to see my notes.

Two subjectivities play out in the material described. The first of these states is a thick-skinned subjectivity associated with aloofness and the selfish use of his objects: the pleasuring subservient girlfriend/therapist. In these cases affect is excised of all vulnerability. He is deadened, scary, omnipotently controlling and/or sadistically rageful. The second state is thin-skinned and is associated with vulnerability, fear and threat. This state, observed mostly through his bodily agitations in the therapy and the corresponding paranoid, intrusive dynamics in the transference, is characterized by psychic equivalence. A panic reaction ensues in which Mr A needs to gain the upper hand at any cost. In order to do this he must destroy triangular reality and the consequent ability to think. This can only be accomplished with violence. Mr A regulates affect through securing and maintaining an all-powerful thick-skinned position. This is the primary aim of his violence.

7.5 Case 3: Mr D – Perversion and the Tri-bar third

Mr D, a man in his sixties, was involved in a series of violent altercations with his boyfriend. In these altercations he had sustained some serious injuries that required ongoing physical therapy. He was constantly beset with terrible pain, and would wince and cry out as he moved his body in the consulting room. When I asked him to tell me about his pain I was struck by two facets of his answer. Firstly, Mr D graphically described his sadistic treatment at the hands of his boyfriend whenever they fought. The boyfriend would beat Mr D until he "broke down and cried". It sounded very much like Mr D's boyfriend required vulnerable submission in order for the beatings to cease. Mr D indicated that he would defiantly refuse to cry, thus prolonging the violent encounter. Secondly, Mr D described the sadistic treatment he had received at the hands of one of his physical therapists, who would "break him until he cried". Being broken and crying appeared to be central to these exchanges.

As the therapy progressed, it became clear that I too was required to "beat" Mr D until he cried. I would sit helplessly in sessions as Mr D regaled me with narrative after narrative of sickening ill-treatment at the hands of his sadistic mother. His pain was palpable and it was often I who felt like crying and breaking down. He contrastingly would feel nothing. He would assure me that getting into the "gory details" was good for him. In one session (about two years into the treatment) when I was struggling to contain my own tearfulness I reflected that he seemed to get no obvious relief or release from telling me his stories. He responded by telling me that he had taken to going to a "flesh pit" (a sex club) after sessions. He would engage in a particular form of sexual interaction. The interaction involved bottoming with a man with the biggest penis he could find. The anal sex was painful and often left him with fissures. When he could not find a man big enough he would ask to be fisted with the same painful result. He would reassure his sexual partners that this felt good despite their reservations. I told him that I thought he and I were doing the same thing in the therapy and that it did not feel like a pleasurable or beneficial exchange. In fact it felt like a hurtful relationship in which he would leave with a bleeding asshole/mind. He responded to this

comment with uproarious laughter. I felt humiliated and Mr D came across as smug and triumphant.

In the next session I noticed that my own emotional response to Mr D had changed. I was now tremendously angry with him and his unrelenting torturous narrations about his cruel mother. About twenty minutes into the session I abruptly interrupted Mr D and said that he was again using the session to fuck and hurt himself, and he was enlisting me to do this. My own aggressive tone and uncontained frustration had a startling effect: Mr D burst into tears and sobbed for the rest of the session. There was a feeling of great relief. My feelings towards Mr D softened considerably at this point. In the subsequent weeks and months after this session Mr D was able to tell me about how frightening it had been to see me respond to him emotionally. He had felt increasingly afraid that I would "fuck him up".

Mr D would relate the cruelty done to him by women (other than his mother) in an emotionally sterile and intellectualised manner. These narrations were reported incidentally. Explorations of these types of mistreatment were dismissed by Mr D as being insignificant or "just the way things are". Mr D was a misogynist who anticipated the worst of women. No amount of cruelty and injustice at the hands of women (most of whom he worked with) was regarded as being significant in any way. He had developed elaborate and bogus "scientific" understandings of the biology of women that he used to account for, and dismiss women's cruelty. Women were understood as biologically inferior. As "breeders", they were a necessary natural aberration that could not help but be infantile, petty and cruel. This cold, rigid misogyny reminded me of the dispassionate justifications for racism by Verwoerd in 1950's South Africa where racial hatred was framed in discourses like "separate development". Despite reporting being profoundly mistreated and ridiculed by his female colleagues, his hatred remained "scientific" and dispassionate. The coldness of his descriptions left no space for affect of any sort in his mind. I was left to feel the anger at his mistreatment, as well as the horror at his deeply hateful attitude towards his colleagues. A similar type of

violence was observed with Mr D's younger boyfriends, who were cruelly and violently treated. These types of violence were understood by him to be "necessary discipline" and were narrated in a cold dispassionate manner.

