Motiveless Malignity: Problems in the Psychotherapy of Psychopathic Patients

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This paper attempts to draw attention to the difference between the states of mind and inner worlds of neurotic, borderline and psychopathic patients, with reference to different types of destructiveness: anger in the neurotic patient; desperate vengeful hatred in the borderline paranoid; and cold addiction to violence in the psychopath. Discussion focuses on technical issues and the need to meet the psychopathic patient where he really is, in the inner bleak emotional cemetery he may be inhabiting. Although most patients refuse to stay put in the neat schematic categories outlined, they do seem to appreciate and to need the therapist's recognition of the specific quality of these vastly different states of mind.

The film Assault on Precinct 13 begins with a sequence of shots of a gang of young men riding around the Watts District of Los Angeles in a car, aiming rifles first at an old black woman, then at a white man, then at a black man. Their fun is at least racially undiscriminating. The aiming seems random, idle, almost whimsical. We get to see the quarry lined up in the sights of the rifle each time, but no-one pulls the trigger. The members of the gang seem to be having a good time. (Bruce Chatwin (1987) observed that in the language of many nomadic peoples, the word for townspeople is ‘meat’.) The scene then switches to a little girl buying an icecream from an icecream vendor while her father makes a phone call from a call box. She returns to her father, but suddenly looks at her icecream with dismay and turns back to the icecream van. She does not realize that by then the gang has killed the icecream vendor, and the man standing in the van is his killer. She says, ‘Excuse me, I asked for chocolate and you've given me strawberry!’ The killer turns and, as casually as he might swat a fly, shoots her in her still open mouth. It is horrifying, and what is particularly horrifying about it is the casualness. The killer does not appear to be angry, nor does he give any sign of sadistic relish. He looks at most mildly irritated.

In another film, House of Games by David Mamet, a con-man tricks his woman psychiatrist out of all her savings. At first she — and we — are led to think he is in love with her. In fact he is a member of a group of con-men. Afterwards, when she learns of her seduction and betrayal, she speaks of their love affair, and asks, outraged, disbelieving and hurt, ‘How could you do that to me?’ He says, calmly, and with a dismissive shrug, ‘But this is what I do.’

Psychoanalysts and psychiatrists have described the lack of conscience in psychopaths, the lack of guilt and remorse for their deeds, their indifference to their victims’ cries for mercy. The more modern psychiatric classifications have tried to avoid what had in part become the pejorative and wastebasket use of the term ‘psychopath’, but the newer terms — ‘conduct disorder’, ‘antisocial personality disorder’, even ‘sociopath’ — are also inadequate because their purely descriptive level of meaning does not distinguish between the kind of destructiveness which is motivated by anger, that by bitter hatred, that by outrage, that by sadism and that by casual brutality. Unlike the textbooks, the patients themselves know the difference. Motivated vengeful paranoid violence, for example, is different from addictive habitual violence. Addictive violence may have begun as a defence against some horror, then gradually acquired sadistic and exciting overtones, but eventually, under certain conditions of lifelong chronicity, become almost motiveless and certainly casual. The enormity of the act may no longer bear any relation to the amount of feeling left in the perpetrator. An addiction is different from a defence. A temporary defensive hardening of the heart is different from a lifelong arteriosclerosis of the emotions. A big freeze is different from a brief chill.

