EFPP JOURNAL

ON BEGINNINGS

EFPP Psychoanalytic Psychotherapy E-Journal

Editors in Chief: Sanem Tayman Eksin & Malby Oliver

Editorial Board: María Eugenia Cid Rodriguez - Odile Gavériaux - Alix Vann-Nicollier

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Sanem Tayman Eksin
EFPP Adult Section, Delegate member for IYPPD İstanbul, Türkiye
sanem.tayman@yahoo.fr

Malby Oliver
EFPP Child Section, Association of Child Psychotherapy, London, United Kingdom
malby.oliver@hotmail.com

"There is no such thing as an infant" (Winnicott, 1960) separate from its environment. It is the environment-mother that carries the baby, physically and psychologically, long before the baby's arrival into the world. In the same line of thought, the relaunch of the EFPP e-journal and publication of this inaugural issue have been possible because of all those involved held it in mind. Our gratitude to the EFPP Board, the past and present Editorial Committees for their vision, the authors and contributors and, of course. the EFPP membership.

We are delighted to publish this first issue of the EFPP e-journal 'On Beginnings'. It includes four different sections: a clinical section, an institutional section, a study day section and a book reviews section. This issue includes papers from the first three sections.

The Clinical Section includes Nadia Kostrzewa's poetic, rich and powerful paper on the first encounter between the psychoanalytic psychotherapist and the patient. Nadia offers a detailed account of her contemplations of the unfolding of this initial encounter moment by moment as a potential space, both lived and created simultaneously.

The second clinical paper is by Darina Ilyanina and Lev Savinykh on their experience of facilitating a hybrid (in person and online) psychoanalytic psychotherapy group and their understanding of the split processes that ensued linking them to the interplay of the hybrid nature of the physical setting, group processes and the external split in the context of war.

The Study Day Section features Ninel Beketova's presentation in the Adult's

Section study day on the understanding of psychic retreats in the work with oncology patients. By referring to the concept of 'Dybbuk' in literature, films and arts and offering a detailed review of a clinical case study, the author presents her discovery of the use of this retreat and explains how it can help the patient "transition from the world of the dead to the world of the living".

Clelia De Vita's response to the paper opens us new perspectives about possible and impossible grieving and withdrawal processes.
Meanwhile, in his discussion Hansjörg Messner reviews the clinical case in relation to themes such as femininity and melancholia.

In the Institutional Section, while Cristina Călărăşanu introduces the Romanian and Bulgarian regulations on psychoanalytic psychotherapy, Chantal Hauzoul introduces the Belgian legislation on psychotherapy.

Finally, we would like to take this opportunity to announce the theme of the next issue of the EFPP e-Journal, "Crossing Borders" and invite you to submit your contributions.

Clinical Section

Beginnings. Before Everything Else.

Nadia Kostrzewa

Psychologist and Psychoanalytic Psychotherapist EFPP Adult Section, Full member of the Polish Society of Psychoanalytic Psychotherapy, Bydgoszcz, Poland

nadia.kostrzewa@gmail.com

Before I am swept away by the current of the narrative, there is first the sound then the image.

The very word *"before"* situates both myself and the patient along a temporal axis, one that presumes a point, a crossroads, a knot where our shared story takes root. The patient calls or writes; appears, though not yet bodily present in the tangible space of the consulting room. For now, they exist only as a sound, in spoken words through the phone. And while waiting. I hear the way they breathe, sense the rhythm and pulse of their sentences at times uncertain, at others urgent. A summons. An invitation. *"Alright, I'll come"* says the voice on the line, and this time it lands like a threat. A shiver crawls across my spine. What is this complementary reaction within me? I feel a knot tighten in my gut, a constriction in my throat. Sometimes my heart races; joy floods me, even exhilaration. *He called!* A deep, velvety voice. I feel stroked, as though he smoothed a palm over a shaved head with only his voice.

Philosopher Brian Massumi (2013), in contemplating how we receive stimuli from the outer world, speaks of *the mystery of the missing half-second,* a sliver of time between stimulus and reaction that resists precise definition. Drawing from his idea, Agnieszka Dauksza (2024) while exploring how we interpret art, especially literature, writes about a *relational interpretation*, a simultaneity of neurobiological processes experienced as synesthetic sensory registration. A kind of *attunement*. A constant sensing of thought and a thinking-through of sensation. In such moments, meaning does not emerge as a product of conscious intellectual labor, there is no search for pre-existing

categories. Instead, we encounter an irreducible mass of sensation. Its nature seems to carry the charge of excess, or of estrangement in that eerie combination Freud once described as *the uncanny*. It is only upon meeting what stirs us, what feels both alien and familiar yet resists conceptual grasp that we are nudged toward mystery, and pulled forward in motion *toward*. Dauksza writes:

"Felt meaning sometimes called 'proto-meaning' or 'meaning-in-process' is a pre-reflective, nearly instantaneous response to a given experience. It is intuitive, pre-verbal, a kind of seed of thought (…). Typically, what arises at the surface of consciousness is a vague, sometimes blurred, sometimes vividly intense impression. Most often, this is a transmodal amalgam in which the senses remain undifferentiated" (Dauksza, 2024:556).

This state precedes differentiation and conceptual thought. And while Dauksza, as a literary scholar, examines how we interpret art, it seems she is describing through a different lens what we might call a *first impression*, and what psychoanalysis would recognize as a pre-verbal, unconscious process of perception. Unconscious, but no less experienced. This mechanism, however, is not one directional. We do not merely absorb reality like passive recipients of surrounding stimuli. Rather, we are perpetually generating affective responses to whatever and whomever we encounter. In this way, the world not only happens *to* us it also *touches* us. And it is precisely this intersection that Winnicott likely had in mind when emphasizing the vital interplay of subjective and objective. The *potential space* (Winnicott, 1971) inseparable from illusion bridges reality and fantasy. It forms the bedrock of infant experience. And it is the wellspring of creativity. For the purpose of art is not reproduction, but creation.

I am drawn to how philosopher Martin Buber described this in 1925, during a lecture in Heidelberg on the nature of creativity (Glinkowski, 2011:177). He observed how children learn to speak not through imitation alone, but through the forging of words as if they were brand new entities, born of sensation. Words must be *tried out*. In Polish, we often say a child has *discovered* a new word, the same way one might discover the taste of a tomato, or the syrupy sweetness of a late August pear. The word is not repeated, it is found, savored, or perhaps more precisely,

created, saturated with the originality of personal sensation. Buber (1992) writes: “One by one, the sound-images rise from the vibrating throat, from trembling lips, into the surrounding air while the whole small, vital body quivers and shakes, caught in the paroxysm of emerging selfhood” (2011:177). And so, we begin to see how this *in-between state* gives rise to a moment when the word though borrowed, handed down from others becomes a singular, idiomatic creation. To paraphrase Winnicott: it makes no sense to ask who invented the word. It belongs to millions before me, and yet, it is wholly mine. Still, Buber adds a crucial caveat: without the mother’s presence, the infant would remain isolated in its creation its acts of expression, stripped of meaning. He writes: “Meaning does not reside in things, nor do we place it there. It may arise only between us and the world” (2011:177). Just as we do not uncover meaning in another person as if solving a riddle pre-planted within them, meaning *happens* between subjects. In psychoanalysis, we are used to the idea that the work involves, among other things, the co-creation of meaning. And, yes, this requires protected time and space. But what captivates me is the very beginning. That first encounter, when patient and analyst meet for the first time. Before a single word is spoken, both of us inhabit the same silence, gazing at one another, co-authoring that enigmatic impression. An aesthetic impression.

It is like stepping into an empty museum hall, where a massive Kiefer canvas dominates the white wall. Something golden and blue coils and pulses. Rough, broken reeds emerge from the mud to form soft shapes. Something spirals within me, just as it spirals through the air. The museum spins, the whole city spins, and my body pricked by stubble spins too. Half a second passes. The blue deepens into azure. The gold reveals itself as a broom handle, jutting from within the tangles. I understand nothing and, yet, the image holds me in its embrace.

Christopher Bollas writes that the aesthetic moment arrives as a flash, and quoting an American literary critic, adds:

“What distinguishes an aesthetic experience from a cognitive or moral one is its self-sufficiency, its power to trap us within itself, to prevent us from moving beyond it in pursuit of further knowledge or practical action” (1978:12).

Can I remain in that moment? How quickly will I want to leave it behind compelled by

the urgent impulse to do, to act, to *understand*?

When I opened the door, he was standing there. And he *happened* to me. A pressure gripped my gut, something warm spilled across my skin and beneath it. A pleasant tingling, erotically charged, hummed in my ears saturating, overwhelming. He was tall, broad-shouldered; for a fleeting instant, it seemed he had swallowed all the light from the stairwell. What remained was a soft dusk, and the contours of his figure blurred into it. But his presence was unmistakable dense, immediate and it elicited hesitation in me. My hand, as if no longer mine, gently drew the door half-closed instead of fully open. My body, in its first impulse, longed to step back not in panic, but in a reflexive, almost cellular recoil. He stood motionless, waiting. After a few seconds or perhaps only a flicker of lashes, I let him in. We entered the space of consultation. I was myself, not only in the constructed sense of a professional identity, expressed through my manner of conducting a first session. I was present in my own idiom breathing in my rhythm, choosing silences that were mine. I reached for words and discarded others. I sighed. I swallowed audibly. *I was not anyone else*. A strange thing to realize; yet that thought lingered. I heard him speak. I followed the narrative thread. But the core of my sensing had shifted as if it still lingered at the threshold, in the liminal space between the world he had emerged from and the one where I waited. Something had already occurred suspended in that half-second of bodily recognition though we were not yet conscious of what. There were no words, no language yet capable of giving it form. There was only the *us* held in gazes, in reverie, in the vivid aliveness of our bodies. Later that day, returning to the consulting room for my afternoon sessions, I felt an echo of that earlier encounter dimmed, but still perceptible. It was the scent. His scent lingered in the enclosed space. It had been present from the start an elemental aspect of his arrival. It was to this, more than anything, that I had reacted. A strange, uncharacteristic intensity for I am not someone acutely attuned to olfactory stimuli. And yet, I sat down and breathed in an absence that felt utterly, almost scandalously, present. The body is not there/the body is there.

In her Nobel lecture, Olga Tokarczuk (2020) recalls looking at a photo of her mother, taken before Tokarczuk was born. She recounts the conversation they had:

"When I asked her about the sadness in that photo — and I asked often, always wanting to hear the same answer — she said it was because I hadn't been born yet, and she already missed me.

- How can you miss me when I don't yet exist? I asked. I already knew longing comes after loss — that it is born of absence.
- But perhaps it's the other way around, she said. If you miss someone, maybe they already exist". (2019: 2)

Sitting there, I thought: *If you feel someone — they already exist.*

I remain captivated, even haunted, by the nature of such feeling. Feeling, un-feeling, over-feeling. A premonition, a post-sentiment.[1] It brought to mind a theory I once encountered in university Theodor Adorno's (1997) notion of the *aesthetic shock.* Originally developed to describe the encounter with modernist art especially in music Adorno's concept describes the rupture of habitual perception. The work enters the sensorium not as object, but as an event dismantling the ego's stable coordinates. It refuses distance. It invades. It leaves us vulnerable to a kind of inner unhousing. This shock can regress the self, dissolving ego-boundaries until they no longer hold back the torrent. We do not respond to it in dialogue. Rather, in parallel processes artist and witness, patient and analyst unfold into a *simultaneous now*, saturated with sensation. No wonder we recoil. No wonder we flinch. Is that not what art does to us? Is that not what patients do? We might call this unconscious communication whether driven by a compulsion to speak, or by projective identification. But what draws me is its aesthetic dimension, this shared, pre-verbal state that so often resembles a work of art. If we follow this intuition, perhaps psychoanalysis begins not with interpretation, but with a creative act. With an aesthetic moment. With a *shock*. Before there is language, there is *This*. Sometimes as seismic as a storm. Sometimes no more than the tremor of a breath. Is *This* the precursor to Bion's *O*?