7.5.1 The tri-bar third and violence

In the cases of psychosis and narcissism I have suggested that threats to the pathological third produce violence. Violent perversion seems to fall into a different category of pathological third in that it is fundamentally fated to produce violence. This form of pathological third, the Tri-bar third, is inherently unstable because there is a split in the ego. Unlike the prosthetic third and the autogenic third, which maintain a state of pretend subjectivity until threatened, the Tri-bar third alternates states of pretend mode and psychic equivalence as a matter of course.

As with other violent and perverse patients, my own reveries with Mr D have often involved imagining impossible structures. Ambiguity, paradox, distortion and illusion have made their way into the metaphorical languages my patients and I have developed to speak about their emotional lives. The most coherent and useful of these metaphors has been the Penrose triangle (1948), or the Tri-bar. The metaphor of the Tri-bar captures the split in the pervert's ego integrity in response to a dangerous primary object. Violent perversion may be viewed as a strategy against primary caregivers whose own aggression and hatred create a mind-threatening problem (Deutsch, 1932; Glasser, 1986; Glover, 1933; Klein, 1946; Stoller, 1986). The violent contradiction of hating and needing the same object places tremendous burdens upon the pervert's ego. Various authors (Chasseguet-Smirgel, 1985; Stoller, 1986; Welldon, 2011; Wurmser, 2003), beginning with Freud (1927, 1938) have described how the pervert adapts to problem of an unbearable affective experience by splitting the ego.

In the previous chapter I extended the Tri-bar metaphor to convey the idea that each split part of the ego characterizes a different form of subjectivity, a different

relationship to affect, and two alternative relationships to the disturbing primary object. These two subjectivities rest on the existence of a horrifying emotional devourer of sorts: the core complex object (represented by the base vector of the triangle). A deathly, annihilating internal experience is a consistently narrated feature of the perverse patient. One subjectivity invokes an emotionally detached way of being while the other invokes an intensely sensational, somatic way of being. These are represented by the two vectors of the triangle.

The Tri-bar illusion offers one way of understanding the affect regulation, ego preserving defenses of Mr D and his subsequent violence.

Mr D's base vector or core complex object is connected to his early experiences of caretaking. Mr D experienced his mother as an extremely sadistic and destructive woman. She had had numerous breakdowns and had been hospitalized in the first year of Mr D's life. Fortunately, Mr D's day- to-day care was almost entirely taken over by the housekeeper in the first five years of his life. She died unexpectedly leaving Mr D deeply bereft, but having had a precious loving experience with her, which undoubtedly assuaged the destructive impact of his mother. Internally, Mr D's core complex object was represented in his dreams as a multi-sexed monster and a suffocating latex glove. As ego manifestations, these internal objects gave no room to be alive or whole. The suffocating, carnivorous cruelty of these internal objects was juxtaposed with another set of dreams in which Mr D found himself utterly alone in freezing, dark places where there was no sound or signs of life. Mentalising this terrible object was too painful and threatening for Mr D. Whenever he came to a point of recognizing his need for, and fear of others simultaneously, the integrity of his mind was felt to be under attack. The moment in therapy where Mr D saw me respond to him emotionally, initially deeply meaningful, evoked his core complex dilemma of both needing and fearing the other; for Mr D it was not possible to respond to this emotionally authentic moment in a healing way. Rather, as was his pattern, he responded by renewed efforts to symptomatically split his mind (and his subjective experience) in two in

order to escape this awareness. These two tracks, which I describe as Vectors One and Two, lead to two forms of violence.

In the first, Mr D involved himself in intensely sensational bodily interactions with others in which his aggression and his fear were sexualized and mindless. Here the object was felt but not known; experience was severed from perception and thinking. The fights that Mr D had with his boyfriend, his anal encounters in the sex club, and his painful interactions with his massage therapist seem to fall into this symptomatic track. Under the sway of this form of subjectivity, mentalization was defensively compromised and conducted primarily in the mode of psychic equivalence. Affect in this mode was regulated by mindless, bodily *doing*. Doing, in this sense, is a pathway to violence.

In the second symptomatic track, vector 2, Mr D offers himself as an unfeeling, cognitive narrator of his subjectivity. The emphasis is on intellectualized negotiations of the relationship to the other and to the self. The 'scientific mysongynist' who bore his pain with a superior unfeeling disdain. What pain there was to be experienced was pushed out of his mind, into his body and into me: all thinking and no meaningful link to feeling, or what Fonagy (2002) describes as pretend mode. In pretend mode, violence can be witnessed, responded to, and engaged in with little or no affect. Affect is regulated because it is negated and projected. As with other perverse and violent patients, negating affect lends a great omnipotence to the self-experience. Without the terror associated with the core complex object, identification with the sadistic superego aggressor can proceed unencumbered. Violence here is committed via affectless identification, or what Anna Freud (1936) has described as (masochistic) "identification with the aggressor", exemplified for Mr D by his masochistic forbearance, and haughty dismissiveness of his female colleagues.