A Psychopathic Child

My own hard school of knocks began with a little girl called Sarah whom I treated many years ago. She was an extremely destructive and violent child who regularly used to attack me physically. When she threw chairs at me in Friday sessions, I would say: ‘You are beating me up today because it's the weekend and we have to say goodbye and you don't like being left.’ She would agree, ‘Yes’, and then she would kick me again. I would make a similar interpretation on Monday: ‘You are kicking me because I left you on the weekend.’ Gradually I began to think, ‘but she kicks me on Tuesday and Wednesday and Thursday too!’ She simply liked kicking people. She had, I learned belatedly, a strong sado-masochistic element in her personality. After some years of the physical violence, she moved to mental cruelty. She knew how to interrupt, with impeccable — almost musical — timing, at exactly the moment when I was about to get something important finally formulated and clear. She knew how to raise hopes and then dash them. It was high art, and her concentration was
Linda I was able to say: ‘You are absolutely furious with me because we've got such a short session to
fact might not be feeling only anger or fury. They might be experiencing despair, or an icy increase in their cynicism. But t
Borderline patients or psychopathic patients might take weeks to recover from such a disappointm
half an hour late for her session, but refused to say more, and sat with her back to me, absolutely furious with me.
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An object somewhere has become capable of witnessing, and taking seriously, the danger to
emotional ice. The internal object may have begun to take on a little substantiality and life, even if only of a dangerous kind. An object somewhere has become capable of witnessing, and taking seriously, the danger to the self: At least something matters. (Clearly, this is nowhere near the depressive position in terms of concern for others; nevertheless developments within the paranoid position remain developments and should not be ignored simply because they do not involve depressive positionconcern or guilt.)

Some Clinical Differentiations Between Neurotic, Borderline and Psychopathic Patients

I would like now to offer some clinical examples of the difference between, firstly, anger in a neurotic patient; secondly, desperation, outrage and vengeance in two borderline patients; and thirdly, icy calculating cruelty in a very young psychopathic patient. I shall then consider four technical issues in the treatment of psychopathic patients.

Of course, live human beings refuse to stay put in these neat schematic categories, and I am using these diagnostic categories for purposes of discussion only. The fluidity of diagnostic boundaries might have been better illustrated with material from a boy, Daniel, who moves from quite psychopathic casual brutality to a genuinely persecuted and despairing state within seconds. (His paranoia is not feigned as in the more consistently hardened psychopathic patient — it is real.) The technical problem — of managing clear-eyed firmness with his psychopathic part, but extreme sensitivity and tactfulness towards his paranoid despairing part, which feels so easily destroyed — is monumental. But I shall have to concentrate on the one psychopathic child, who in any case does show some slight movement between the two states of mind. (I have also become interested in recent years in the element of psychopathy in some children with autism, another issue which requires more space to discuss.)

A Neurotic Patient

I will begin with a brief example of more ordinary interpretations about anger, due to loss or jealousy, in patients who are neither psychopathic nor borderline, but functioning at a relatively well neurotic level where it is positively helpful to say something like: ‘You are cross, you are angry
the last session of the week. It must be my fault’ — and she swung around and said: ‘Yes, and I've got exams next week.’ She calmed down quite quickly and she did manage to allow herself to have something of a session before it ended. A point I wish to underline is that it was enough to interpret her anger: it was not necessary to consider her desperation nor to carry for her the sense of injustice because she was in touch with that herself. Some borderline despairing people need us to contain this for them, but she did not. She was capable of standing up for herself — what needed processing was her anger. This girl still has difficulties around conflicts about her aggression and her adolescent problems, but for some while now she has no longer been symptomatically depressed. Anger as a defence against, or reaction to, loss or disappointment is a graspable, digestible concept for her.

**Two Borderline Patients**

A different situation arose with a little boy called Peter whose therapist was leaving the clinic in a month's time. He came to his session in a very desperate, wild, fragmented state. His mother who, like him, was upset about the ending and unable to acknowledge it, had taken to bringing him late. He had had a very deprived first year of his life, when his (anyway) rather withdrawn mother was very profoundly depressed. After he'd been in the room for a few minutes, he took out a paper on which the therapist had previously drawn a calendar of their sessions, asking when they would be stopping and which was today. She asked if he wanted her to tick off the days, something they had recently stopped doing. He said, ‘No’, and started to tear up the calendar. When he did so, the therapist said that Peter was cross with her about their meetings stopping (i.e. ‘angry because’ — a defence interpretation). At that point he got wilder and overturned a chair; she tried to prevent him, and then again said that he was angry because they were stopping the meetings. He began to get even more excited, and then started banging his head against the wall, which is something he did regularly as a baby. Here I think it is not enough to interpret anger. There is despair, and the child's desperate impotence and helplessness may be increased and escalated unhelpfully at such moments. He is incapable of hearing it, because he is in no fit state to think about and process anger. The necessary ego functioning and the necessary hope are both lacking. On the other hand, if the therapist is willing to take some of the badness into herself or himself, the child may begin to find things slightly more bearable. It is then easier to process the experience. So one might say (with some feeling, by the way) something like: ‘It's really terrible for you that I'm stopping. You feel you should be able to bear this whole experience up. It shouldn't be happening, I shouldn't be leaving you.’ This would involve acknowledging the child's desperation and amplifying and carrying for him his as yet unnamed, unverbalized, but possibly at least ‘pre-conceived’ (Bion, 1962) sense of injustice.