Art and aesthetic experience lives at the confluence of beauty and terror. Which brings us to Freud's (2013) *Unheimlich*. In Polish: *niesamowite*. In English: *uncanny*. But in German, the word carries *Heim* home within it. As Ewa Kobylińska-Dehe

[1] A play on words difficult to render in English, built around the Polish prefixes 'przed-' (before) and 'po-' (after), which generate new words suggesting altered or temporal modes of feeling.

(2022) writes: “Heim is not merely ‘a place to live’. It appears in terms like ‘orphanage’ or ‘nursing home’ liminal, tender, sorrowful homes. What is alien threatening our domesticated identity. And so, it must be exiled repressed. Heimlich becomes unheimlich. But there’s another twist: Heimlich also means secret, hidden. And unheimlich? the sudden unveiling. The tearing away of the veil. What was meant to stay buried, flares into view. The veil protects. It allows us to project, to keep the object at a safe remove. It is not the mystery itself that wounds but its abrupt exposure.” So, what, then, was revealed on the threshold of my consulting room? What shimmered with pleasure and beauty and what shadow crept in, the one we would come to face across years of analytic work?

What is the clinical value of this way of seeing?

I stand with Bollas, who reminds us that our first aesthetics are born from the mother’s idiom from the form she gives to experience (Bollas, 1978). A form that contains but also transforms. This early imprint sensitizes us to future encounters and shapes our subjective being with the object. So, the moment of *This* -this sensory amalgam, this mutual creation- carries within it a foreshadowing. Aesthetics precedes hermeneutics. And if we are fortunate, transformation follows sensation not in a single act, but in a continuous unfolding. The first encounter stayed with me. At times, I even wondered perversely whether all that followed was merely annotation. Together, we descended into dreams, hallucinations, memories filled with scent, with the stink of faeces and longing, withdrawal and return, rupture and embrace. Trembling and waiting. Revulsion and the swallowing of it, lips sealed, teeth clenched. I do not know what I opened for him that day, beyond the door. But something, undeniably, remained ajar. Even if only by millimeters.

I wanted to write about the later stages of this patient’s psychoanalysis. But I find myself hesitating. This is no longer a beginning it’s more of a circling, a wandering through labyrinths. There wasn’t much light there; rather, the half-light hinted at from the very start remained steady and unrelenting.

I feel a similar hesitation when it comes to the work of Van Gogh. Not long ago, I stood before his canvases in Amsterdam. I could have said a great deal about his creative periods, his technique, the

autobiography etched into his self-portraits. That is what happens when you grow up with a mother who is an ardent lover of art. But. I felt nothing. A constant. Pleasant colors. Landscapes. Ah yes Impressionism. I even nodded: yes, yes, artistic expression. I had to walk away. Elsewhere, I stumbled upon Kiefer. And for a moment, the world trembled. And suddenly, I could feel. Of course, much has been written about his work too. For now, I'm staying away from those analyses. What I hold on to are the images behind my eyelids and the sensation they leave. Which is why I will place a period here. One that ends the sentence while also beginning it.

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Abstract

This text is a meditation on the unspeakable moment that precedes understanding a threshold, a sensation, a breath before the first

word in psychoanalysis. It begins with an encounter: a man at the door, whose presence casts a shadow and stirs something beneath the skin, a bodily knowing that eludes language. What unfolds is not yet therapy, not yet story, but an aesthetic event a silent eruption of feeling, echoing Adorno's notion of aesthetic shock, where perception is shaken free from the familiar. The essay lingers in this space: between the seen and the sensed, between the analytic and the artistic, between Freud's *Unheimlich* and the scent that remains when the body is gone. Psychoanalysis here is not just interpretation, but a co-created act of presence, an art form born from the immediacy of feeling.

About the author

Nadia Kostrzewa is a psychologist and a certified psychoanalytic psychotherapist of the Polish Society of Psychoanalytic Psychotherapy. She is the editor-in-chief of the quarterly *IDioMY-psychoanalysis and social life*, a laureate of the PTPP essay competition on psychoanalysis, and a lover of literature and wandering around the world. Her essay on the situation at the Polish-Belarusian border was included in a compilation of texts published by IPA titled *Mind in the Line of Fire*, representing a voice from Poland.

Integrating the Split: on the path from traditional to hybrid analytic group and back

Darina Ilyanina
Psychologist and Group Analyst EFPP
Group Section, The Society for Group Analysis, St. Petersburg, Russia.
darina.ilyanina@gmail.com

Lev Savinykh
Psychologist and Group analyst, GASi member, supervisor and teacher Training Centre of Group Analysis, EFPP Group Section, St. Petersburg, Russia
lev.savinykh@gmail.com

We would like to share our attempt to theoretically understanding the splitting processes in a group.

We are going to talk about our new experience of leading the group analytic group in hybrid format. In 2022, we had to use this format, because the military operation and mobilization begun in Russia and most of the members were going to leave the country. Our group was 4 years old then. We, two group analysts, jointly facilitated the group and accepted the challenge.

Paying tribute to the processes of splitting, we divided this story in two parts, Darina's thoughts and Lev's thoughts.

In this paper we discuss and think about splitting which is spreading to all society around us and every person, who we know, in some ways.

Thinking about it, we understand splitting as inability to manage object ambivalence and perceive it as a whole, and, as a result, assigning bad and good traits to an object and dividing it.

We know mechanisms of splitting can be very effective defenses decreasing an anxiety and providing a self-esteem; however, splitting always leads to falsification which makes this process dangerous.

Darina's thoughts:

Analyzing the split with the group

All we see around us now and my thoughts about hybrid groups are very connected with views of Melanie Klein and

her conception of the paranoid-schizoid position.

In her work "Envy and Gratitude" she writes:

«There are other primal activities of the Ego, which, in my view, derive from imperative need to deal with the struggle between life and death instincts. One of these functions is gradual integration, which stems from the life Instinct and expresses itself in the capacity for love. The opposite tendency of the Ego to split itself and its object occurs in part because the Ego largely lacks cohesion at birth, and in part because it constitutes the defense against primordial anxiety, and is therefore a means of preserving the Ego. I have for many years attributed great importance to one particular process of splitting: the division of the breast into a good and bad object. I took this to be an expression of the innate conflict between love and hate and of the ensuing anxieties" (Klein, M. (1975: 191). “Envy and Gratitude, and other works, 1946-1963”, The Free Press, New York, p.191). We know the process of splitting is infectious.

Its manifestations are multidimensional. One of these is formation of hybrid groups, the format which nobody could think about. What is my position about hybrid groups? If I have to choose between life and death, I would choose life. I am more a practitioner than a theorist.

When I can get back to the original offline format, I will do it, because I am sure it is better. But if hybrid format is the only one accessible, my attitude towards it is positive. Some time ago I came up, but may just heard somewhere, with new term "well-structured spontaneity" as one of conditions for a "good enough relationship" inside a loving couple. This term sounds for me as Zen - the contradiction, which brings no conflict but release. And now I can speak about the newborn term - about hybrid format as controlled enough splitting.

There is a proverb “If you can’t beat them, join them”. I think similarly: if we cannot stop the process of splitting, we should try to control it. If we had refused hybrid format in September 2022, when mobilization in Russia began, the splitting would have swallowed us. One member of our group moved suddenly at that time, and most of the others were going to follow him.

We could have been sitting in the room, where the group used to meet, and have been waiting for another person to lose like in Agatha Christie’s "And there

was no one". The hybrid format, in spite of its disadvantages, became evidence of the possibility to save a connection even in such a difficult case. And this ability to coherence transformed our group to the island of relative reliability and certainty, because everybody knew - we could be together in any case.

Equality underlies group analysis. When we meet in hybrid format, we are not equal.

We are divided into members who are in the circle and members who are on the screen (they called themselves "talking heads"). And we see the group very different from these two positions.

But I hope, that our group stays a group analytic group anyway.

The process of splitting started outside the group, not inside. It divided people into those who support the war and those who are against it, those who are in danger and who are not, and so on.

So, we could not be equal in that situation anyway and nobody asked us if we wanted it or not.

This external inequality resonated with internal processes of splitting, especially for people, who had this defense as a dominant.

A group analyst follows a group. If this group turned out in the situation of inequality, all we can do is to - keep working with it.

I suppose that hybrid format gave the group a chance to speak, to feel, to realize everything, which applies with a splitting, and to connect external and internal processes.

My main arguments for groups success are the following:

- the group did not lose any members during its work in hybrid format
- the group managed to integrate the new member
- several participants got important improvements.

I suggest getting back to the practice now. I collected here several significant cases, which we faced with the group, and I would like to share them with you.

Vignette 1: Attacks on the facilitators

The main question we heard that time was: Why don't you leave? The group bombarded us with this question and one day we realized why: there was a huge anxiety about survival, in metaphorical and in direct way, because not everybody had a chance to leave. And we made a decision to give the answer: we stayed in Russia.

It stopped a wave of panic, but gave a beginning for a new process. The group was swinging like a pendulum from fear that the conductors had opposite political views to fear that we could die while staying in Russia.

One woman said: "I am seized with sadness and fear, when I imagine that all of us are in safety and only Lev and Darina stay in Saint-Petersburg. It is a beautiful, but senseless sacrifice".

When the military operation started, Russian media began using a new symbol - letter Z (“za voinu” which means “for the war”) to show those who support the war.

Participants constantly tried checking my political views. For example, they asked: we see, you have sneakers "New balance" with letter Z on them (which actually means letter N but not Z). Do you support the war?

It lasted till our group managed to digest all of it and it was expressed in one story. The young woman, Eva, spoke about her mother and her political views, which were absolutely different. Eva could not stand this fact. She even felt physical pain. She said, that if someone had a different point of view about war, or even had the same but not so strong, it destroyed everything good which he or she ever did. Speaking in the language of object relations theory, the good object has been totally destroyed. So the main problem is that in case where mother or conductors have opposite opinions, the good object protected with all her might can be extremely damaged.

Melanie Klein wrote, that some infants, who did not get a breast too long, could refused of it, when they got it. It is too long period of time for these infants, and they spoiled good object inside with envy and hatred during this period.

Maybe for Eva this difference was too big, and made too long distance between Eva and her mother.

As a result of group work Eva, and the rest group with her, managed to accept the idea, that she loved her mom and would love in the future, that she was grateful for all good primal things, and that political views were secondary things, but important, of course.

I need to say, that everybody in this group had troubles with their parents. And this turning point helped them to move to the side of accepting differences, to the side of ability to stand ambivalence. As a result, three female participants made big progress in their relationships with mothers: they gained more warmth and freedom, and became less rejecting.

Vignette 2: A newcomer

It is difficult to say now, what made us accept the new member in such a hard moment, at the beginning of mobilization, and when another newcomer had not integrated into the group completely. Later, I regretted letting this happen because it was the first time after 5 years of working, the group created not one but two scapegoats.

There were two reasons to accept Olaf: we really needed another male member and Olaf really needed group therapy.

We could not wait, because Olaf was going to leave, and we wanted him to join the group offline before his leaving. The group had been working in hybrid format by that time already.

The group discussed his coming and they said: if he has different political views, he must go away.

Olaf's political views were the same, but he had the other unique difference: he was 25 years old, and other members were about 30.

This group were very tolerant for many years. Many times, they asked us to invite some participants who were older or younger. And now they started to say again and again that: "Today adolescents are stupid, boring, useless, and only waste our time".

When Olaf gave his very relevant comments, as conductors thought, other members started to laugh and rolled their eyes.

Olaf seriously tried to cooperate with the other only man in the group, David, who just moved to Kyrgyzstan. David deprived him, not with aggression, but with no compromise.

I do not know how Olaf managed to stay with the group. When it was too hard for him, he did not come, not very often. And he always tried to do something good for others.

At some moment our interpretations toward realizing that Olaf only became a container for the group's weaknesses and worthlessness, and toward siblings' rivalry, brought a result and the group could understand what was going on and accepted Olaf to their circle.