Pathological thirdness in violent perversion, then, is intensely unstable. It requires a constant move between the split minds in order to function. And, as it functions it compulsively repeats the mind's undoing, leading to ever escalating violence. Mr

D's solution could not be stable because the object was experienced as lost – it could never be completely reconciled with. This sets up a consistent leaping back and forth between the two tracks, each offering an incomplete although mind-preserving solution. But this preservation of the mind never quite escapes the threat of the core complex other.

The chapter now turns to some of the technical implications that might be drawn from the discussion.

7.6 Technical Implications

7.6.1 Mentalisation-based approaches

Fonagy (2000), Bateman (2013, 2012) and Allen (2006) provide robust, manualised accounts of technical guidelines when working with borderline patients who struggle to mentalise and for whom attachment is fraught. These approaches have been invaluable in work with volatile patients. I would like to focus on two particularly salient aspects in these brief observations. The first relates to affect regulation and the relationship; and the second speaks directly to the concepts of psychic equivalence and pretend mode.

It is imperative to keep the affective temperature of the therapeutic relationship cool. When the patient becomes overly affected thinking becomes extremely difficult for both therapist and patient. This is usually because the patient feels threatened or scared. In these moments I have found it better to go quiet or work actively to restore calm. I do not interpret in these moments. By keeping a close eye on the emergence of more aroused states in the therapeutic contact, I have increasingly been able to anticipate, and head-off, emotional outbursts and defensively motivated therapeutic process. This being said, it is virtually impossible to avoid outbursts in work with patients of this sort. In the event of this happening, I have found it most useful to shut-up and write up detailed accounts of the session afterwards. Reading these notes carefully is invaluable for the rich information about the patient's pathological third and how it manifests in the

transference. Supervision is an essential part of this out-of-the-room thinking. This work cannot be undertaken alone. This thinking can be shared with a patient when things have calmed down: "strike while the iron is cold" (Pine, 1985. p. 153).

Another valuable tool when working with violent patients is to speak about, and describe, pretend and psychic equivalence modes of functioning. I have found that patients relate well to this plain, direct theory of emotional functioning. It cedes a simple and robust theory of mind that can be actively observed and negotiated in the therapeutic relationship. It also provides a practical way to speak about affect regulation in that emotional aloofness and overly aroused states are seen within the context of the mind. Violent patients are prone to leaving out the mind in accounts of their emotional lives. Restoring the mind to understandings of mental life is a good starting point in any work with violent patients.

7.6.2 Interpreting close to the drive derivative: language and its tie to the body

In my own training it was generally held that interpreting close to the drive derivative is a bad idea with psychotic, perverse and borderline patients. I have found this to be untrue in my work with violent patients. To speak about being "annoyed" or "scared" as opposed to being "enraged", "terrified"; or "mess" and "beating up" as opposed to "shit" and fucking-up" is unhelpful. Language for violent patients is closely tied to the body and its impulses. Considering the powerful oral and anal fixations inherent in my patient's developmental arrests, and the contaminating effects this has on genital processes, this seems logical. When speaking to patients I have found it useful to speak with language as close to the body and the drives as possible. Needing to 'shit an experience out' or 'cannibalise his cock' or 'get fuck-faced drunk', for example, are symbolic articulations of intense drive and bodily preoccupations. Not speaking at this level can convey to the patient a reticence or judgmental stance to her preoccupations. At worst the patient confirms her convictions that she is unreachable; at best this opens up the possibility to using graphic language to intimidate and violate the therapist. The caveat to this technical suggestion is that the language used should always follow

and closely match the patient's own language and mental content. Using a 'fuck' when the material is not genital, or using idiomatic phrases that don't match the drive content is ill-advised for the reason I have outlined. Talking graphically with a patient represents an authentic attempt to closely follow the nuances of a speaking body in distress. It is also a body that is used as a weapon. There is a caveat to speaking closely to the drive derivative: it should not be attempted when intense affect compromises the therapist's and the patient's ability to think.

Violent patients bring their bodies into their psychic lives in overt ways. Paying close attention to how a patient uses their body in the consulting room, how a patient dresses, what adornments they wear, what tattoos or piercings they have, how they cut their hair, what they smell like, if they use the toilet in the session are important entry points for association and articulation. This is equally important when it comes to the patient's body outside the consulting room: their sexual lives, their personal habits, hygiene routines etc. The violent patient's body speaks loudly of their pathological thirdness. Considering that violent patients use their bodies to discharge their defensive violations and violence, it is inconceivable that it be left out of the therapeutic conversation.