This next example involves a further elaboration of Betty Joseph's technical extension of Bion's concept of containment (Bion, 1962): she recommends with certain borderline patients holding and exploring their projective identifications in ourselves rather than returning them prematurely (Joseph, 1978). In this instance, I'm referring to the moments when the patient may be projecting or externalizing an internal object of an extremely bad kind. A psychotic adolescent boy named Luigi wanted to strangle a seductive but patronizing woman relative. Interpretations of his hatred and anger seemed to escalate these. Interpretations of the fact that he felt she deserved death for the way she treated him, however, seemed, to calm him down instead of turning him into a homicidal maniac. This involves important and often dangerous questions of whether we push it all on to patient with a ‘you’ interpretation or let it be contained elsewhere in us or even in some other object. (‘You really hate her’ versus ‘You feel she (or I) deserve punishment.’) The relieving calming effect seems to have to do with an understanding that badness needs to stay out there. Otherwise, humiliation, despair, shame and revenge can lead to explosive and dangerous eruptions in patients who may have been very heavily projected into.

Kundera, in his novel The Joke (1982), pointed out that there are two kinds of rectification — forgiveness and vengeance. He describes how a person's whole inner balance may be disturbed when a lifelong object of hatred decides to make friends and cease to be hateful. (A friend who betrayed him and had caused him to be sent to a labour camp for fifteen years.) He asks, ‘How would I explain I couldn't make peace with him?’ … and, ‘How would I explain I used my hatred to balance out the weight of the evil I bore as a youth … How would I explain I needed to hate him?’ This kind of desperate, embittered hatred has to be carefully distinguished from the aggression of the more casually brutal, or more coldly murderous, psychopath who, of course, could experience such interpretations as collusion. (I have discussed rectifying phantasies of revenge and justice in borderline paranoid patients at greater length elsewhere (Alvarez, 1992).)
Psychopathic Patients

Hyatt Williams has pointed out that if one worked very carefully with murderers with an adequate theory of splitting, displacement and projection, it was possible to discover that they were not without conscience: they did have a conscience but only in regard to particular split-off objects. For example, a man who had murdered a woman might not feel guilty about the woman, but might suddenly feel pity and remorse for an injured pigeon (Hyatt Williams, 1960). Symington makes the similar point that, if you look carefully at the internal world of these people, they do have a good object and love for it somewhere, but it is often invisible and hidden (Symington, 1980). They are not completely conscienceless, not completely loveless. They have an excess of guilt. He cites Heathcliff's symbiotic love for Catherine in Wuthering Heights (Bronte, 1847). I would stress that what also kept Heathcliff going was his belief in her love of him. My own guess is that in some of the colder psychopathic people it would be hard to find even that bit of light in the darkness.