Another newcomer, Sofia, who had joined the group some time before Olaf, was quickly attacked by women because she had a husband and a child, while other women did not. Sofia had been trying to cooperate with David, the only man at that moment, because he had a family too, and was attacked even stronger, with envy and jealousy. The group could not

digest this situation at that time and just dropped the subject. And Sofia felt deprived, and it was a repetition of her family's script. When the mobilization started, Sofia's husband sent her and their son to Turkey, for their safety. He could not go with them. New wave of envy arose, and it was completed with paranoia about her rich husband. They began to think that he was a special services agent, and of course, he would come and put other members in jail.

Olaf represented the group's worthlessness. Sofia became a symbol of unattainable desired things, and the group hated her like her sister in her childhood. In one session without Sofia, the participants managed to pour out feelings, to speak sincerely and to become aware of their envy. The situation became better after that, they could speak with Sofia about it in a soft way. Sofia could speak about deprivation. The projective identification of a "scapegoat" was partly neutralized.

Vignette 3: The resistance of the facilitators

When we started to work in hybrid format, at first the group felt euphoria, because David and Sofia, who had left the country, could stay with the group. But euphoria finished and attacks on the equipment began. Our group stopped to discuss the war and session by session spoke about the inability of conductors to organize good internet connection. They were right. It took us about one month and half to find suitable technology.

There were no reasons for not doing it earlier. I think, it was our resistance.

At first, we worked using a laptop, without external microphone.

Both online and offline subgroups complained about quality of sound and video. The offline subgroup had aggression towards the online subgroup, they felt that online members were excessive and only wasted a limited resource of the group.

The online subgroup felt offended by the offline, when they spoke at the same time, because they could not hear well and felt deprived.

We were listening to it and did nothing. We only felt helplessness. Then we could realize this projective identification and we could buy equipment, a good laptop and microphone and a large screen. It was not a panacea, but we had normal conditions for speaking and trying to integrate these two subgroups. Now members can criticize this format and

express gratitude to it at the same time, because it is very important for all of them - to know that they can stay with the group as long as they want.

Vignette 4: Session without facilitators

The group started actively discussing the possibility of a session without conductors before summer holyday.

I thought the group wanted to take away from us a magic wand to control the splitting and begin to control it by themselves by splitting members and conductors. Maybe it is envy too, but for me it is a positive dynamic like this: " Conductors found some way to manage with splitting, we want to find our own way".

We decided to let the group meet without us and offered to do it at the end of September. After that decision the group, in spite of some anxiety about their ability, felt gratitude to us as we trusted them and felt more confident in their power.

Lev's thoughts:

Containing the Hybrid Group

I first heard the word "hybrid" from my grandfather when he was grafting one variety of apple tree onto another. The new hybrid was supposed to combine the best traits of both varieties – to be more frost-resistant, for example.

The Motivation for Hybrid Transition

The motivation of the conductor enabling the transition to a hybrid format is crucial. When mobilization was announced, some members had been part of the group for 4 years and did not want to leave it, despite relocating. As conductors, we took the risk of trying this new format because it was the only chance to preserve the relationships the group had worked so long to build.

As mentioned earlier, the hybrid group emerged due to external pressures while we, the group conductors, wanted to preserve the group. Additionally, we had experience running groups online during COVID. Furthermore, immediately reverting entirely back to online would have symbolically meant returning to the COVID era for the group.

Technical Setup: A Prerequisite

We paid significant attention to testing equipment and connectivity. Technical tools are a necessary condition for a hybrid group. Therefore, we first addressed the technical issues by installing:

* A 55-inch TV screen

* A microphone capable of covering the entire group room (over 20 meters)

* Powerful and reliable Wi-Fi

* A camera that could capture everyone in the room simultaneously

Additionally, the hybrid format introduces a connection lag. We learned with the participants to account for this to avoid talking over those online or offline. If two people in the room speak simultaneously, Zoom interprets it as noise and does not transmit it clearly to those online.

All participants had previously seen each other in person and had a sense of each other.

Early Destructive Phenomena

The first destructive phenomena appeared shortly after starting the hybrid format. One participant struggled to accept it.

Vignette 1: Marina

Marina, a group member, remained silent for most of the session with a displeased expression when the TV sound was loud. We discovered she felt the sound from those online was drowning out the voices in the room. Marina calmed down when the volume was lowered. However, she remained in a comfortable position on one "side," refusing to accept the reality of "siblings" existing in another part. This illustrates how jealousy towards group members in a special position can intensify hostility between the two subgroups. Sometimes, jealousy is so fueled by destructive forces – the «anti-group» (Nitsun, 1996) – that it can turn into envy with a tendency to eliminate the envied object.

Anxiety and the Group-as-a-Whole

I was most anxious about whether we could preserve the group as a whole under such different participation conditions. We visit those online "inside" their screens. Those online spend up to an hour traveling to the group but have the opportunity to prepare for the group on their way.

Theoretical Framework: Bion, Container-Contained, and the Group-as-a-Whole

According to Bion, O exists, and we can never fully grasp or understand it, but we can experience and become aware of some part of it. Foulkes' concept of the "group-as-a-whole" resonates, in my view, with the concept of "containment," where

a mature group is perceived by participants as an inseparable whole. A whole that can contain split-off parts and make them more digestible.

The concept of the container is often simplified even in professional circles and described as a unified object that holds. According to Bion, the container is not indivisible (Bion, 1962). It consists of "cells", where a piece of the contained (plus uncertainty) corresponds to "cells" of the container, and there is an emotional link between them.

This idea gives us a way to conceptualize the hybrid group as a whole by placing each subgroup in a separate receptacle of the container and connecting them through an emotional link. This allows for building a shared container that unites the group as a whole.

Perception Differences and Creating Material

The group looks completely different from the online perspective than from the room. We encourage participants to verbally express their perception of the group. In doing so, we create material for the linked elements: contained1 (uncertainty) ↔ contained2. This is what will later be placed into the container.

Vignette 2: Sophia

Sophia from the online part says that her upstairs neighbor floods her apartment and refuses to do anything about it. I interpret that it seems, symbolically, there are also two floors (online and offline) in the group. I wonder what they are really exchanging with each other?

This intervention enlivened the group discussion, and participants began expressing their feelings about those online and offline more directly.

Unique Dynamics and Therapeutic Work

In a hybrid group, two teams emerge with unique dynamics between them. The therapeutic work involves exploring the splitting and the experiences it hides. During group sessions, my co-therapist and I monitored that both parts of the group were active. For working through splitting, as with the Oedipal conflict, the transition to the depressive position is a key factor. As is known, the depressive position is only attainable temporarily, with constant fluctuation between the paranoid-schizoid and depressive positions. Setting aside conservatism and fear of new experiences, I came to understand that the question of whether a

hybrid group is truly therapeutic hinges on whether learning from experience occurs in the group (according to Bion), whether the alpha-function works, enabling the "dreaming" of current experience and returning split-off parts to the psyche of individual participants and the group.

The Core Conflict: Oedipal Dynamics

As we can see in the next example, at the heart of the hybrid group, as in a classic in-person group, is always the Oedipal conflict. As my supervisor, Sue Ainhorn, mentions, groups are always about sex and death. This idea is deeply rooted in the psychoanalytic origins of group analysis, namely the interconnectedness of the life drive and the death drive.

Bion (1962) writes that envy stimulated by the breast that provides love, understanding, experience, and wisdom creates a problem that is solved by destroying the alpha-function. As a result, the breast and the infant appear lifeless, leading to guilt, fear of suicide and murder, dread of the past, present, and future...

Vignette 3: Eva

A group participant recounts real events that simultaneously feel like a dream. She and a friend are at a club, meet and start drinking with unfamiliar men. Then one of them climbs through a basement window into a basement containing an old, dirty sofa. They somehow squeeze back out onto the street. Then the participant is left alone in a swimming pool while her friend has sex with a stranger. These dream-like events make the participant feel excluded, terrified, enraged, and desperate. The men, in her eyes, are reduced to mere functions.

Group Analytic Interpretation

As group analysts, what do we see in this material? We are witnessing the experience of a primal scene, where dream and reality are confused, as if the alpha-function is not working because it has been destroyed. Hence, there is no boundary between dream and reality. We see a split group with a window that must be crawled through. Archaic fantasies about the parental couple copulating "over there," beyond the screen, are activated.

The participant herself tends to act out leaving the group by missing 1-2 sessions in a row. Presumably, in her fantasy, she

thus projects feelings of exclusion into the group and the conductors through projective identification.

Gradually, the group helped Eva reclaim her perception of men as functions and linked her dissatisfaction with men outside the group to the men within, including the conductor. This created an opportunity to explore relationships and, consequently, the possibility of periodic transitions to the depressive position. Somewhat later, this participant shared: "I scold my mother, but you shouldn't scold her," thereby splitting and projecting into the group members the ability to maintain a depressive position towards the maternal object. I commented: "You're afraid the bad will overshadow the good that exists." A year later, this participant was able to care for her mother, helping her through a long rehabilitation period after a serious illness.

Summary: Roots, Dynamics, and Therapeutic Potential

Roots in COVID and Oedipal Themes

The matrix of the hybrid group undoubtedly has its roots in the COVID era. The death instinct then prevailed over the possibilities for building traditional face-to-face communication. Online invaded ordinary life as the only alternative to complete isolation. Making virtual toasts ("chin-chin") became normal. Simultaneously, group members could see their therapists' home environments. I recall one patient who watched the background behind me very closely and actively projected her fantasies onto why I, for example, changed locations – moved from one room to another – "My wife must have kicked me out, of course!" Thus, Oedipal experiences from the group unfolded using the specific domestic setting of the conductors: whether they live poorly or richly, what other circumstances are visible on camera, what pets they have, and how the therapist treats them.

I believe that with the emergence of the hybrid format, part of the group experienced "rejection" – when the in-person part moved back to the traditional office, they lost the opportunity to be "admitted" into the therapist's home. Oedipus was expelled from the house according to the myth.

Two worlds emerged. The online Oedipuses are deprived of physical contact with the group. The others – exert

more effort. After all, it is now again their responsibility to physically reach the office.

Conclusion: Therapeutic Capacity and Key Factors

Based on the lived experience, we can conclude that a hybrid group, like a traditional one, can be therapeutic if its specific features are considered by the conductors and if it can process beta-elements into alpha. It can help participants "dream" their experiences and learn from them. To achieve this, it's important to organize a space for containment within the group.

Key factors include:

* Predominance of K-links (Bion's concept).

* The conductors' vision of the group-as-a-whole and understanding of the real split into online and offline parts.

* Interpretation of early defenses like splitting and projection.

* Conductors achieving a sufficient level of abstraction in understanding the group process.

* Interpreting the group's and each participant's relationship to the creative couple (the co-conductors).

* Conductors reminding themselves that they are not perfect, but also not as bad as the group might experience them.

Transition and Mourning

After some time working in a hybrid way, we proposed the group move entirely online. The in-person part of the group, which had not wanted to stay online, nevertheless reached the depressive position, creating the possibility to mourn the impossibility of meeting in person as before. The group gained the opportunity to return to experiencing the equal status of all members and continue working on sibling dynamics.

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Study Day Section

Narcissistic Defences: idealization, psychic retreat and self-devaluation in serious illness

Ninel Beketova
Clinical Psychologist and Psychoanalytic Psychotherapist
EFPP Adult Section, Delegate member for Society for Psychoanalytic Psychotherapy
Moscow, Russia
nelbeketova@me.com

When the truth is found to be lies
And all the joy within you dies
Don't you want somebody to love?
(Somebody to Love* Jefferson Airplane)

In this paper, I would like to discuss my understanding of idealization, self-devaluation, and omnipotent control in long-term work with oncology patients. These narcissistic defences organize into a structure very similar to a psychic retreat that, on one hand, protects the weak, deficient self, and, on the other hand, provides an illusion of immortality and the possibility of an internal connection with someone who has ceased to exist, in symbiotic fusion. This unconscious psychic retreat gradually captures the relationship with the therapist. This phenomenon is quite difficult to recognize and explore, but developing the ability to process grief and analyzing the retreat itself helps the patient transition from the world of the dead to the world of the living.