7.6.3 Working in three dimensions with violent symptomology: the subjective, the inter-subjective and the objective

All of the clinical material I have analysed in the thesis has involved threatening dynamics in the transference. This happens when the pathological third has been evoked in relation to some threat posed by the content of the session. Similarly, when patients report on their violence, what the clinician hears it not the violence per se, but its reconstruction in the symptomatic shape of the pathological third. After the primary business of affect regulation and establishing an atmosphere of thoughtful calm, analysing these threatening and destructive moments in the transference is paramount. Technically I have not found it productive to approach destructive transference by taking the forensic psychiatric approach. In these approaches patient and therapist seek external triggers for the violent and threatening behaviour in order to establish causal pathways. In my experience

patients are most eager to locate causality as an external sequence precisely because it elides the mind. Nor is it helpful to focus exclusively on the cognitive-affective underpinnings of these dynamics, as is the case in some applications of mentalisation-based treatments. Focusing on analysing the interpersonal dynamics between victim and perpetrator, therapist and patient, including the mentalisation-based technique of hypothesis-generating about the mind of the other, is only partially helpful. Important in the analysis of destructive dynamics is to link the external, the internal and the intersubjective. Causal pathways to violence are most authentically conveyed and understood as a dynamic interplay of subjective, inter-subjective and objective dynamics. This means that part of the frustration of a comprehensively analysed destructive act is that it cannot ever be complete. The patient can never fully know the mind of the other, nor can he ever fully know his own mind. Giving a patient the idea that this is possible diminishes genuine understanding (which includes not understanding some things) and lends itself to the omnipotent defences. Even a comprehensively understood destructive act faces the limits of the unconscious. And it is here that the most productive opportunities for thinking lie.

7.6.4 Working associatively with violation symptomology: speaking with the unconscious

The unconscious facets of the violent patient's life are an important engine for understanding and transformation. Violent patients have often been through the psychiatric and psychotherapeutic mill. They may anticipate what mental health professionals are going to say. The violence and psychopathology sector abounds with practical, sensible advice and truisms. These insights often feel rote. In my experience these practical inputs help significantly, but only to a limited degree. Mentalisation approaches bear more productive fruit, but still fall short of giving a patient a potentially transforming experience of her mind. To be interested, surprised and curious about unconscious content is a most desired outcome for violent patients. A violent, thick-skinned narcissistic man in his early twenties complained over several weeks about his tinnitus. The tinnitus had begun after he had been assaulted outside a night-club by several bouncers. He complained about

the discomfort, he was furious about the assault and he was particularly disgusted with my wholly ineffectual psychotherapy. His belittling and undermining complaints signalled that I was being unfavourably compared to "real doctors" who would be able to help him. I asked him to listen to the sound he was hearing and try and tell me about what came to mind. He looked at me sarcastically and a few moments made a loud and shrill atonal sound; an 'Eeeeeeeeeeeeeeeeeh!'. He gave me quite a fright and I jumped. The patient found this funny and laughed for the rest of the session. I felt humiliated and his laughter made me smart with rage. His half-hearted association to the sound was a siren. The following session he casually remarked on a strange coincidence, he had dreamed of the exact sound he had startled me with the previous session. In the dream the sound had come from a big black car. His associations to this led us back into the story of his assault where the bouncers had been leaning on a big black Mercedes Benz after they had beaten him. They were laughing at him as he tried to stand up. This was a source of great humiliation for my patient who felt utterly powerless. The laughing was 'the most terrible sound he had ever heard'. When I pointed out the link between the tinnitus and the humiliating sound of the laughter, (connecting it with my own rageful and humiliated feelings in the previous session) my patient became pensive – an extremely rare state of mind for him. Although he never explicitly mentioned tinnitus again, I often wondered if he had experienced any relief from the symptom. From that session onwards, my patient would frequently highlight his bodily ailments and bring numerous theories to bear upon their meaning.

Another patient whose perverse symptom was to render herself unconscious to be raped was describing how tired she was feeling in the session. I was also feeling like I was barely able to stay awake. I asked her to associate on being tired. She told me that she would like to curl up and go to sleep on the chair. She noted that I would be in the strange position of being able to watch her sleeping. She imagined that I would laugh at her and write "slut" on her forehead. I would then take a picture of her and post it online where it would go viral. The extended reverie was intriguing and bore a striking resemblance to the structure of her masochistic offering of her body to her rapists. I asked her if she imagined her rapists would do the same. She agreed with this saying that she would have the last laugh because

they would have posted evidence of their crime and would be arrested. I felt this indicated the emergence of a reflective function that could identify that what happened to her on these nights was criminal. This was the first time that any such understanding had arisen. I was also able to hear an overt anger towards the abusive object. It was also the first indication that such an object might be stopped/arrested.

Destructive dynamics in the therapy reproduce the destructiveness of the pathological third. This destructiveness can be listened to, articulated, elaborated and transformed if given the chance to emerge.