Technical Problems with Psychopathic Patients

I want now to draw attention to a major theme in Symington's paper: his brilliant delineation of the three responses evoked by the psychopath. He points out that one of the most common responses is collusion. People simply let bullies have what they want. He suggests that this has something to do with gratification of some of our own psychopathic parts. He says that the second common response is disbelief and denial. I think it is possible, but useless or dangerous, to use psychoanalytic explanation both to the patient and to ourselves in exactly this denying way, in order to evade the disturbing facts of what we are feeling in the countertransference; and these patients know when we are being evasive and cannot stand what they are dishing out. Symington is quite forgiving about the fear such people evoke in their analysts, therapists or jailers, and the naturalness of our cowardly denials. He points out that it is only sane to want safety and peace. The third response is condemnation (Symington, 1980). These patients do provoke the most powerful feelings of horror, outrage, condemnation and retaliation. Unfortunately, such responses only serve to excite the patient or make him strengthen his armoury and become even more determined to defeat you. The hardest thing to do is really to lookevil in the eye, bravely but not in a retaliatory or condemnatory way. When I finally became aware of how much Sarah relished putting the knife in and then twisting it, I was at first shocked and horrified. I would say: 'You really want to break my heart, don't you?' I suspect my use of the word 'really' still carried a note of disbelief, and the vain hope that she would deny it. Instead, she would lean forward intently and whisper — fervently — 'Yes!' I think if you work with these patients for any length of time you have to grow and change because they change you. One has to get beyond the stage of denial, then beyond the state of outrage to a state of mind requiring courage and steadfastness, and also, in one sense, respect for the patient's courage in surviving in his empty world.

I wanted to say something about a book by Barbara Docker—Drysdale, a follower of Winnicott who ran a residential unit for extremely disturbed children (Docker-Drysdale, 1990). She talks about 'frozen' children who, I think, may be even more ill than Heathcliff and the people Symington talks about. I think we have to leave room in our minds for the fact that some children get frozen so early in life that there isn't a lot of love even hidden. Docker—Drysdale makes it clear that she would always be looking for some flicker of feeling in assessing a child for acceptance into the school. She writes most interestingly about the difficulty these children have with symbolization. She gives the example of a child new to the school who may steal something from the refrigerator, not because the food has any symbolic meaning, but simply because he's hungry. A couple of years later, when the child is by now very attached to his primary care worker, he may steal from the refrigerator because he is upset because she is going on holiday: the theft may be full of symbolism. She talks about 'frozen' children who, I think, may be even more ill than Heathcliff and the people Symington talks about. I think we have to leave room in our minds for the fact that some children get frozen so early in life that there isn't a lot of love even hidden. Docker—Drysdale makes it clear that she would always be looking for some flicker of feeling in assessing a child for acceptance into the school. She writes most interestingly about the difficulty these children have with symbolization. She gives the example of a child new to the school who may steal something from the refrigerator, not because the food has any symbolic meaning, but simply because he's hungry. A couple of years later, when the child is by now very attached to his primary care worker, he may steal from the refrigerator because he is upset because she is going on holiday: the theft may be full of symbolic meaning. Docker—Drysdale thinks it is important not to confuse the two. Hanna Segal's distinction between the symbolic equation and the true symbol is relevant here (Segal, 1957), as is Winnicott's concept of the transitional phase (Winnicott, 1951). It is fascinating to watch these children move from vicious acting-out, to played viciousness, to, say, a cruel verbal joke and then a kinder joke, a progressive process which may take months or years but which is nevertheless an important develop- opment involving some considerable sparing of the object. Docker-Drysdale thinks that such children are 'unable to make any real object relationships or to feel the need for them'. And, importantly, "This kind of child cannot symbolize what he has never experienced or realized' (p. 179). In the same way, I am suggesting that it is important to find a language sufficiently bleak for the psychopath to feel we are at least attempting to meet him where he really is, rather than where we think he ought to be. In a large part of his being, he may be inhabit- ing an emotional cemetry. We can neither exhort nor coax him into the depressive position, and to join the rest of the human race. He will only think we are misguided fools if we talk to him about the anger or loss or pain which he may be years away...
from feeling. Nor should we imagine he is necessarily defending himself against dependency on us or refusing to see our goodness. I may really see us as useless, because he has a use-less internal object. His violence may have begun as a defiance against pain, but it may have changed into a way of life.

Docker-Drysdale makes an interesting distinction between experience, realization and symbolization: she points out that it is not enough to give these children good experiences; they have to realize they're having them. This is similar to my own views derived from working with very deprived or very abused children. You may need to interpret when you see that - for example: 'You feel that I like you today' or 'You like me today' - but you also need begin show them that they like being liked, they like having loving feelings. 'You like me please, and you like it when I like you.' These children are often caught up in a vicious circle in which they do something provocative, the object punishes, they then do something even more provocative, and they may rarely notice the other, probably very fleeting, moments of good contact.