The Concept of 'Dybbuk' in Literature and Cinema

I will start illustrating this phenomenon by describing and analyzing two works: Semion An-sky's play "The Dybbuk: Between Two Worlds" and the Coen brothers''film "A Serious Man."
Recently, I had the opportunity to visit the exhibition "Dybbuk: Ghost of a Vanished World" at the Paris Museum of Jewish History and Art, on the image of the Dybbuk in cinema and literature. In Jewish mythology, a Dybbuk is the malevolent soul of a deceased person that can possess a living human, disrupting their consciousness and behavior. The term derives from the Hebrew "דִּיבּוּק" (dibbuk), which translates as "attached" or

"clinging." Typically, a Dybbuk is considered a spirit that has not found peace after death, often due to unresolved issues in life, evil deeds, or unfortunate circumstances. In myths, the Dybbuk is frequently portrayed as a powerful force that takes possession of a person's body, merging with them, which can manifest in altered behavior, speech, thoughts, and actions.

This concept became famous through Semyon An-sky's play "The Dybbuk," which he originally titled "Between Two Worlds." The plot centers on the relationship between Leah, the daughter of a wealthy merchant, and Khanan, a yeshiva student who lived in their home for some time. Leah had lost her mother and was trying to cope with her grief, while her father attempted to find her a wealthy, advantageous match, ignoring his daughter's feelings and desires. Khanan dies instantly upon learning that Leah has been betrothed, but during the wedding ceremony, he enters her body as a Dybbuk and disrupts the proceedings. During preparations for the exorcism, it is revealed that Leah and Khanan are the children of two friends who had promised them to each other by oath, a pledge that was broken by Leah's father. After the Dybbuk is exorcised, Leah cannot continue living and dies, following Khanan.

This play became very popular throughout the 20th century, likely because it touched on deep human experiences that many people could relate to, even those unfamiliar with Judaism. When analyzing the play, I noticed several themes that also appear when working with patients. High death rates, constant attacks on Jewish communities, poverty, and hunger forced people to live in a mystical way where the line between living and dead became unclear.

People processed grief through practical activities like embroidery, while poverty existed alongside deep philosophical ideas. Wealth was often viewed negatively, and characters struggled to truly see each other. Leah's father ignores his daughter's feelings for Khanan. Khanan is so absorbed in studying Kabbalah that he only realizes he loves Leah just before he dies. Leah can only fight against her unwanted marriage through possession by the Dybbuk.

The demands are enormous, while the psychological resources to meet them are very limited. The world of the dead is understood as continuing to live: deceased relatives are invited to the wedding, the wedding ceremony includes

a dance on the grave of a bride and groom who died during a pogrom, and there is a trial between Leah's father and his deceased friend, which the deceased wins. All this creates the preconditions for escaping from an unbearable life by merging with a dead object in search of oneself.

Marriage in Judaism has a profound meaning of integration, and if this process is disrupted, one is left to cling to the dead and live an illusory life, rocking imaginary children in one's arms. Another important aspect is the impossibility of forcibly extracting the Dybbuk - without an integrated self, a person's life is either miserable or impossible.

The Dybbuk is also present in25the Coen brothers' 'film 'A Serious Man' (2009). What appears on the surface to be a comedy turns out to be a profound exploration of a person's world before receiving a cancer diagnosis.

The film begins with a parable. A man returns home and tells his wife that he was just saved from death by Traitle Groshkover, who helped him fix his cart wheel during a blizzard. In gratitude, he invites him over for soup, but his wife immediately decides that this is a Dybbuk, because the rabbi died three years ago. Refusing to hear his version of events, she stabs the guest in the chest with a knife.

The plot of this film revolves around a brief period in the life of physics professor Larry Gopnik and the numerous events that happen to him during this time. The film ends with a call from his doctor delivering troubling news right as a storm begins.

This work portrays an interesting phenomenon of disrupted relationships with others, which is especially evident in the transference process during early stages of working with oncology patients. The main character, Larry, faces a series of traumatic events: his wife's infidelity and divorce, an investigation by the university ethics committee based on a complaint from his wife's lover, a student's attempt to bribe him to change a grade, and his brother's legal troubles. Larry tries to make sense of what's happening, but instead of clarity, he encounters lies and constant pressure.

His state can be described through the metaphor of "Schrödinger's cat," where different perspectives create opposing interpretations, and Larry himself cannot find objective truth. He turns to rabbis and lawyers for help, but their advice proves subjective and does not lead to understanding. In the end, confused about

himself and those around him, Larry violates his principles and accepts a bribe from a student.

At first glance, the film tells the story of the protagonist's inner struggle, his despair, and inability to escape a state of "superposition," where he simultaneously strives to remain honest but is forced to submit to circumstances. However, upon deeper analysis, it becomes clear that there is a confrontation between two worlds in which the main character exists.

In one of these worlds, Larry lives a harmonious life: he is happily married, his children are honest and do not steal money from his wallet, his brother is fascinated with Kabbalah rather than gambling, neighbors respect the boundaries of his property, and he himself is an ethical professor who evaluates students solely on their knowledge. In another world, everything falls apart: his marriage is breaking down, his children deceive him, his brother is mired in questionable calculations, and those around him do not understand him. Larry cannot accept this new reality—he prefers the version of the world where Schrödinger's cat is alive. However, both realities exist simultaneously, and the hero is stuck between them.

The phenomenon of the dybbuk, as a symbol of refusing to accept reality, deeply resonates with the protagonist's inner state. Larry clings to the past, creating a protective shell around it—a kind of metaphorical 'pregnancy or even "tumor'. This resistance to reality intensifies the alienation and misunderstanding between him and those around him.

His life before the traumatic events was already characterized by detachment and unwillingness to see the truth. This led to increased pressure from others. To protect his inner reality, Larry builds a wall where external defenses include idealizing others''opinions and devaluing his own self. Internally, the hero tries to preserve a fragile illusory world, protecting his "self" from destruction.

This approach reminds us of the nature of the dybbuk in Jewish tradition: a spirit that cannot find peace enters a person to find refuge. Like a dybbuk, Larry becomes a prisoner of internal conflict, where the struggle to preserve illusions becomes the source of his suffering.

Clinical Case: Ms O

Ms O approached me with complaints about psoriasis and difficulties

related to her divorce. I was immediately struck by how she casually mentioned her cancer diagnosis - stage two breast cancer - as if it were something insignificant. This carelessness towards her own health resonated with her appearance: her natural beauty was hidden behind a complete lack of self-care.

During the initial interview, it became clear that the patient associated her illness with deep resentment towards her husband, whose infidelity she accidentally discovered in his correspondence. The irony of the situation was that her husband tried to deceive her by claiming he had non-existent lung cancer, while she herself was subsequently diagnosed with breast cancer. At the time of her visit, she had already been undergoing hormone therapy under an oncologist's supervision for a year.

A special place in her stories was occupied by her mother's death from heart disease. Although nine years had passed since the loss, she spoke about it so emotionally as if it had happened yesterday. She described her condition metaphorically – as if she was 'chained to her mother's coffin and lying beneath it'. She was tormented by guilt over an argument before her mother's death and anxiety about the reburial of the body in cellophane at a Jewish cemetery. The obsessive 'mom cannot breathe' fantasy, as well as the conviction that 'death does not exist' were expressed with remarkable persistence.

Ms O's family history was filled with unspoken traumas. Her father came from a family of rabbis, but almost his entire family had disappeared, with relationships maintained only with his sister, whose emigration was a forbidden topic for many years due to her father's fear of losing his job. The history of her father's family during the revolution and war remained unknown to the patient. Her father never discussed this with her. He died during the coronavirus pandemic, suffering from severe dementia.

Her maternal family line carried its own trauma. Her grandfather was politically repressed. Her mother was born in the early 1930s after her parents returned from Europe. Her grandmother never adapted to Soviet reality, maintaining European habits even in rural conditions. Ms O recalled how her grandmother lost her milk after childbirth and refused to feed her daughter 'dirty cow's milk' until a neighbor intervened. In 1937, her grandfather was arrested and sent to work in a special prison laboratory during the war. Ms O proudly recounted how her

grandfather managed to send bags of dried bread to the family during wartime. After his release, he did not live long. Her grandmother spent her final years suffering from dementia, sharing a room with the patient.

At the time of seeking help, Ms O was married and raising a teenage son. Despite having two university degrees – in technical and humanitarian fields – she had only worked for six months before marriage. She spent most of her time at home, smoking in the kitchen with a cup of coffee. Intimate relations with her husband had long ceased. She complained of fear of birds, fear of driving (either running over a dog or being crushed by a large truck), inability to clean and cook at home, fear of choking on large pieces of food, and lack of appetite.

Narcissistic defenses permeated her entire psychological space. She idealized her father, describing him as kind, loving, caring, and successful, while devaluing her mother as a constantly ill and suffering woman who never had energy for her daughter but demanded success in school and later in career. Ms O recalled how her mother compared her to Olympic champions, reproaching her thin, weak daughter for not achieving anything by the age of 13. She idealized her grandfather, who managed to build a career and support the family even while in prison, and devalued her grandmother who wore beautiful dresses and beads but was completely unable to care for the family. Describing her choice of husband, she said she rejected a physically perfect partner in favor of a promising scientist, who turned out to be a rude alcoholic, unable to earn properly and constantly criticizing and demanding. About herself, she complained that she was useless and incapable, that men stopped paying attention to her, that she was needed by no one, especially after her breast was removed. Simultaneously, she called herself a princess who deserves the very best in life.

This internal landscape made me wonder how our relationship would develop and what would happen in the transference with me. The patient quickly began to idealize me, not hiding her admiration. She saw me as a successful, wealthy woman who drives a car, knows and can do everything, that will definitely teach her how to live. She said that being near a successful person would make her successful too. At the same time, she was constantly 15-20 minutes late, sometimes simply missing sessions because she lacked the strength to leave home.

Initially, she tried to talk to me during breaks when I went out to smoke. She explained this by saying there was something unbearable in the office and it was difficult for her, while during breaks it was much easier to communicate in a friendly manner. I asked her to stop this, and she quickly agreed.

Something truly unbearable was unfolding in the consulting room. Perhaps this is the hardest thing to describe. At first, Ms O tried to get me on her side by telling horrible stories about her husband, about his greediness, rudeness, constant demands, and desire to turn her into a cleaner. She looked at me warily from under her brow, and I felt that any wrongly spoken word would break our fragile connection.

I tried to clarify her feelings, contain her, analyze and interpret the transference and defenses, becoming overly active, but constantly encountered the indestructibility of her internal picture, feeling helplessness and fear of saying something that would destroy her. I felt constant pressure from my supervisor, who criticized me for excessive activity and insufficient analytical space. When I tried to create this space and remained silent, Ms O fell into emptiness and became silent, as if she had been abandoned and was completely lost. Desperate to make me an ally against her husband, she revealed that her mother had always admired her husband, successful, handsome and promising, while considering her unworthy of such a wonderful man.

Her husband completely disappeared from her material, and an oncology center emerged with corrupt, rude doctors and disgusting patients. She perceived herself, on one hand, as a victim of the system, and on the other, as an impostor who receives something undeservedly. Conversations about her illness and death quickly transformed into ideas of her immortality and the impossibility for people to comprehend this knowledge. Again, the analysis of transference proved unsuccessful, as with her husband—all my attempts to connect her experiences with me hit a wall of incomprehension. She said I was completely different; she had no anger toward me, and she was late exclusively because she had done so all her life. I felt strong pressure to work correctly on one hand, and complete helplessness and absence of change on the other.

Then she shifted focus to herself, to the impossibility of meeting other requirements, the impossibility of sorting

through things and caring even for herself and her belongings, the impossibility of throwing away her mother's old things, renovating, or even simply washing dishes in the kitchen. In her world, she lived in a room without windows or doors, filled with flowers, and only there felt happy. I felt pressure to help her sort things out and change something, to fix and improve her, while simultaneously experiencing an unbearable heaviness and impossibility of working.

And then came an illusory relief. Ms O sensed that I was interested in working with her dreams, and began bringing them to every session. A fusion occurred then. The work appeared to be analytical—after all, we were analyzing her dreams—the entire outside world completely disappeared, and this continued for 2 years. I noticed that dead children often appeared in her dreams, that they contained an enormous number of details and images, that she simply brought the dream and waited for me to chew it up and place and acceptable picture in her mouth. Meanwhile, I reassured myself that she was alive, and that was the purpose of my work. Simultaneously, I felt wrapped in cellophane in a deep grave, bound hand and foot, with illusions in my head and hopelessness in my soul.

In one of her dreams, she took an elevator with an ice cream vendor to the highest tower in Moscow, and when she reached the top, she felt happy at the peak of the world, while the vendor somehow remained below at the foot of the tower. Then I thought about her deep loneliness in these narcissistic defenses, but later I understood that this was her triumph in conquering me and getting inside, while refusing everything delicious in this life.

I had to wake up from this deadly dream of the soul during a conference in Spain dedicated to psychic retreats and work with borderline patients. There I realized that I was in a deep retreat with Ms O, and I was overwhelmed by anger and guilt for such ineffective work. Then this anger redirected towards the supervisor who had not noticed this trap, and then the thought that all this had meaning and was somehow necessary restored my interest in this phenomenon.

Understanding the characteristics of psychic retreats in oncology patients as pathological disorganization in response to loss

Understanding the concept of psychic retreat and its role in a patient's

psyche was not easy for me, most likely due to the multitude of parameters involved: manifestations of the retreat in the communication with the external world, reasons for creating this defensive organization, the patient's experiences within it, the impossibility of verbalizing this experience, lack of words, and the predominance of imaginal thinking.

The Dybbuk and Schrödinger's Cat are two interconnected symbols that most accurately describe this phenomenon. The cat, placed in a steel box, may be alive if decay has not occurred, or dead if it has. Everything depends on the observer's perspective. The Dybbuk is someone or something that can be alive or dead, and again, everything depends on the observer's view. While for the external observer, there are two contradictory concepts, while for the internal observer, there is only one, and all others are untrue. Similarly, tumor cells drive to survive and exist eternally is evident while for organism this is a destructive process.

John Steiner (1993) writes that the perversity of the retreat lies in the paradox of two realities, in which the patient simultaneously both sees and does not see external reality. Apparently, this paradox likely extends to the therapist, who simultaneously both sees and does not see the internal reality of the patient. What reality does the patient protect inside their retreat? How do they perceive the therapist and therapy?

Freud (1915) revealed a psychic paradox regarding death. He described it as two realities, two worlds that strive not to come into contact with each other. This is probably the discovery of the psychic retreat in psychoanalysis. A person, on one hand, sees that people die, perish in wars, become ill, lose loved ones, and on the other hand, is absolutely certain of their own immortality, and even descriptions of their own death and funeral reflect the presence of a living observer.

This certainty is seriously tested only when confronted with the death of loved ones, and the process of mourning likely brings a person closer to accepting their own mortality, which from the perspective of the unconscious is an absolute absurdity. If the internal reality is fragile, it cannot withstand the pain, guilt, and attacks of the mourning process, and in its pursuit of safety, it inclines toward the immortality of the unconscious, successfully removing all signs of the opposite from reality.

The other important discovery of Freud was his theory of the death instinct. The life instinct, or libido, strives towards the

object and towards development, integration of the new, and knowledge of life, that is, towards changes, while the death instinct is directed towards the pursuit of non-existence, absence of changes, stability, and fixation on the familiar. These two forces are in constant interaction. Melanie Klein viewed the death instinct as a drive toward destruction and annihilation, which at first glance contradicts Freud's understanding. But this contradiction is resolved through the paradox of two worlds and two perspectives, where an observer from outside sees the destruction and destructiveness of the death instinct, while an observer inside sees in it a striving for safety and survival.

Herbert Rosenfeld in his work "Impasse and Interpretation" (1987) proposed distinguishing between the libidinal and destructive aspects of narcissism in transference. The libidinal aspect manifests in the idealization of self and object, as well as in processes of introjection and projection of omnipotence. The destructive aspect manifests in the destruction of positive libidinal strivings toward the object and the libidinal part of one's own self that contains the drive towards the object. According to Rosenfeld, the source of destructiveness is the intolerance of differences and separateness of the object that contains idealized and so attractive parts. Concealing any envy and destructiveness from the object serves as the main task of narcissistic defenses. This paradox of interaction between the life and death instincts was also manifested in the transference with the patient.

Ms O ignored, through imitation and false "yes', any attempts to bring a different reality into her internal world and, apparently, perceived them as external pressure. Simultaneously, she strived for fusion with me through intuitive understanding of my interests, which can be interpreted as a striving for contact, but precisely the kind that the patient herself needed. At the same time, the entire first stage of work was accompanied by twenty-minute delays and absences, which can be viewed as manifestations of destructiveness.

Analysis of resistance was impossible because these delays were ego syntonic for Ms O—she did not see a problem in them, did not experience guilt, and did not feel aggression. The only explanation was that it was extremely difficult for her to make herself get ready and leave the house. Much later, when we began to explore the retreat and talk about it, I

interpreted she was trying to steal time from me, while in fact robbing herself. This idea struck her so much and opened up to her the world of her own self-destructiveness that she completely stopped being late.

Reflecting on the analysis of destructiveness, I nevertheless concluded that it is impossible in the early stages of therapy. For the retreat to be analyzed must manifest in the transference neurosis, and the patient's ego must be strong enough to be able to emerge from sweet non-existence and perceive another person's perspective. From the position of the therapist-observer, the retreat is undoubtedly destructive and destroys the living contact and the patient's development process; from the patient's perspective, the retreat is the only possibility to preserve a weak and fragile ego from the pressure of reality's demands.

Donald Meltzer's concept of the Claustrum (Meltzer, 1992) allows for deeper understanding into the processes of psychic retreat formation and its purposes. The special form of pathological projective identification, which he named intrusive, enables the patient to avoid both the destructiveness of normal projective and introjective identifications and the mourning process characteristic of the depressive position, while completely eliminating envy and shame. The patient, dwelling in the Claustrum of their internal maternal object, attempts to reproduce it in the transference with the analyst by penetrating some part of their body. Meltzer described the claustrum in the head, genitals, and intestines, but these three types of refuge still somehow connect with reality through the parasite carrier's body—through eyes, ears, smell, drives, and excrement. The ideal claustrum, where contact with the external world is maintained only through the mother's blood, where the world is always satiated, warm, and calm, is undoubtedly the claustrum in the womb.

Pierre Marty's theory of progressive disorganization and his follower Claude Smadja's work appears key to understanding the psychic retreat in oncological patients. The primary mechanism is the withdrawal of libido from both objects and from the self, while all other processes serve to ensure this phenomenon and its consequences (Marty, 1968).

Operatory thinking provides an illusion of contact with external objects while completely lacking libidinal investment in them. Since real interaction is no longer

necessary, the process of mentalization development ceases, which is normally based on the living exchange between projective and introjective identifications. Essential depression manifests as an existence within a claustrum where any development and transformation become frozen.

Marty (1968) referred to relationships with such patients as "white," likely due to the absence of genuine libidinal contact, where its mere appearance negates any progress. Perhaps narcissistic idealization of the object and intrusive identification remain the only modes of interaction.

Marty (1968) linked the emergence of progressive disorganization to a significant early deficit in psychic functions resulting from disturbed mother-infant interactions during the first months of life and subsequent poverty in forming representations of mental states. This likely creates the necessity to seek refuge in non-existence when confronted with losses and life difficulties. Death imitation becomes a peculiar path to immortality and omnipotence over life.

While psychoanalytic concepts help us deeply understand and comprehend the inner world of a person, attachment theory allows us to observe external phenomena based on scientific research. It distinguishes two concepts of disorganization: reaction to trauma and loss, as well as disorganized attachment type with unresolved trauma and loss.

Disorganization in response to trauma and loss is conceptualized as a process of deconstruction of the pre-existing internal working model under the influence of reality, culminating in reconstruction and the formation of new models. This process, particularly protracted in the case of bereavement, encompasses phases of denial of the new reality, painful confrontation with it through intrusive flashbacks, struggle for the restoration of the past, and despair at the impossibility of this endeavor.

In instances where the psyche cannot tolerate such intense affective states, the normal process of disorganization is arrested. All psychic energy is then redirected towards the preservation of the old model and the refusal or avoidance of accepting the new reality in which the deceased no longer exists. All stimuli reminiscent of the loss are isolated and annihilated by defensive mechanisms, becoming objects of avoidance for the patient. Two parallel realities emerge in the patient's world: an unconscious one where the deceased persists, and an external reality where their absence is

perceived as a falsehood. This psychological state is termed a disorganized internal working model.

The disorganized attachment pattern can be observed in infants from 12-18 months. Its central feature is the disruption of fear behavior, wherein the infant simultaneously seeks proximity to and exhibits fear of the attachment figure. Under favorable circumstances, this attachment pattern may evolve into a controlling internal model of two varieties: either control is exercised through intimidation of the attachment figure, or through caregiving and submission.

Contemporary research on disorganization in children elucidates the transference and countertransference phenomena in work with oncological patients. It illuminates the tragedy of the inner world's inability to withstand the demands of external reality, leading to retreat into psychic refuges. The maintenance of the split between these two realities necessitates the deployment of primitive defense mechanisms, including idealization, devaluation, and omnipotent control.

This psychoanalytic understanding provides a framework for comprehending the complex psychological processes at play in trauma and loss, particularly in the context of severe illness. It underscores the importance of a nuanced approach to therapeutic interventions, recognizing the intricate interplay between attachment patterns, defense mechanisms, and the capacity for psychological integration in the face of overwhelming experiences.

In conclusion, I would like to add my reflections on emerging from the psychic retreat for oncological patients. John Steiner's recommendations on analyzing the retreat played a crucial role in the therapeutic process with Ms O. This technique allowed the patient to begin cautiously stepping out of the retreat. Initially, she noticed a crack in the wall of my office and was struck by the realization that my world and I could be imperfect. Perhaps this crack symbolized the emergence of a fissure in the stone wall of her detachment from the real world.

She dreamed of a monkey in a glass aquarium, where she broke it, and the monkey ended up bloodied. Emergence is always accompanied by fear and pain, and the main question is whether the patient can or is ready to endure this. Ms O decided to learn to drive, and despite it taking two years, she succeeded, further strengthening her ego. One progress created opportunities for subsequent steps, and she began earning her own money and regularly practicing yoga,

overcoming her weakness with a now conscious understanding of gradual and difficult development.

There were many such steps over the next four years of therapy, and the patient never retreated as deeply into the refuge as she had at the beginning of therapy. This fact prompts consideration of applying the retreat analysis technique specifically with patients suffering from severe systemic diseases. Perhaps residing within it for several years alongside the patient provides opportunities to strengthen the autistic self and develop the ability to manage one's own affects, which in turn becomes a prerequisite for the final emergence.

With other patients, analyzing the retreat at the beginning of therapy did not yield such an effect, as patients constantly returned to it on one hand, and on the other, perceived this analysis from an internal position of these interpretations being imposed. However, for the therapist, awareness of the retreat phenomenon plays a decisive role in working with deficit patients.

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Discussion of Ninel Beketova's 'Narcissistic Defences: idealization, psychic retreat and self-devaluation in serious illness'

Clelia De Vita

EFPP Couple & Family Section, Member of Società Italiana di Psicoanalisi della Coppia e della Famiglia PCF, Roma, Italia

The case presented by Nellia concerns a patient with deep wounds in her body and psyche, wounds that are connected to a family history full of traumas. We know that the patient does not have a good relationship with her mother, who has not mirrored her, supported her in her growth. We can imagine a primary relationship that is lacking, deficient from the very beginning. The patient does not seem capable of representing her suffering, as if a traumatic quality had acted in that time of development in which there is no psyche to record it, nor words to say it. So, first of all, I think that the patient has experienced a primary relationship in which the mother was not able to perform the function of a protective shield. Early on, the child patient was invested by those ego-alien elements of the parent, which leave an unthinkable traumatic imprint. I imagined the patient's cradle besieged by "ghosts of the nursery", by all the unprocessed remains of the parents' history, in turn heirs of generational ghosts.

Telling the patient's story, Nellia spoke to us about the presence of unspeakable family traumas. I think the term "unspeakable" is very appropriate for these traumatic elements that pass from one generation to another as silent, "unspeakable and unthinkable" forms, not psychically elaborated.

In the family psychoanalytic reading, the subject is inhabited by the group, family unconscious; affections, fantasies, representations pass from fathers to children through a positive transmission, which conveys elaborate psychic experiences, useful for the structuring of family and individual identity; and a negative one, relating to experiences that have remained un-representable, unspeakable that will be an obstacle to the

construction of the subject. The subject, therefore, forms within an extended psychic space. Freud had clarified it, in Introduction to On Narcissism (1914): “the individual actually leads a double existence: one in which he is an end in himself, and the other as a member of a chain to which he is subjected against his will or, at least, without the participation of this”.

Every child becomes part of a generational chain, of an unconscious plot, of alliances, pacts, rules, implicit and explicit, which preserve the continuity of the group and, at the same time, allow the child to become the subject of an inherited history. Piera Aulagnier defined the unconscious alliance that binds the newborn to his parents and to the family group to which he belongs as a “narcissistic contract”.

Therefore, the primary relationship develops within the broader intersubjective family and generational dimension; the mother is the “spokesperson”, the interpreter, for the child, of the family idiom, of its excesses and its gaps, of the unsaid.

Nellia described a patient who is unable to assert herself, who does not feel she can exist in a vital form, as if the patient were experiencing the effects of a failed process of subjectivation.

Nellia described the patient’s suffering, a suffering that is enigmatic, inexplicable in the light of her personal history. What place has her parents assigned to her in the generational order?

The patient appears entangled in the family and generational plot, full of unsymbolized traumatic elements. Wars, religion, persecutions, make up a legacy that is difficult to appropriate. Her parents were unable to digest for her a cumbersome past, full of unprocessed remains, so the transgenerational chain seems to have sucked her in, without leaving space for the construction of her identity. The narration of the family history is cumbersome and lacking at the same time. A “denegative pact” (Kaes, 1986) seems to have hidden some elements in the generational passage. These secret, and unconscious elements, manifest themselves through symptoms and pathological forms, which express the subject’s identification with aspects of the past.

A tangle of past experiences, silenced, secreted, inhabit the patient like a foreign body of unconscious identifications.

Nellia's patient seems to have identified with various traumatic aspects of her history; with the empty, deadly breast, which takes away vital nourishment (of the grandmother to the mother), with a dimension of the feminine-maternal that I would describe as "dead mother" (Green, 1983), women incapable of investing their daughters with libido, prisoners of a melancholic dimension. Nellia's patient found herself, in the process of filiation, identifying with aspects of the history of her grandmother, of her mother, which she did not live, but which, through transmission, reached her as present elements. In these cases, identification becomes an alienating mechanism, which condemns the patient to repeat the same, to lose herself among the fragments of others' identities.

Possible and impossible mourning

The reference to the Dybbuk introduced us to the intertwining of the dead and the living, or rather the importance of unfinished mourning in the transgenerational passage; the Dybbuk is a tormented soul, suspended between two worlds, the soul of someone who died in a traumatic and violent way, who tries to satisfy his greed for life by possessing someone who is alive.

In addition to the film “Between Two Worlds” cited by Nellia, I think it is interesting to report the plot of another film “Never Born”, in which a girl who had a difficult childhood, abandoned as a child, feels a deep resentment towards her mother after her death, and is haunted by merciless dreams, and obsessed during the day by a Dybbuk, who took the form of a child who died in a concentration camp. The girl will find in her friend, a spiritual advisor, an ally to put an end to the curse that has tortured her family since the time of Nazi Germany.

Within the pathologies linked to family ties, mourning, or rather, the failure to process mourning, occupies a central place. Many forms of psychic suffering, in fact, are linked to the impossibility of processing losses, for example of a child, by the previous generation. Missed mourning generates family ghosts that, like the Dybbuk, haunt the living.

The idea of the dead mother haunts the patient in the fantasy of the return of the “dead-alive”, which condenses in itself the image of a mourning “left pending”; it is difficult to complete one’s mourning if one has to carry the weight of suspended,

frozen mourning, not processed by the previous generation.

Racamier reminds us that mourning is not feasible if it does not concern personal history of the subject. Mourning, not done by a family member, pours into the child like a “fog of affections” (Racamier, 1993) that obscures his ability to complete the personal work of mourning.

Nellia's patient seems forced to play the role of “luggage carrier” (Racamier, 1993), burdened by family experiences related to dead people who were never truly buried. The family "ghosts" prevent her from feeling alive.

The processing of the mother's mourning has become impossible and has blocked the patient in a melancholic area. From this summit, this melancholic area, seems to originate both, from the patient's ambivalent relationship with the maternal object, and from the persecutory burden of the many mournful knots never resolved in the generational passages.

As Freud taught us, melancholia is distinguished from mourning because, in it, there is a mortification of the feeling of self. The ambivalence, (part of love), towards the object, is exacerbated by the loss; hatred is poured out on the ego, causing a struggle between the desire to live and the desire to be one thing with one's own dead object.

The case presented by Nellia, illustrates this oscillation very well, the splitting between the idealized good object and the persecutory bad one, from which the patient's ego is emptied and impoverished.

It seems to me that, within this ambivalent and persecutory dynamic, one can read the patient's experiences relating to breast cancer. The patient seems to identify the diseased breast with a dead internal object (the “depressed mother”), hated because lost.

The diseased body becomes “other than itself,” an alien, which bears the narcissistic wound. At the same time, threatening the continuity of the Self, the disease becomes a traumatic moment that recalls the “nameless anguish”, inscribed in early bodily experiences.

It is not easy, in these cases, to be able to help the patient to transform the anguish of loss and disintegration that recalls traces of agony, non-verbal, early and unremembered suffering. From such a burden of anguish, the patient has tried to

defend herself through omnipotent thought, triumph, and manic reaction.

Cancer, like the Dybbuk, threatens the patient' present, like a lump of psychic elements from the past.

The dream of the tower

The dream of the Moscow tower reminded me of the film "The Awakening of the Guardians", set in the same tower, in which a group of superheroes, endowed with extraordinary powers, must carry out an important mission of liberation from the enemy attack.

This association brings me back to the patient's need to escape from the siege of the transgenerational, of the parents' experiences, related to war, to enemies, which have become part of the patient's imagination. In this sense, we can think that, in the manic defense, in the omnipotent thought, the patient is looking for superpowers to fight an impossible battle.

Taking refuge in the tower, to protect herself from the siege of reality that threatens her identity, made me think of "castling", a move that in the game of chess makes the king or queen protected by the tower. When psychic fragility and the sense of impotence are too intense, all that remains is to "castle", to retreat into a corner, as an extreme attempt at defense.

The tower, as a phallic symbol, makes one think of an identification with the father, which has conferred a certain protection from the difficult relationship with the mother figure. It seems to me that, inside a tower-armor, the patient has sought protection for her very fragile Self; her father's tower provided her with a structured container for a very precarious sense of identity.

Withdrawal and regression

Towards the end of her work, Nellia introduces the theme of psychic retreat, on which I propose to reflect with Winnicott, who has dedicated two beautiful works to "withdrawal and regression".

Although it is not easy to distinguish between the two defensive states, Winnicott traces a fundamental difference, between the two defensive positions, in relation to the dependence on the object, which is present in regression; on the contrary, in the psychic retreat, the patient puts into action a form of pathological independence (Winnicott, 1965) that excludes the object. Since these two different states occupy different positions

with respect to dependence, it leads us to deduce the

different role played by the environment, in relation to the infantile needs of the patient; in the same way, they are connected to a different a different involvement of the analyst.

The patient who withdraws during analysis, defends himself from a failure of the environment in the early stages of development. The analyst finds himself working with a patient who does not feed on the analytic relationship, who isolates himself from internal reality, as well as external reality.

The case presented has shown us that withdrawal brings with it a hopeless condition, which makes the analyst experience a sense of uselessness; in fact, the state of withdrawal, does not bring any evolutionary advantage because "when the patient comes out of this state, he has not changed" (Winnicott, 1954).

Nellia has shown us how difficult it is to work with the patient in a state of psychic retreat, tolerating

the difficulty of moving forward in the analytical process. These are complex clinical situations, which attack the treatment function and require a great labor of countertransference, in order to grasp what the patient puts inside us, by projective identification.

We can ask ourselves, as Nellia suggests, what is the most suitable theory or technique to approach the patient who has taken refuge in the tower.

How can we help these patients?

Winnicott suggests that we have to respect the withdrawal, in which the patient tries to keep his self united until the patient can experience the analyst as an object that can contain him and respect his times. It will therefore be important to wait for the moment in which the withdrawn psychic nucleus opens outward, allowing the patient to experience the “regression to dependence” (Winnicott, 1965).

Although difficult to handle, regression represents a more positive moment for the analytic relationship. When the patient is willing to regress, hope will have been born in the analytic environment, and we will be able to help the patient to recover his emotional growth. In fact, withdrawal is a style of psychic survival when a “good primary illusion” has not been experienced.

It will be important that, when the patient leaves the retreat, he finds an analyst who, like a “live company” (Alvarez, 1992), is available to be found and “used”; I mean, by this, that it is important to help the patient access the vital use of aggression. The role of the object, in fact, is crucial in ensuring that the child can access the creative use of aggression in his development.

In this regard, it seemed to me that the monkey’s dream contained an element of hope; the glass that separates it from the outside world, is broken: the monkey is bloodied, but alive. Perhaps, the dream

represents the possibility of coming into contact with the primitive part-monkey, previously rigidly kept under glass. Perhaps the retreat has opened up, revealing the fragile Self, contained within it.

Reading Nellia’s case, I thought of “autistic barriers in neurotic patients” (Tustin); there are some analogies between retreat and the psychogenic autistic states that we find in adult patients. In both clinical conditions the patient defends himself from a fear of existence, the fear of being inanimate surrounded by a threatening world; what we consider resistance in neurotic patients, in these cases takes the form of extreme protection.

From my experience with autistic and psychotic children, I have learned that the unfolding of the autistic nucleus is associated with somatic effects, with moments in which the patient's mental conditions seem to worsen; hope and trust are needed to go through these phases together with the patient, which requires to the analyst, a particular emotional involvement.

Working with patients, with extensive and primitive traumatic areas, who have left traces without words and memory, requires us an attention to the recording of the smallest variations: like a seismograph, the analyst "listens with all the senses" to capture the non-verbal, bodily, sensorial aspects, and tune into the tone of the session and the musicality of the transference (Mancia).

The variations in rhythm are worthy of note; thus, the patient's delay, can be read as a communication of her difficulty in having her own space, in taking something for herself, since she did not seem to feel she had the right to a life for herself.

In conclusion, I think that in order to be able to “hold”, contain a difficult patient,

like the one Nellia presented to us, it is important that the analyst can also feel welcomed and supported; I think, for example, of the role of the supervisor, of the exchange with the community of colleagues, of our group today. Perhaps, not by chance, Nellia spoke to us about this case, to elaborate the sense of uselessness, the lack of hope experienced for a long time in working with this patient, finding a group that could look at her and the patient, from other perspectives, like the one I proposed to you.

Discussion of Ninel Beketova's 'Narcissistic Defences: idealization, psychic retreat and self-devaluation in serious illness'

Hansjorg Messner

Psychoanalytic Psychotherapist, EFPP
Adult Section, Member of BPF, BPC, EFPP

Ninel Beketova has presented an interesting and challenging paper about a twice? weekly therapy of a female patient suffering from cancer. I concluded from the narrative by the therapist of the relationship with her patient that Ms O's illness with cancer, although initially only mentioned in passing, appears to be one of the central features of her psychopathology. More specifically, the material allowed, in my view, to infer, that the cancer was experienced as an attack on her femininity and exposed her continually to persecutory and paranoid feelings. While the patient presents with an inaccessible and immobilized, incapsulated internal state of mind, I was uncertain and could not see enough evidence as to whether the perverse aspect of Ms O's psychic retreat was a dominant feature as I think Ninel suggests. Even within the psychic retreat there is a permeating sense of profound fragility. The therapist is made to fear "saying something that threatens to destroy the patient's precarious mental existence".