7.7 Conclusion

For violent psychotic, narcissistic, and perverse patients, this chapter has suggested, authentic engagement with a third is threatening. Instead, such patients construct a pathological third in service of evading reality. In a sense, they conjure into reality a pseudo-third. For psychotic patients, this pathological third takes on the concrete quality so distinctive of psychotic functioning. For Mr K, his manuscript soothed his jagged affects and gave him an organized structure and meaning. For narcissistic patients, this pathological third supports the narcissist's centrality in his own universe by warding off awareness of competition and by negating triangular reality. In both of these cases, it has been argued, the pathological third holds a fragile coherence in place and regulates affect; disruption of the pathological third leads to violence in order to recreate psychic safety. Perverse patients similarly create a pathological third in order to evade reality, particularly the reality of their need for and fear of others. In contrast, however, violence is not prompted when the pathological third is disrupted, but rather violence is enacted in order to preserve the pathological third. If this difference in dynamic is indeed pervasive, it holds important implications for understanding the pleasure associated with violence for perverse patients, as well as the intractability of violent behaviour for this particular group.

Despite these differences in the relationship between thirdness and violence enacted in patients' lives, in my work with violent patients there has very rarely been a situation where violence has been enacted in the session. This no doubt has something to do with the basic containment functions offered by the psychotherapeutic setting, as well as sensitivity to registering certain cues that have signalled the risk of an onset of violence. As I have become more attuned to these cues they have started to take on a technical significance of their own. These cues have ranged from subtle shifts in the affective-relational minutia of the exchange between a patient and myself, to more overt signals of aggression and distress. What all of these cues have in common is an attempt to ameliorate or negate an aspect of the interaction that poses a threat to the patient's sense of safety and integrity. This sense of safety is brought about by the pathological third. It is in these moments that the patient's pathological third dynamics come most clearly into view.

Although violence has not been enacted, it is possible that the therapeutic relationship offers a receptacle for a certain relationship to violence to be enacted in the therapy, thereby obviating the need for actual violence to take place. Talking about violence to a therapist may offer patients a particular kind of coherence that, like the function of the pathological third, regulates affect and protects the patient from some painful aspects of reality. I would like to offer a vignette in this regard.

In one particular session I was in the unenviable (although subsequently useful) position of hearing an account of violence from a patient who had observed another patient of mine in a fight. The accounts were structurally similar but it was clear that an enormous amount of information had been lost in my violent patient's version. In the violent patient's account, he spoke of "fucking up this dude" for hitting on his girlfriend. He had spoken about punching the boy's face several times and bashing his head into the ground. The story had then meandered into the tribulations of getting into trouble from the principal and the macho interactions he had had with the other boy the day after. My other patient, an articulate and sensitive adolescent girl, reported how this young man had started the fight as a

sadistic bully, but at some point this stance had collapsed. She described how he had begun moaning in an animalistic and guttural manner; how tears streamed down his face as he was punching his victim; how terrified and disorientated he looked as his eyes rolled and spittle stained his cheeks and chin. As she explained her terror to me I found myself revisiting my own experiences of observing violent interactions. Like a lid had suddenly been lifted on my own repressions I recalled countless moments of the same type of observations. Minds slipping in and out of coherent subjectivity and the subsequent animalism of bodies behaving instinctually. These eventualities were perhaps not as dramatic as my patient described, but most certainly omnipresent in every encounter I recall. I do not believe that my patient was consciously leaving out the detail of how he "lost" himself. I believe that he could not know about it because the experience had no mind to recall it.

When I cast my mind back over the many accounts of violence I have listened to I am virtually certain that most of the time I have been listening to reconstructed and re-imagined events. The narratives of violence have an emptiness that is tricky to hear amidst all the highly charged affect and destructive excitement. Like death, violence is a radically unsymbolisable other. When violent patients narrate their violence, I suggest, I am listening to an event reconstructed by the pathological third. Often these narratives serve as threats themselves, warning the therapist to back off and be frightened, probably in identification with the damaged fragile ego. In this sense narrations of violence need to be treated in the same way that a competent psychotherapist would approach a dream – a reconstruction from the unconscious to be associated to in the hope that something of its meaning will be reclaimed from the unconscious. As with all dream interpretation its value lies in the respect it has for patients' defensive processes.

When understood in relation to pathological thirdness, it is possible to conclude that violence can be held within the therapeutic relationship, but that, precisely because pathological thirdness prevents full engagement with reality, the underlying dynamics are difficult to change. For the therapist, this goes some way

to addressing the issue of how difficult it is to prompt psychic change for violent pathological patients. Although violence can be bound within the therapeutic relationship, it may continue to be enacted in the patient's life. In taking the concept of the pathological third forward, the arguments presented in this chapter have a number of implications for therapeutic technique, as well as the limits of therapeutic change, which could be fruitfully explored in future. Nonetheless, it is helpful to posit that the pathological third emerging in the therapeutic relationship reproduces the patient's destructiveness in a different form. This destructiveness may be elaborated keeping some of the described technical approaches in mind.