I think Docker-Drysdale's concept of 'realization' is similar to Bion's concept of the need to get 'alpha function' around a thought to make it thinkable (Bion, 1962). The baby, he thought, needed his experience to he met by the caregiver's thinking/feeling mind. Stern's ideas about how a mind grows from the experience of shared meanings and amusements are similar, although he is describing a rather more pleasant set of meanings than is Bion (Stern, 1985). Here the experience we are invited - or rather forced - to share or contain is disturbing and often horrifying, and it is easy to miss tiny reductions in the level of cruelty, for example,

or fleeting moments of friendliness. But when these moments come, we can learn not to greet them too eagerly, and not to make too fancy symbolic explanatory interpretations. It seems better simply to stay with the patient and think about one moment of his experience at a time. With psychopaths, Strachey's concept of 'minimal doses' in the transference probably needs reducing to 'minimalistic doses' (Strachey, 1934).

A Second Clinical Example of a Psychopathic Child: Tom

Sarah, whom I mentioned earlier, was only 10 years old, and it was originally hard to believe that such a young child could be capable of such dedication to cruelty. More recently, I have been treating a little 4-year-old boy whom I shall call Tom, referred because of his coldness towards his mother. (His mother believes the child has never looked at her since he was born. In fact, the mother was rarely at home, and the child became profoundly attached to his nanny, who then left and was replaced by a series of different nannies.) At one point Tom became very withdrawn, but, both before and after this period, he had hardened up chillingly. He is an attractive child who can charm strangers wonderfully with his intelligence and lively, rather driven, sense of drama; but he developed an icy glitter, and a manipulativeness which worried even his father, who did not feel rejected by him. Tom is extremely jealous of and cruel to his younger more favoured 2-year-old sister and, in his sessions, he indulges in slow, calculated tortures performed by a 'doctor' (himself) on a toy baby teddy. I am instructed to speak for the teddy, and, obviously losing my capacity to bear it at one point one day, I made the mistake of asking, in the teddy's voice, why I was receiving such punishment, why the doctor was doing this to me. He looked at me as though I was utterly stupid, and replied, 'Why? Because I like it!' I had seen him a day or so before sticking the pin of his badge into the teddy's eyes, infinitely slowly and with almost loving relish, and I should have known better.

Terms such as 'conduct disorder' do not capture the flavour of such moments. Such destructiveness is different in kind from impulsive anger or fury: it feels lifelong, abiding, enduring and, even in a 4-year-old, lifelong means just that — his life of bitter disappointment has been inordinately long.

His parents were never sure that psychotherapy was what they wanted for him, and it became clear that, as soon as he was accepted into the school of their choice, his treatment would have to end. He was by now less withdrawn, somewhat more manageable at home and that seemed to