There are, however, other indications in the material that I found noteworthy. The patient in her initial interview reports the death of her mother nine years earlier, "as if it happened only yesterday". The patient feels "chained to the mother's coffin and lying under it"! This made me think of the "shadow of the object that falls upon the ego" in Freuds paper on mourning and melancholia (Freud, 1918). The clinical material reveals an incapacity to mourn, intense self-reproach and an internal world devoid of meaning; aggression turned against herself and an ego becoming increasingly diminished and empty. I wondered if the assessment of the patient suggested that Ms O suffered or was threatened of collapsing into melancholia. This, then, could be seen as the second pillar (as opposed to the

paranoid features) that renders the patient immobilized and, as Ninel shows us later, trapped in a psychic retreat and increasingly divorced from herself.

Abandoned by her husband in her hour of need and incapable of mourning the loss of her mother some nine years earlier, left her chained to mother's coffin and stuck between a terror of not being able to breath and an illusionary flight into believing death does not exist.

The breast-cancer is initially mentioned only in passing but the narrative increasingly allows to infer that the cancer represents a malignant object; an object that is alive while causing death at the same time. Cancer obviously implies the loss of personal health, the threat on life itself, an attack on one's own sense of self and the shattering of narcissistic stasis. In the case of Ms O, we also are witness to a sustained attack on her femininity.

In Ms O's mind being a woman appears to be less than desirable, in fact, shameful and unworthy, while men seem to hold everything that is good; even the metaphorical feeding breast in form of dry bread send from the distant gulag. One can only imagine how shameful and humiliating, how helplessly devastating it all is for Ms O. She presents increasingly lifeless in the treatment, incapsulated and in hiding; we detect little of her phantasy life but see her involved in sustained acting out while keeping the therapist at bay and her inner and outer life on hold.

The narrative of the assessment contains noteworthy historical backgrounds and includes elements of transgenerational history. I could not fully understand or see sufficient evidence for Ninel comments that "narcissistic defenses permeate the entire psychological space of the patient" but there certainly seems dissociation and absence of real emotion.

In further elaborations we learn that the patient idealizes her father and grandfather and indulges in the idea that she could have married a physically perfect partner but ended up marrying a rude and useless alcoholic. There is a teenage son in the picture but we do not hear anything more about him. The first impression is one of a split between mostly impressive and resourceful and able man who even feeds the family from far away while the woman's milk runs dry and Ms O's breasts are surgically removed. Women are depicted as weak and sickly, in need of being thought how to live their lives and mostly useless, even disgusting,

and this, of course, includes the way Ms O sees herself.

There is a sense that being in one confined space and in the proximity of the therapist is unbearable because it mirrors her internal reality; images of greed and constant demands are projected into the husband and later into the oncologists who are also seen as corrupt but surely also into the analyst whom she tries to protect from her greedy demands but also from contaminating her with the greedy aggressive cancer that eats away at her. She finds relief by fleeing outside the confined, claustrophobic space of the consulting room to join the therapist at a cigarette break.

On the basis of the clinical material presented, which is often of a conceptual and hypothetical nature rather than of a felt experience, Ninel illustrates her perseverance in her attempts in understanding her patient who is very difficult to reach and, at times, keeping her alive which is the only tangible therapeutic aim in the absence of any discernible movement in the inner world of the patient which is reflected in the therapeutic process. Ms O acts out, comes regularly late to sessions or misses sessions altogether and wishes to live in a fantasized room without doors and windows but surrounded by flowers. The therapist conveys her feeling of helplessness in the precarious situation of dealing with a very fragile but apparently, perhaps paradoxically, very greedy for life patient that is terrified of coming alive and making contact with herself and the therapist. She immobilizes the therapist by conveying a sense that a single word, spoken wrongly, could be detrimental and lead to a breakdown. Ninel feels the pressure to act, work things out and to make the patient better with a sense of urgency. Two years of dream analysis reveals itself as a refuge in which the therapist is meant to greedily feed from Ms O's theatre of dreams that do not really reveal much about herself.

It is a conference in Spain on "mental refuges" that Ninel feels sheds some light on her struggles to understand and help her patient. She feels that the concept of the "psychic retreat" offered her a key in seeing a way forward and understanding her patient. It seemed to me that Ninel is wrestling with her very difficult patient and was looking for a theoretical frame or a better theoretical frame to understand her patient. I felt in that context that the countertransference is sometimes

reported in form of “thinking about” the situation in a theoretical framework, but the raw emotional experience of the therapeutic situation appears to be more difficult to convey.

Ninel premises her understanding of transference and countertransference in the dynamic with this patient on the discovery of a malignant narcissistic defensive organization or a psychic retreat which renders the patient trapped in a state between being alive and dead and from which she cannot emerge. I found myself questioning whether what Ms O presents constitutes indeed a “malignant narcissistic defensive organization” or is more akin to a space in which feelings get hidden or obliterated and from which it is difficult to emerge.

This state of mind does not allow Ms O to mourn her losses and find a pathway to what Kleinian analysts understand to be the recognition and acceptance of reality: the depressive position. The patient fears being in communication with her feelings of loss and vulnerability, she is afraid to be seen and is no longer able to see herself. The patient is divorced from herself and blind to it.

Two cinematic examples, rooted in Jewish mythology (the Dibbuk and Schrodinger’s cat) which are prefaced to the clinical material as metaphors, to illustrate aspects of her understanding of the “psychic retreat” and its conceptual complexities. It highlights the idea of the patient being trapped in between two worlds, neither dead nor really fully alive; from which he or she is unable to emerge.

What I recall from quantum physics is that an uncertainty principle is somehow involved and so I found myself wondering whether the point of the “two perspectives” intrinsic to Schroedinger’s cat, referred to ‘not knowing” and to tolerating uncertainty. It struck me that Larry in the Coen brothers’ film cannot hold on to two contradictory notions and remain true to himself at the same time.

Ninel introduces us to various theoretical concepts relating to “defensive organizations” of the post Kleinian canon and also mentions Freud’s musing on “we and death” Eros and Thanatos.

Pierre Marty’s and Claude Smadja’s work on “la pensée opératoire“ and their psychosomatic explorations of “disorganized attachment theory” get particular attention as Ninel feels their work is not only highly relevant to cancer patients but illustrates a further facet of a psychic retreat and internal depletion by

avoiding all libidinal cathexis and hence becoming lifeless and empty. This deficit in psychic functioning is seen as rooted in a failed mother infant relationship at the outset of the infant's life and the failed relationship with its mother.

I think the difficulty with presenting different theories of defensive organizations and psychic retreats in a clinical context, is that while they all are relevant and clearly interesting concepts on a theoretical level in the absence of extensive clinical material however aspects of all of these theories or indeed none of them, might apply to the patient in question.

John Steiner, while building on other post Kleinian authors mentioned above, has developed a deep understanding of patients who seek shelter in a psychic retreat. He illustrates what might guide the analyst in helping the patient emerge from such retreats and finding a way out of the hideaway.

What does it take to make the patient feel sufficiently safe and understood as they emerge "from the room without windows and doors" to quote Ninel, into the gaze of the other and into the light of being seen.

Being exposed to the gaze of the other, as is inevitably the case in a psychoanalytic setting, experiencing vulnerability, exclusion and helplessness might well evoke feelings of narcissistic embarrassment and shame, even unbearable narcissistic humiliation as they become visible to another.

Steiner is interested in the subjective experience of such patients and uses simple and experiential language to meet them at the threshold to help them move out of their refuge and into the light of visibility. We might theorize about malignancy, aggression, guilt, envy, and omnipotence but I think with John Steiner in the clinical setting with the patient, we are better off speaking about the difficulty of experiencing shame, about feeling small, inferior and excluded when she/he are gradually able to venture out into visibility.

As the patient loses the protection of a psychic retreat, he/she might need to tolerate a degree of separateness, an awareness of self-consciousness which is frightening and can sometimes feel very difficult to bear. Clinically it requires delicate handling of the situation. It implies the recognition and the mourning of the loss of the chosen protective space

and hence of being seen or allowing someone to see, but also of seeing him/herself in relation and in dependence of others, also of his internal objects.

In conclusion

Ninel and I come from different psychoanalytic traditions. I have tried to illustrate how we might wrestle with a specific clinical picture in similar and different ways.

She presented a concept in theory and to a certain degree in clinical practice of a narcissistic defensive organization manifest in a psychic retreat that is perceived as a malignant narcissistic organization which keeps the patient trapped between two worlds and leads to psychic immobility or paralysis.

My thought was that this narcissistic defensive organization is a shelter and a hideout; also, a protection from feelings of what has been lost and what is threatened to be lost. Ms O might be caught between extremes of paranoid ideation, on the one hand, and melancholia, on the other, which relate to historical and actual loss inflicted by her illness. Ms O is too terrified to leave the “psychic retreat” in which she has found shelter.

Ninel introduces us to several post Kleinian thinkers and illustrates her understanding through Jewish mythological concepts and elements of attachment theory (la pensée opératoire) in wrestling with the predicament of her patient.

The ’psychic retreat” is an important concept in a wider theoretical frame that constitute a complex clinical situation in which the patient feels unable to show him/herself to the gaze of the other. The therapist needs to find a language in which the patient can be made to feel safe and understood while gradually tolerating separateness and accepting help.

Institutional Section

Introduction

Cristina Călărăşanu

Couple and Family Section Chair, EFPP

Vicepresident, Bucharest, Romania

During our last Delegates Online Meeting, in March 2024, we had the opportunity to learn more about the diverse national and political landscapes surrounding the regulation of psychoanalytic psychotherapy across Europe. These discussions sparked a high level of curiosity, concern, and deep interest in the future of our field. It became clear that, although each country faces unique challenges, there is a shared sense of urgency and a collective need for clarity and support.

In response to this, the EFPP Board carefully considered the feedback gathered from the Delegates and recognized the importance of continuing and deepening this vital conversation. To that end, we have established an institutional working group dedicated to exploring the various regulatory contexts across Europe. The aim is to better understand the political and institutional frameworks and to clarify the EFPP's position and role within these evolving processes.

As stated in our constitution, the EFPP was founded to protect and promote psychoanalytic psychotherapy. In these uncertain and shifting times, it is more important than ever to reflect together on how we can fulfill this mission. Our commitment as a federation is to act as a guardian of our field, and this new working group represents a concrete step in that direction.

The central task of the group will be to produce an official EFPP document addressing the regulatory issues, which will serve to support all EFPP members in their engagements with local regulatory bodies. Through this collaborative effort, we aim to strengthen our shared voice and ensure that psychoanalytic

psychotherapy continues to thrive within Europe's changing professional landscape.

Romanian Regulations on Psychoanalytic Psychotherapy

Cristina Călărășanu

Couple and Family Section Chair, EFPP

Vicepresident, Bucharest, Romania

Who Regulates the Profession of Psychotherapist?

In Romania, psychotherapy is a legally regulated specialization of psychology under Law 213/2004. The primary regulatory body is the Romanian College of Psychologists (Colegiul Psihologilor din România - CPR). CPR includes multiple divisions, such as:

- Clinical Psychology
- Educational and Counseling Psychology
- Military and National Defense Psychology
- All forms of Psychotherapy

Although the CPR is the official authority, it is sometimes criticized as being more bureaucratic than active. Several efforts have been made to establish an independent professional body for psychotherapy, but none have succeeded.

Regulations in the Public vs. Private Sector

The main distinction lies in the form of employment:

- Private Sector: Psychotherapists operate through licensed private practices.
- Public Sector: Psychotherapists work under standard employment contracts.

All other regulations, including ethical and professional standards, are the same across both sectors.

Position of Psychoanalytic Psychotherapy (PP) Among Other Modalities

Psychoanalytic Psychotherapy is officially recognized and regulated under the CPR's category of psychodynamic approaches. However, it is somewhat peripheral in practice due to:

- Limited representation in academic programs (e.g., university curricula favor CBT-based clinical psychology masters).
- Training available only through specialized psychoanalytic institutes.

Despite this, Romania has a rich tradition of psychoanalytic schools that continue to provide rigorous training.

Relationship Between Psychiatrists and Psychotherapists

- Some psychologists work alongside psychiatrists, forming integrated patient care teams.
- Psychologists are not legally subordinate to psychiatrists but may collaborate informally.
- Many psychiatrists remain skeptical of psychotherapy, particularly psychoanalytic methods.

Referral Sources for Psychotherapy

Patients may be referred to psychotherapists by:

- General practitioners (Family Doctors)
- Specialists
- Teachers or school counselors
- Or they may seek therapy on their own initiative

Are There Different Regulations for Different Types of Psychotherapy?

Yes. Regulations vary depending on the modality. Key distinctions include:

- Duration and structure of training
- Requirements for personal analysis
- Theoretical coursework and clinical supervision

Psychoanalytic Psychotherapy often has the strictest requirements, involving extensive personal analysis and long-term supervised clinical work.

Who Can Become a Psychotherapist?

- Psychologists can specialize directly.
- Other professionals (e.g., medical doctors (only psychiatrists), social workers, philosophers, theologians) must complete at least one additional year of psychology coursework before beginning psychotherapy training.

State vs. Insurance Responsibilities

- Romania does not have private health insurance coverage for psychotherapy.
- Since 2018, certain psychotherapy services have been partially reimbursed by the state.
    - Requires a referral from a medical doctor.
    - Reimbursement is limited to a small number of sessions.

- Mostly supports counseling-level services rather than psychotherapy
- Professional Confidentiality is governed solely by:

- The Ethical Codes of the CPR and training institutes.
- There are no additional laws or formal state procedures affecting therapeutic confidentiality in Romania.

Conclusion

Romania has a formally structured but centralized system for regulating psychotherapy, in which psychoanalytic psychotherapy holds an officially recognized—yet operationally peripheral—position. While access and funding remain limited, especially for deeper psychoanalytic work, the framework continues to evolve within the broader

European discourse on professional autonomy and recognition

Belgian Legislation on Psychotherapy

Chantal Hauzoul
EFPP Adult Section, Delegate for Fédération Francophone Belge de Psychothérapie Psychanalytique until March 2025.
Member of Association pour la Recherche en Psychothérapie Psychanalytique.
Member of the Comité de Vigilance en Santé Mentale.
Member of the EFPP Legislation group.
chantal.hauzoul@telenet.be

Who is regulating the profession of psychotherapist?

In Belgium, for a very long time, psychology and the practice of psychotherapy were not governed by any legislation.

It was in 1993 that a law appeared protecting the status of the psychologist.

In 2014 the code of ethics for psychologists came into force.

Also in 2014, following many years of difficult consultations between representatives of different therapeutic models, a first law was finally passed regulating the profession of psychotherapist.

In 2016, because of some legal and transparency problems, the Minister of Health amended this law. In reality, the mentality is completely transformed: the activity of psychologists is now governed by the law on health care.

Psychotherapy is now defined as: “a form of health care treatment that uses, in a logical and systematic way, a coherent set of psychological means (interventions), which are anchored in a psychological and scientific frame of reference, and which require an interdisciplinary collaboration within a psychotherapist/patient relationship.

This definition emphasizes a treatment to be administered in a logical and systematic way "within a psychological and scientific frame of reference", as in physical medicine and it no longer insists on the fact of supporting the subject in search of his own meaning. Luckily, the notion of relationship is still mentioned.

The profession of psychotherapist no longer exists. Only the act of psychotherapy is regulated. It must be practiced in conditions (of training, of functioning) which are far from favouring psychoanalytic processes.

The law wants to reserve the performance of psychotherapeutic acts only to psychologists, orthopedagogues and doctors, who have followed a specific training (with preservation of acquired rights for psychotherapy professionals practicing since before 2016). It thus puts an end, for better or worse, to the great diversity of psychotherapeutic ideologies, practices and practitioners

The law also expects the university environment to provide this training (at least 70 ECTS credits and 2 years of full-time internship) and no longer makes a distinction between the different therapeutic trends (psychoanalytic, systemic, humanist, cognitive-behavioural). Nevertheless, the training institutes for these different streams, which have decades of training practice both theoretical and experiential, and which, for many, promote interpersonal skills and personal psychotherapeutic experience, have claimed, with success, to continue their work in their same framework while allying themselves administratively with an academic institute.

A recent law (2019) on Quality in Health Care Practice (which concerns all health care practitioners -physical and mental -, therefore also psychotherapy practitioners) imposes procedures (in particular an Electronic Patient File), which seriously endanger professional secrecy and the intimacy essential to the psychoanalytic process and work with the unconscious.

No distinction is made, in the requirements of this law, between physical health and mental health.

Another law, relating to patients' rights, initially published in 2002 and last amended in 2024, refers now to the file kept by the professional as being the patient's file. The patient has access to all information concerning him. “Personal notes” of the therapist, a professional tool for reflection and work, are no longer excluded from that file, and so, no longer personal. However, a file, particularly in mental health, is also, for the professional, an essential working tool, on which he relies for his own reflection, reflection which he writes as part of his personal annotations: journal of interviews, diagnostic hypotheses, relational feelings relevant to understanding the therapeutic

relationship, self-criticism, etc.

However, does this part of the file not represent the intimacy that the therapist himself needs to reflect on how best to conduct and apprehend the therapeutic relationship?

No more room therefore, in the file, for a reflection which is specific and intimate to the therapist and which constitutes an essential basis for his work. The EPF is no longer the therapist's file…

More generally, digitization and the social control that it makes possible raises the question of the place of respect for privacy and its boundaries in relationships between humans. This translates, in our profession, into fundamental ethical questions, particularly around professional secrecy and, even more fundamentally, around our conception of the unique, singular human being, the subject, in his relationship to the world.

These aspects are obviously not specific to Belgium.

What are the regulations in public and private sector?

In Belgium, every legally residing citizen is covered by compulsory health insurance managed by an institution linked to the State. At the same time, there are possibilities of additional insurance policies for more extensive coverage. Furthermore, care institutions are subsidized by the State or the Regions (public sector), which allows, in some cases, such as mental health services, to offer care (for example psychotherapies) at lower cost. The psychotherapists who work there often also have a private practice.

Private practice is rather poorly refunded. It can be done within the framework of additional insurances or within the framework of "care circuits", for a reduced number of sessions and with a certain jeopardy of professional secrecy.

Indeed, in the apprehension, the management and the funding of mental health care, a distinction is currently made between basic psychological care (first line interventions) and specialized psychological care of psychotherapeutic type. In both cases, a limited number of sessions can be reimbursed subject to the redaction of a functional assessment (overview of the current situation on social, medical, psychological, psychiatric and historical level). This assessment is considered as a working tool between the patient and the various professionals, with the patient's agreement. It must be written following the initial consultation and given to the patient. However, the patient can decide not to transmit it.

Where is situated the psychoanalytical psychotherapy in relations with other psychotherapies?

There is actually a decline in interest in psychoanalysis among the general public and among the professionals. Different factors contributed to this situation:

- The rise of cognitive-behavioural therapies,
- the attacks initiated by some of their protagonists,
- the difficulty and reluctance of psychoanalysts to occupy the public square,
- the arrival of the digital age and its immediacy,
- the context of social precariousness

It is currently in the minority and, alongside standard cures and individual face to face, it has adapted and, over time, added other tools: mediator tools, psychodrama and other group practices of analytical inspiration, brief therapies, etc. This is certainly an enrichment and we need to go on developing our adaptation and creativity, provided we do not lose the essence of psychoanalytic thought.

One of the basic characteristics of psychoanalysis is the taking into account of the existence of the unconscious. Nowadays, it is fundamental that psychoanalysis, with the richness of this specificity and original point of view, invest in reflection, research and expression on what could be most useful and effective in the current social, global, planetary context that is in dazzling evolution.

Is there any link between psychiatrist and psychotherapist? Who refers the patient to the psychotherapist?

Patients arrive at the psychotherapist's consultation:

- by word-of-mouth advertising
- via the media, social media included
- sent by other health, welfare and educational professionals, including psychiatrists in particular (these exchanges work both ways)
- via judicial authorities

How is the issue of professional secrecy handled?

Respect for our intimacy and our private life is essential to the quality of care in general, and is an integral part of the psychotherapeutic process. It is the primary condition of the care process. In Belgium, this respect is guaranteed by article 458 of the penal code dealing with

professional secrecy, by the GDPR, and by numerous codes of ethics including that of psychologists.

However, a recently emerged legislation risks, in its current formulation, of dangerously weakening these fundamental benchmarks.

The law of April 22, 2019 relating to the Quality of Healthcare Practice requires each healthcare professional to keep an electronic patient file. The application of certain articles must still be regulated by royal decrees.

In its article 33, this law specifies the data that have to be inserted in the EPF, including in particular: -the reason for the contact or the problem at the time of the consultation; -personal and family history; -the report of some consultations meetings; -health goals and statements of expression of wishes received from the patient; -the diagnosis made by the relevant health care professional; -patient characterization; -the chronological overview of health care provided; -the evolution of the affection, …

It also lays down the conditions for sharing this file (therefore within the framework of shared professional secrecy), in particular the patient's consent which is global, given once and for all, but which can be withdrawn by him if he wishes.

The patient may also exclude certain data from the exchange and exclude certain professionals from the right of access, but... subject to a procedure introduced - by the patient -10 days in advance. Healthcare professionals who have a therapeutic relationship with the patient may also access the EPF under certain conditions, but compliance with these conditions would be left to the discretion of the professionals. The patient will have control over who has accessed it, but only after the event. Wouldn't the mental health file of each of us then become a sort of public square for health professionals? Not to mention the risks of hacking or fraudulent access by “interested” non-professionals , or of the use of this data within the framework of exceptional laws by less democratic regimes? How can you, as a patient, truly invest in a therapeutic alliance if you fear that your private and intimate experiences could be revealed?

The paradigm of professional secrecy has therefore undergone a major reversal: from “nothing can be revealed, unless…” to “everything can be revealed (at least between professionals), unless…”

Physical health and mental health do not belong, at least in part, to the same paradigm: whereas in physical medicine,

the signs and symptoms objectively lead to the establishment by the doctor of a diagnosis and treatment, in mental health, these symptoms (which together only sometimes constitute a mental illness) represent the signs of discomfort, of suffering linked to internal and/or external conflict situations (family, social, societal), that the therapist gradually decodes in alliance with the patient.

By including psychotherapy in health care legislation and above all by regulating it like physical medicine, as in the Quality law, the legislator wipes out the dimension of psychotherapy as support for internal journey and as a search for meaning. He establishes rules that make this work rather impossible.

Références

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- loi du 22 avril 2019 relative à la qualité de la pratique des soins de santé
- loi modifiant la loi du 22 août 2002 relative aux droits du patient et modifiant les dispositions en matière de droits du patient dans d'autres lois en matière de santé
- avis du CFPSSM concernant le dossier patient informatisé
- avis 857/2021 du Conseil Supérieur des Indépendants sur le dossier patient informatisé et l'échange des données de santé
- avis 937/2024 du Conseil Supérieur des Indépendants sur le dossier patient informatisé en santé psychique
- code de déontologie des psychologues : arrêté royal fixant les règles de déontologie du psychologue entré en vigueur le 26 mai 2014
- Autorité de protection des données (APD). Avis 100/218 du 26septembre 2018 et avis DOS¬2019-04611
- RGPD Art 9: protection particulière des données sensibles
- Nouwynck Lucien, procureur général honoraire : Travail médico-psycho-social et secret professionnel partagé. Ethica clinica mars 2022
- Avis 100/2018 de l'Autorité de Protection des Données relatif à l'avant-projet de loi relatif à la qualité de la pratique des soins de santé

NB. clinical orthopedagogy is the habitual accomplishment, within a scientific reference framework of clinical orthopedagogy, of autonomous acts whose aim is prevention, screening and the establishment of an educational

diagnosis, with particular attention to contextual factors, and the detection of educational, behavioural, developmental or learning problems in people, as well as the care and support of these people.