8 CONCLUSION

8.1 What is violence?

Violence in the thesis is defined as a destructive act upon the body. It is coordinated and meaningfully linked to multiplicity of psychological processes and structures. Violence is linked to affects. Its primary affect is rage that is subsequently expressed through a matrix of instinctual affect systems in response to environmental factors. Of these environmental factors, object-relations are particularly important. When primary object-relationships fail in the form of disrupted attachment trauma, primitive affects, most especially rage, cannot be thought about; nor can they be linked to a representation of the world in which love and care have the ascendency. Representations of others are disturbed and partial, directly leading to an internal world in which the self is disturbed and partial. The fundamental ordering principals of subjective and objective reality, including the self-other distinction, breaks down easily or may never established in the first place. These problems are embedded in the pathological personality of the symptomatically violent individual. Violently symptomatic individuals experience the concomitant distortions in affect regulation, cognitive style and worldview which predispose him to consistently repeat his dysregulated, paranoid and survivalist bent. Violence is either re-enacted as a form of self-preservation in a malignant world, or as a triumph against it. This may importantly include sexuality in some instances, notably perversion.

8.2 A summary of the findings

This thesis has sought to formulate symptomatically violent patients psychoanalytically using the notion of thirdness as a particular theoretical and clinical lens. It has examined three psychopathological cohorts, those being psychosis, perversion and narcissism. Each of these three examinations has introduced a pathological third. The thesis has argued that the pathological third plays a role in the production of violence, and in the process observed in treatment. It has also suggested that one of the primary functions of the pathological third is to regulate unbearable and overwhelming affects. The form of affect regulation associated with the pathological third was understood to be unstable and defensive in that it produces a recalcitrant separation of psychic equivalence and pretend mode modes of experiencing reality (Fonagy, 2002). The thesis has also compared the three psychopathological cohorts in a discussion of how each of the pathological thirds produces violence.

Below is a table that presents a summary of some possible differences between these psychopathological cohorts

	Psychosis	**Perversion**	**Narcissism**
Pathological Third	Prosthetic object	Tri-bar split in the mind	Autogenic phantasy
Affect regulation	Via the organising principles of the semiotic object	Splitting of pretend and equivalence. Erotising pain and hatred. Conversion of affect into sensation.	Pretend mode negation of external reality
Primary Affect	Fear	Hate and dependency	Envy and rage
Feared Object	Reality	Core Complex	The reproductive couple

Relational style	Paranoid	Sadomasochistic	Aloof and controlling
Pathway to violence	Disruption of the prosthetic third	Expressed in concordance with the split mind	Perturbation of the autogenic phantasy

The first pathological third, the prosthetic third, is an object that has organised, or semiotic properties. The violent, psychotic patient uses these organising principles to cohere their ego. The violent psychotic patients discussed in the thesis were fundamentally afraid of certain aspects of reality. The patients described in chapter four were afraid of a thinking therapist, sexual difference and a person in authority. Affects were managed in the pretend mode (Fonagy et al., 2004) by using the organised, controlled meaning system of the semiotic object. Their relationship style was evidenced to be paranoid, and when the prosthetic third was disrupted, violence was shown to be a possible outcome. This violence was understood to be self-preserving in nature (Glasser, 1998).

The second pathological third, the tri-bar third was discussed in relation to two masochistic perverts in the thesis, Mr D in the discussion chapter, and L in chapter six. The tri-bar third was discussed as a visual metaphor describing a split in the pervert's mind. This split was argued to be in response to an infantile, dangerous, annihilating object – what Glasser (1986) has called the core complex object. This object threatened the psychic integrity of the patient's described, yet was needed in order to survive. The two cases suggested that in order to retain a connection to the object, it was necessary to split contact into a sensational and thoughtless one on the one hand, and a rigid affectless deadened one on the other. These two forms of relationship were shown to correspond to two forms of symptom that were similarly characterised. It was suggested that the two parts of this split corresponded to these two symptomatic tracks. These cases proposed that the two truncated contacts with the dangerous object manifested in the therapeutic relationship and the symptomatic violence. The affects of hatred and dependency

were pathologically regulated by somatising and eroticising them in the sexual symptom; and intellectualising them in other symptomatic expressions of violence. The sensational track was associated with psychic equivalence and the rigid, affectively deadened track was associated with pretend mode (Fonagy et al, 2004). It was suggested that both symptomatic tracks lent themselves to violent symptomology. The relational style of the masochistic pervert is experienced as sadomasochistic, although the psychodynamics underpinning the violence was understood to be primarily self-preserving (Glasser, 1999).

The final pathological third introduced in the thesis was the autogenic third. This pathological third was associated with the violent narcissistic patient. Two patients were analysed, Mr L in chapter six, and A in chapter seven. These two patients suffered from an unconscious conviction that the world was of their own making – especially the reality of the self. The autogenic third distorted the reality that a reproductive couple had come together and created them. As long as this unconscious phantasy remained unperturbed the patients described were dismissive and exploitative in their relationships, including in the psychotherapeutic encounter. Envy and rage were regulated pathologically by negating the significance of others. It was proposed that in this unperturbed state the narcissistic patients described operated in pretend mode (Fonagy et al, 2004). However, when the autogenic third was contradicted by psychosexual reality, the patients resorted to symptomatic violence in order to restore it. This violence was understood to be sadomasochistic (Glasser, 1999).