be enough for them. I had begun to see the ice melt a little; there were some signs that he could feel heated anger, and even allow me to witness this. In the session I am about to describe, one can see some alternation between the more psychopathic moments and some real desperation, and me trying to keep up. The Monday after the weekend when Tom's parents had rung to confirm their decision that he should stop in July, he came into his session in a bullying but blustering and wild state. First he blocked my path on the stairs down to the playroom. I said it seemed to be my turn to be shut out. Then in, for him, a very muddled way (he is usually icily clear and coherent), he began to say, 'They say I am not coming — they asked me what I … I don't want to come here any more. No … they don't want … No … I don't want …' I said I thought he was muddled, because he wasn't sure who it was who didn't want him to come. He kept on repeating, as he opened his case, 'I don't want to come any more — you're a bad witch.' Yet, although at one point he was facing me, and normally he has the boldest of unchildlike gazes, this time he would not look at my face. Instead, he was staring down somewhere around my
middle. I said I thought he was having difficulty looking at me and maybe this was because he wasn't sure what he wanted and whether I really was all bad. (A fairly minimalistic comment.) He began throwing all his toys out of his box onto floor, but when he got to the bottom layer, which contained the farm and wild animals, he first took out the little lamb, placed it carefully inside a glove puppet and placed a white and brown foal in front, as though to stand guard over it. They had been good figures guarding the little lamb the week before — definitely a new development — and I was surprised at their survival. He went on with terrible and final deliberation, throwing all the other animals out on the floor with total contempt, and grinding his feet slowly and thoroughly onto the soft baby teddy. He seemed too wound up and icy even to get into one of his sadistic ‘games’ with me where the animals were to be killed and eaten. In the weeks prior to the decision, the fact that his murderoussness was being played out in the drama with a faintly shared quality, i.e. signalling a tiny move into the transitional area, had given me hope. But now his contempt (and, I think, his despair) was too total even to play. I acknowledged this, but I did comment on the lamb's preservation. I said I thought that he was leaving a little room in his mind for friendly feelings and some good memories of the time he'd spent here. I kept it cool and minimalistic, as I believe is right with him. It saves his dignity and in a way acknowledges his courage in the enormity of his task, which involves managing his own enormous hatred and the hatred which he feels others have for him. (Certainly the bitterness of his mother is quite open and declared and, I was told, so was the dislike of his current nanny.) I did not, therefore, refer to the teddy as representing his own baby part, nor to infantile dependency feelings being spared. This is partly because it was not clear whether the teddy stood for himself and he was identified with it because he felt crushed by the adults’ decision to remove his treatment to which he had become very attached; or whether it stood for a more split-off baby whose killer he was identified with. I was not sure, but even during the ‘healthier’ sadistic games which had a slight shared quality in the previous weeks, I considered it premature to suggest that the teddy was really him. I believe the desire and, in a way, as Kundera suggests, the need for rectifying revenge phantasies (not actions) may need addressing for a very long period. The clinician has to decide when the patient is able to accept the return of the split-off or projected part. This may be a few seconds or a few years later. The clinician also has to try and sense when and whether the vengefulness has become addictive and is no longer really desperately needed — or when frenzied perverse violence has become somewhat desultory and is also no longer needed.

A little later, he shouted, ‘You'll be sorry!’ and I, feeling absolutely terrible anyway, said I thought he felt I should be the one to feel the sadness about his going, and that maybe he knew I was very sad, and didn't want to lose him. After a bit, I added that he must feel I ought to be sorry about not being strong enough to have persuaded his parents to let him stay. He began to glance at me a little. He began to order me, in a very tyrannical manner, to pick up the fallen toys. I felt the situation was mixed because he was a tyrannical child, and the services he gets people to perform in this way are invariably done grudgingly, if not with hatred. (There was a constant battle of power and of will between him and the current nanny.) But I also felt he was getting more and more desperate, and that he actually needed me to pick the things up, and to show that I was willing to do it because I liked him, not forced to do it because I feared his tantrums. Also, he was finally engaging me in a jointactivity, in however bullying a manner. So I began to pick the things up, keeping my eyes on him, which was always hard to do when he was glaring so unpleasantly and coldly, but felt important because it was less submissive. I think he was certain, as all tyrants are, that his slaves hate him. There was a noise from upstairs in the building, and he startled very suddenly. I said that I thought that he was afraid somebody up there didn't like him bullying me like this, and that he felt I really didn't like him when he ordered me around like this. (My years of incomprehension and denial with Sarah may have taught me something, because I did say this with great seriousness, but note the ‘really’). It is painful to acknowledge what the child knows to be true — that we weary of our servitude.) He started to say, ‘I don't want to come here’, but it came out, ‘You don't want to come here’, and eventually I said, making myself look at him, realizing that there was truth in it, ‘I think you feel I'm glad you're going.’ He gave me a very direct look. I did not say, ‘You are afraid that I'm glad you're going’, as the verb containing doubt — ‘afraid that’ — can serve to deny what is really happening between the patient's self and his object. It is important to contain the reality of his emotional experience, and I find the word ‘feel’ to be less denying.

When it was time to go, and we had put the toys and the baby teddy in their box, he shouted on the stairs up, ‘How would YOU like it if you had to be put in a box!’ and I had just time to say that I thought he felt really it ought to be me and not him that this was happening to. I let him know I thought he was right, because it seemed that this time it was a desperate, not a cruel, projective identification. In fact, I think on reflection that it was not even a projective identification, more an acknowledgement of his failure to project, his inability to find and keep an object that could receive his projections. He now rarely sees the beloved nanny of whom the mother is so jealous, and I think he was describing his own fate as the receiver of his mother's powerful projections. But the further element in his question, which I could not address in the
 month remaining to us before July, was ‘Do you really care to know in full what it's like to be me?’ I suspect Tom knew that a part of me did not.

**Discussion**

I would like to conclude by discussing four issues which arise in working with such patients. In order to avoid Symington's trio of collusion, denial and condemnation, it is important, first, to avoid the last: that is, instead of condemnation, it is necessary to look evil straight in the eye. This implies not evading the full bleakness and horror of the patient's impulses, nor the inadequacy and foolishness of their internal objects and of ourselves in the transference. As the doctor-torturer-child replied to me, ‘I like it!’ It also implies not evading what they know to be our own dislike, distaste and even hatred for their ruthless, cruel and often brutal treatment of us, their objects and themselves. I don't know if I have conveyed the degree to which Tom's play with the baby teddy is not simply ordinary aggressive phantasied play, or why I feel that he is the kind

of child who might really cause an accident to his baby sister, so carefully managed that no one will ever know that it was anything but an accident. I think he knows I know what he is capable of. I debated telling the parents a bit more clearly what I thought, but the problem is that this would have played in at that stage with the mother's desire to project all badness and evil into her 4-year-old son, who was unfortunately the tragic recipient of projections which belonged to previous generations. Tom's cruelty probably did start as a re-projection of his own hurt, but even if I were to keep him in treatment for years, I think it would not be useful to try and return the projections to him for a long time for the reasons stated above. This involves addressing the desperate paranoid element in him which needs containing outside himself. Premature reintrojection could only increase his desire to hurt any baby, so long as it wasn't himself. It would be important for someone to accept those projections which some figure somewhere should have held, and to be honest about what he knows to be his capacity to evoke his object's hatred and weariness. Hopefully one could try to do this without retaliation. Unfortunately, there is the further problem that his cruelty is no longer only desperate and vengeful: it has become the possible grounding for a sado-masochistic perversion. He ‘trembles’ with excitement in some of his scenes. This would certainly need addressing in future work with him (work which was finally undertaken again about a year later). Secondly, we must struggle not to collude or deny, but to find, unsentimentally, the patient's friendly feelings and whatever faint beginnings there may be of trust and faith. We should not appeal for a good self or good object which is not present, but we need to be alert to the tiniest flickerings of faith and hope which are there. It is dangerous to elevate or amplify them; it is better by far to play them down. The patient may be able to agree that he is somewhat irritated at the recent break's interruption to his routine, but be nowhere near getting in touch with painful feelings of loss about the gap. Also, at times we may have to acknowledge, unsentimentally, what he may observe to be our hurt, our defeat and our fondness when the patient cannot do so.

Thirdly, it is important to avoid symbolic interpretations of either positive or negative feelings. For example, interpretations along the lines of ‘You feel abandoned by me as you did by your mother’ may carry too much meaning, and meaning may simply not be available to patients in these hardened frozen states. We may need to respect the patient's insistence that he ‘just’ likes what he does, or ‘just’ is irritated, not angry today, and that it has no meaning. Then, slowly — perhaps — meaning can grow.

Finally, interpretations directed toward searching out and revealing the patient's vulnerability are usually dangerous or useless. Such patients are not functioning at the level of the depressive position. They are living in a paranoid world where survival, not love, is at issue. Values of intelligence, daring, courage, skill, triumph — the values of the battlefield — are paramount. Premature interpretations regarding hidden vulnerability or dependence WHICH THE PATIENT HAS NOT YET OWNED may produce dangerous eruptions, or, at the very least, earn the patient's appropriate contempt. It is important, instead, to save his dignity and respect his courage in going on in the face of the dead world he inhabits.

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