8.3 Implications of the research for formulation, diagnosis, technique and clinical practice

In the following section I would like to spell out some of the implications and contributions of the research for my own work with violent patients. I offer a conceptual distinction between violence, an act associated with the collapse of the ego integrity; and violation, a destructive act that is a correlate of the pathological third. I understand violence to be self preserving, and violation to be sado-

masochistic (Glasser, 1998). I then describe some of the diagnostic and technical contributions that the thesis has made to my clinical practice with violent patients.

8.4 Contributions of the thesis

The thesis has contributed to the area of violence and psychoanalysis in three ways. Firstly, the thesis offers a novel way of formulating, conceptualising and comparing violently symptomatic patients using the psychoanalytic notion of thirdness. The concept of thirdness has allowed the researcher to draw upon different schools of psychoanalytic literature, and bring them to bear upon the task of thinking about violent patients. It has allowed for creative language and thinking to proliferate with a patient population that generally forecloses on thoughtfulness and mindful play.

Secondly, the thesis seems to contradict the notion that there is a form of violence that is mindless (Fonagy, 1995; Glasser, 1999; Perelberg, 1999). This form of violence is associated with self-preserving violence, and violence in which the patient cannot mentalise. While the thesis supports the notion of a perceived-mindlessness on behalf of the patient in the act of self-preservation, I suggest that the term is somewhat of a misnomer. In terms of a non-mentalising mind, the thesis has shown that these capacities are defensively and developmentally disabled as an unconscious strategy to manage a disturbing object. It does not go far enough to suggest that mentalisation has not been acquired because of adverse infantile circumstances; rather it seems more accurate to suggest that non-mentalising states are *specifically* and *idiosyncratically* compromised in accordance with the violent patient's psychodynamics.

Thirdly, the thesis demonstrates that particular forms of mentalising are associated with the pathological third across the psychopathological cohorts. Pretend mode (Fonagy et al., 2004) is associated with the prosthetic third, the one side of the split mind in the tri-bar third and the autogenic third. These states deal specifically with a disturbing facet of reality. Psychic equivalence is associated with

violent action. It is perhaps not enough to say that the violent patient cannot mentalise, but in addition the clinician/researcher needs to interrogate how and why it is that he or she cannot think about feelings. The pathological third is the patient's defensive attempt to approximate affect regulation and mentalising. The psychotic patient affect regulates and mentalises using the prosthetic third. The narcissistic patient mentalises by organising his psychic life around the autogenic phantasy. This position strenuously negates all those aspects of reality that produce overwhelming affect. The pervert keeps psychic equivalence and pretend mode separate by splitting her mind. Disturbing reality is truncated and therefore never completely known in its full horror.

Finally, the thesis concludes with some formulation, diagnostic and technical implications drawn from the research. These have included distinguishing between violence and violation, understanding the fluidity that may exist between self-preserving and sado-masochistic expressions of violence, the importance of mentalisation-based approaches, the necessity of combining subjective, intersubjective and objective understandings to bear upon patient material, and finally the importance of working associatively with patient material in order to hear the unconscious of violent symptomology.

8.5 Limitations of the research

The research makes some prelimminary comments about technical approaches to violence. It is a limitation of the research that these are not developed further. This is an important potential outcome of the work bearing in mind that many clinicians avoid working with this cohort. In a country like South Africa which is beset with pandeminc levels of violence, these technical skills may contribute to general capacity to treat and think about violence. Thinking about and formulating violence has been the thrust of the work. Linking formulation to interventions, both clinically and more broadly, has not been addressed.

The primary limitation of the thesis is that is has a small sample size that significantly limits the generalizability of its findings. Although this is in keeping with phenomenological-hermeneutic method, this does not alter the fact that the

findings are relative, contextually bound and specifically linked to the immediate material in the therapeutic process in each case. It remains to be seen if the findings have relevance for other researchers and clinicians.

It is also the case that the sample is skewed towards men. Only one woman, L, is discussed in relation to masochistic perversion. It may be the case that the sample reflects a general trend in violence studies, in that men are more likely to commit violent acts than women (Felson, 2014). The sample was also skewed in that only one child case, a boy, was discussed in relation to psychosis. Although I have treated numerous violent children, psycho-diagnostic systems tend to reserve pathologising violence in juveniles because they are regarded as not fully developed (Fonagy et al, 2004). Discursively, there is also a tendency to focus on children as victims of violence, rather than as perpetrators (Geffner, Spurling and Zellner, 2003; Jenny, 2011).

I have opted in the thesis to use very precise and limited aspects of the clinical material to illustrate the pathological third. This may leave the reader in a position of needing to have a great deal of trust in the selection of the material and its relationship to the vast amounts of clinical data not included. I recognise this as a limitation within the context of an attempt to preserve confidentiality and attempts at stylistic parsimony. This is an endless tension in clinical writing which I have tried to address in the numerous supervisory inputs and methodological procedures as outlined in the method section. I cede that it is decidedly imperfect, and that the thesis consciously engages with such difficulties without necessarily resolving them.

The thesis has also not taken into account socio-economic and cultural-historical factors in the cases analysed. This may be regarded as a serious critique of psychoanalysis in general (Frosh, 2016), but also pertains to this thesis. The research, which was conducted in South Africa, does not in any way acknowledge the violent, traumatic history of the country; nor does it address the devastating contextual deprivations that have affected the stability of social systems. These

factors are prevalent and significant in the production of a social epidemic of violence in South Africa (Ashforth, 2005). This is noted as a significant limitation of the thesis.

The thesis relies heavily on metaphor, and metaphorical language. Although the thesis has argued that this strategy is important in forging understandings and creative play with violent patients, there is the risk that the metaphors may lead to abstractions that are no longer relevant to clinical evidence. This is not a new problem in psychoanalysis. Freud (1915) himself cautioned against the abstraction of metapsychology, saying that the clinician should always pay close attention to direct clinical evidence. It would be a mistake to assume that things like the prosthetic third, the tri-bar third and the autogenic third exist as things in and of themselves without linking them directly and rigorously to instances of clinical interaction.

8.6 Suggestions for further research

The main potential outcome of applying thirdness in formulating violence lies in what it may offer to technical approaches to treating violent patients. Technical utility has been alluded to in the thesis but has not been fully developed in relation to the formulations. In the work with violent patients described in the thesis, there have been numerous technical innovations and findings that have not been within its scope to describe. It is flagged as potential for further exploration and research. As I have mentioned in the limitations, the cohort of patients described in the thesis are often avoided by many clinicians. Bearing in mind the pandemic levels of violence in South Africa, this avoidance is costly and has dire consequences. By providing clear, pathology-specific, formulation-related technical research, it is hoped that treating violent patients may be less daunting for clinicians. If formulation represents a higher order of clinical thinking, and thinking itself is ameliorative against violent action; further research in practical applications of formulation is inherently valuable.

Limitations regarding the small and skewed sample may be addressed by further research that examines different patient cohorts than those described in the thesis.

It is my hope that further research will integrate other psychopathologies within the framework of thirdness. Different socio-economic and gender variables would also potentially be fruitful additions in further research. In practical terms, this would mean a clearer focus on women and patients outside a university clinic and private practice setting. Researching clinical interventions with violent children is also suggested as an important focus area considering the potential benefits of early intervention. In a related point, infants raised in violent settings and with violent parents is flagged as an important additional area of potential research.

It is suggested that notions of thirdness and violence have significant potential to be applied to social violence and criminal violence specifically within a South African context. This would go someway to addressing one of thesis' main limitations, that of its social acontextuality. Despite the pandemic proportions of violence in South Africa (perhaps because of this fact), violent action tends to be regarded in moralistic and binary terms (Hamber, 1998). There is a deep-seated defensive need to split perpetrator from victim, good from bad, and to divorce acts of violence from their history and context. On the other hand, there are social discourses that vaguely posit amorphous links between apartheid and violence without the necessary analytical rigour to provide mechanisms of intervention (Simpson, 1993). Thirdness is a concept that inherently bridges the divide between what is most intimate and familiar, to that which is structural. In this sense, it may be a useful tool for these analytical purposes.

Finally, it would be valuable to link the metaphorically-laden concepts in the thesis to other forms of positivistic enquiry to the extent to which this is possible. Triangulating these findings with research from other disciplines, such as psychiatry and public heath would potentially allow the findings to be interrogated and potentially integrated into epistemologies beyond the subjective and the metapsychological.

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10 APPENDIX 1

CLIENT CONSENT FORM

This document concerns the acquisition of your consent for the use of confidential clinical information from your sessions for academic purposes.

I am writing a PhD with the University of the Witwatersrand's Psychology Department. I am being supervised by Dr Gavin Ivey. My PhD topic is on "Violence and Thirdness". I will be examining how violence (directed at others and towards the self) relates to "thirdness". Thirdness refers to a psychological process that facilitates a meaningful relatedness between people (including between client and therapist).

I_____, hereby give Clinton van der Walt permission to use my session information for his academic purposes. I acknowledge that this information will be carefully disguised so as to protect my anonymity.

_____ _____

Client's signature Clinton van der Walt

11 APPENDIX 2

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Walt

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H0 91102**
PROJECT	Violence and thirdness: An examination of violent behaviour in obsessiona hysterical and perverse patients
INVESTIGATORS	Mr C van der Walt
DEPARTMENT	Psychology
DATE CONSIDERED	13.11.2009
DECISION OF THE COMMITTEE*	Approved unconditionally
NOTE:	

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 18.01.2010 **CHAIRPERSON** ..... (Professor R Thornton)

cc: Supervisor : Prof G Ivey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES