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SELF-EXPERIENCE AND THE FACILITATING ENVIRONMENT

Margret Tonnesmann

When I came to write a paper on "The Theory of the Self" which I was asked to give to a Meeting of the Group for the Advancement of Psychotherapy in Social Work, I first consulted Fowler's "Modern English Usage" (1968). He indicated that Self and I are interchangeable and can be substituted for each other in certain circumstances. Stimulated by a paper of my German colleague H. Thomä (1981) I then mused about the use of Self in colloquial English: Self does not take the role of an acting subject. (I can do things but Self cannot do things). Self, however, is often used as a reflective compound. I, myself, can do things. It usually denotes a kind of physical presence. Moreover, I can take my self as an object and I can have a dialogue with myself.

In the early psycho-analytic literature, in particular in Freud's writings, the phenomenological ego, the I, so-to-speak, is used synonymously with the self. This becomes more understandable when we read James Strachey's (Freud, 1923) account of his difficulties to translate some of Freud's terminology. The difficulty was the following: What has been translated as ego is in German I (Ich). Up to the twenties, Freud was mainly concerned with the study of the properties of the unconscious and with the instinct theories and he was only secondarily concerned with the study of the ego. At that time, he used ego (I), self, person and personality interchangeably. But when he introduced in 1923 his structural theory, the Id-Ego-Super-Ego model of the mind, the ego (the I) became a substructure of the mind. From then onwards, the emphasis of study shifted and the American school of psycho-analytic Ego Psychology has developed a comprehensive theory based on this structural model. One of the consequences of this has been an increasing trend amongst psycho-analysts to speak of the id, the ego and the super-ego as if they were concretely existing substances so that the structural model of the mind has at times become anthropomorphised.

Because Ego Psychology theories have become more and more sophisticated and abstract there has been a counter movement towards formulating psycho-analytic concepts in a language which is nearer the actual clinical situation we find in our consulting rooms. The English and the British Schools of Object-Relations Theory (Sutherland, 1980), for example, have on the whole maintained this clinical orientation from the beginning, but those analysts particularly who have treated severely disturbed patients felt the need to study the disturbances of ego-feelings and ego-experiences in the closer context of their clinical work. Amongst these was Paul Federn (1932/1952) who already treated psychotic patients in the twenties in Vienna and later in the States. He said that the ego, the "I", should not be seen only as the sum of its functions. There was another ego which could

be understood as a psycho-somatic unit with feelings of continuity. He pointed out that everyone is conscious of his ego-feelings, of his mental ego and of his bodily ego. The ego is the bearer of consciousness but, paradoxically, we are also conscious of our ego and its boundaries. That is why we can say that the ego is at once subject and object. As subject it is the I, as object it is the self. We can take ourselves as an object and we do so when we speak of our better self or our bad self. What we experience as the totality of our selves, we call our self (or ego) identity.

Masud Khan (1977) has recently drawn attention to the philosophical literature on the subject of Self and he stressed that neither Descartes nor Montaigne nor the various existential schools have succeeded in conveying a clear concept of self which is communicable even if each individual author seems to be clear as to what he means by it. Kahn then states that the paradox of the experience of self is that nobody can speak directly of his self nor can anybody relate directly to it. The self, he continues, is at the same time created but also experienced through its symbols. Winnicott (1960/65) has also stressed that the self itself stays incommunicado. But we are nevertheless experientially aware of our selves. Here then, we could make a link to the colloquial use of the word: it cannot become an acting subject.

Federn came to study the self because he was one of the first analysts who treated severely disturbed patients. Over the last 20 years or so there has been an increasing trend amongst psycho-analysts to study self-experiences and their disturbance in their patients. This has come about partly because the complaints of our present-day patients have changed. Freud's patients came to him because they suffered from crippling neurotic symptoms which he came to understand as a compromise solution. When he investigated their complaints he found that they suffered from conflicts arising from their sexual urges on the one hand and their disapproving ethical standards of shame and disgust on the other hand. In time, he developed his theory of infantile sexuality and by doing so he challenged the taboo of his time and shocked his contemporaries. He and his early circle of co-workers found themselves separated from the rest of the scientific world and psycho-analysis in consequence developed in nearly complete isolation. Freud (1910) once mentioned that he could, nevertheless, envisage a time when the theory of infantile sexuality with its central Oedipus Complex would become common knowledge. Neurotics then would have to give up their symptoms because they would no longer be able to conceal the secret wishes underlying them. Freud was right in one respect and wrong in another. The theory of infantile sexuality has indeed become common knowledge but society as a whole has reacted differently from Freud's predictions. It has instead developed a certain tolerance for neurotic disorder. In this way it accommodates the neurotic individuals' need to avoid painful

anxieties arising from their intrapsychic conflicts. The neurotic has nowadays ample opportunities to act out his conflicts in his daily life. One of the frequent consequences of this is the threat to marriage and family. In my opinion, neurotic disorder has become the domain of the marriage guidance counsellor and the family therapist. Their therapeutic interventions aim at mobilising ego adaptive functioning in interpersonal relationships. At the best they may loosen ego defensive structures and so give an impetus to spontaneous intrapsychic growth. At the worst they may stabilise ego defensive and false self structures which are better equipped to comply reactively with the demands of interpersonal relationships.

Those patients, however, who explicitly seek psychotherapeutic help are casualties of their society. We all know about the society of which Freud's patients were casualties. But what has made our patients casualties of our present-day society? Is it not society's denial of the individual's search for self-expression? Instead, we find an ever-increasing demand for adjustment to ever-increasing role-identities and multiple group integration. Concomitantly, life in confined spaces and high mobility in big cities has often reduced individuals to anonymous entities without roots or stable relationships.

Since the late fifties, we find movements, especially amongst the young, which demand the individual's right to self-expression, more care for the young, the old and the weak. More recently voices have grown stronger demanding the preservation of nature from technological exploitation. During the affluent sixties, some of these movements were hypomanic in character. Remember the elation of the flower movements with their belief in total happiness and love. It was felt that aggression could be mastered by total passivity and then all aggressive forces would finally disappear. Remember the movements which demanded the right of patients to stay psychotic because this was considered to be their authentic answer to the threatening environmental corruption of their selves. Was it this manic flavour which has prevented these ideas from undergoing transformation and evolution during the seventies? What has followed the elation is depression and apathy. The economic recession has most likely played an important part but it cannot be the sole cause of this development. Another important factor is, in my opinion, our present-day inability to accommodate mankind's inherent feelings of anger, hate, violence and even murder (and with it, suicide). In the midst of the swinging sixties it was Winnicott (1963) who drew attention to the severe strain which permanent peace in the face of its alternative, the ultimate total nuclear war, puts on everybody except the emotionally mature and he adds that emotional maturity is a rare achievement. When he discussed the adolescents' special problems with aggression and their discovery of the power to kill (this in contrast to the five-year-old who only dreams of killing his father) he wondered whether adolescence in general would be able to put all its

aggression into competitive or dangerous sports. And he asked whether society will not clamp down and make even this unrespectable or even antisocial? He referred to the times before the threat of nuclear war and said 'We do know that a localized war, with all its immense tragedy, used to do something positive for the relief of individual tensions, enabling paranoia to remain potential and giving a sense of REAL to persons who do not always feel real, while a life of ease brings a threat of depersonalisation.' (1963). This may be a very uncomfortable statement but it does not make it less true. But should we not feel less frightened or incensed about the very localised wars on the football fields or during demonstrations than about the wide-spread pathological forms of depression and apathy of the present-day which feel unreal and only hide the violent, murderous forces which may irrupt at any moment? We know that the baby batterer is on the whole a very depressed individual who suddenly irrupts into uncontrolled, violent action.

Winnicott (1960/65) regards feeling real as an essential manifestation of the 'true self' whereas feeling un-real (or depersonalised) is a typical propensity of the 'false self'. How did he come to develop these concepts and what is their significance in our work with patients? Donald Winnicott was primarily a paediatrician who also became a psycho-analyst and a child psychiatrist. He thus had the unique opportunity to observe infants in his clinics and also in his consulting room when treating severely disturbed adult patients. He once stated that the specific transference relationship of his severely disturbed adult patients gave him the most valuable opportunity for baby observation (1959-64/65).

I have already mentioned that it was the widening scope of psycho-analysis, in particular the treatment of severely disturbed patients, which shifted the emphasis of research to the study of the self and also, especially in England, to the study of early object relationships of the infant. Melanie Klein was one of the first analysts who studied the conflicts which arise from early object relationships in their relation to severe forms of emotional and mental ill-health in adults and children. She perceived infant development in terms of the conflict of the opposing life and death instincts, with characteristic anxieties which evoke typical configurations of primitive ego defence mechanisms. In time, an intrapsychic world of objects and self is created through projective, introjective and identificatory processes. Klein saw the role of the good-enough-mother as supporting these developmental processes which no human being can escape.

Donald Winnicott was at first influenced by her teaching but in time he came to see earliest infant development as a process to which the good-enough-mother (or her nursing substitute) makes an essential contribution. He, as also Balint (1968) and Fairbairn (1952), developed theories concerning the earliest beginning of human existence, which

can only take place through the facilitiation of the infant's environment. It is the quality of the nursing environment's adaptation to the infant, which can be either good enough and facilitate potential health, or may significantly fail. The outcome of the latter is emotional or mental ill-health of varying degree during later childhood or adulthood. In Winnicott's classification (1959-64/65) they are called environmental deficiency diseases which include the whole range from chronic schizophrenia to false self living. The latter can be so well organised that the individual can fit in with the demands of ordinary living. But adaptation is then compliant, without spontaneity, or emotional colour, only a reactive response. A patient of mine explained this state very aptly when she complained that she had no interests in her life, no energy to pursue any activity. Her constant silent search for anticipation of other people's expectations of her responses to them was exhausting and compulsive. She actively avoided human relationships but she was secretly engaged in thought dialogues with others. But these objects were her own subjective objects which arose from her intrapsychic world even if she projected these subjective objects on to those people whom she had recently met in her ordinary daily life.

Winnicott (1960/65) saw the beginning of human existence as evolving from the infant-mother unity. Hence his often quoted saying 'I cannot conceive of an infant. I can only conceive of a nursing couple.' At the very beginning there is the infant's body functioning which is given ego coverage by the nursing mother. There is no Id there as yet, as there is no ego yet. The infant is un-integrated and absolutely dependent on his mother. (Winnicott, 1963/65). The mother who holds her infant physically and figuratively with primary maternal preoccupation gives cohesion to the sensory-motor elements. In time, the infant makes a gesture and gives expression to a spontaneous impulse. The mother meets this gesture and gives her infant the experience of omnipotence. She thus makes sense of the gesture for the infant. The infant creates the breast but the breast is there to be created. This is a paradox which Winnicott says should never be challenged. (1952/58). The mother who meets the infant's spontaneous gestures and so provides just what is needed protects her infant from having to cope with an external factor, a 'not-me'. Every mother who feeds her baby satisfies the baby's oral instinctual needs. The hunger disappears and the sucking is a pleasureable body state mainly of the oral-erotic zone of the mouth. The good-enough mother will present the breast in such a way that the infant can have <u>an experience</u> of satisfaction. The hungry baby makes a gesture wanting the breast, creates a want for the breast, one could say. The breast is just there to be wanted and the infant has an experience of magic omnipotence. Such experiences constitute ego nuclei which in time become integrated into a first primitive ego. When this happens the infant can experience I which feels to him like a unity. The breast which is omnipotently created is I also. I, however, feels <u>real</u> to the baby and as I have said

earlier, to feel real is one of the basic propensities of the true self.

The not-good-enough mother cannot meet her infant's gestures. She substitutes instead her own gestures for them. Whereas she may be able to satisfy her infant's oral needs and so becomes a satisfactory Id object, she does not give her infant an experience of omnipotence which would foster ego growth. In consequence, the infant cannot develop an emotional I, cannot any longer make spontaneous gestures and the true self will remain in its archaic state. It will stay isolated and will be defended and protected by premature development of ego functioning. (M. James, 1960). The latter will enable the infant to make sense of mother's gestures and comply with them by mind activity.

But not only mother's holding function, also her handling of her infant, her enjoyment of the baby's body and feelings of bodily closeness, enrich the build-up of ego nuclei. In time, there will be an integration of the psyche-soma unity and the baby can experience "I exist" within my body and with my skin to hold it together. Winnicott (1962/65) calls this the personalisation aspect of ego integration. If the mother's handling of her infant is deficient, the infant will be left with a weak psyche-soma integration and may be later liable to psycho-somatic illnesses.

It may have become clearer now that the true self is already potentially active in the first spontaneous gestures of the infant. However, some ego-integration has to take place before we can talk of a true self, this core feeling state of feeling real, being spontaneous, creative, authentic. The true self concept is not the same as the phenomenological use of the term self as an object of the ego. We can experience our true self when it actualises itself in our feelings of being real, our experiences of living, but we are not conscious of our true self as such. Winnicott (1960/65) maintained that the true self evolves from the primary unconscious where primary process functioning, dreaming and unconscious phantasies are located. That is why he says it stays incommunicado. but it can actualise itself in creative activity in its widest sense, in object relating and in our feelings of continuity-of-being. The true self has the capacity for the use of symbols, it is essentially primary and it becomes part of our intrapsychic reality.

Winnicott (1960/65) said that the true self is a theoretical concept which makes sense only through the concept of the false self. The false self is a defensive structure which protects the true self and reacts to environmental stimuli by compliance. No human being can live in our society without some false self organisation. The child is taught from early on to use socially approved manners when relating to others. It thus develops an ego adaptive system to comply with society's basic standards of behaviour. Health means here a compromise between feeling real and ego-adaptation to

environmental demands.

I have already said that earliest object relating is the baby's omnipotent creation of the breast which he can then experience as a 'me'-object. In classical psycho-analytic theory this is called primary identification or complete merger with the object. What Winnicott has added is the experiential aspect which, he reasons, is one of the prime movers for emotional ego-growth. With increasing ego integration, object relating develops and the infant can acknowledge the breast as a subjective object by projection. The breast is then not just a 'me' object any longer but it is not yet a proper 'not-me' object either. It is in between, neither inside nor outside. It stays at the border so-to-speak. A space is created in the infant's experience of the object. The transitional space (1951/58), the space in between, is the area of illusion. What is objectively perceived and subjectively conceived, takes place here. As I have said, at first the infant creates the breast in this space and the mother presents the object. In time, the infant finds a transitional object which can stand for the breast (mother) in both its senses: objectively perceived and subjectively conceived and created. In the course of further development, the transitional object gradually loses meaning for the child. It becomes diffused in playing and later in life in the adult's experience of culture and religion etc. (W., 1971, chapt. 3, 7).

When the child has reached some integration of ego unity, the good-enough mother will facilitate gradual failing for the infant. 'She will let him down' as Winnicott (1969/71) said. The infant experiences that the breast, the object, is not always under his omnipotent control and he will be very disillusioned. The infant repudiates the breast (mother) as 'not-me' and places her into the world of shared reality. It is this 'let-down' which introduces the baby to the reality of the object. The 'not-me' object is destroyed by the infant. The facilitating mother's most important task is containment and survival of the infant's attacks without retaliation. 'There is no anger in the destruction of the early 'not-me' object, only joy at its survival.' This is also the time when the baby starts to kick and to bite the breast and oral-sadistic impulses are at their height. The repeated experience of mother's survival of the attack makes the destruction of the 'not-me' object potential. The infant can trust the object, the mother, and use it. The not-good-enough mother, however, is unable to let her infant down. Winnicott (1960/65) felt that one of the worst failures of the not-good-enough mother is her inability to disillusion her infant. She thus fails to facilitate that growth process in the infant which makes shared reality real for him.

The true self, we can now say, feels real when the destruction of the 'not-me' object and aggressivity towards it becomes a fact. (1960/65). If the not-good-enough mother cannot survive the infant's attack, if she retaliates so-to-

speak, then actual destructiveness will become a feature. This can be defended against and aggression can then either become grossly inhibited or it can only become actualized by becoming the object of an aggressive attack. I think it has become clear that clinically, the more aggressive child is the healthier one. (Winnicott, 1969/71). When the baby has developed a secure enough capacity to potentially destroy the 'not-me' object (that is the object of perceived reality) and this depends on enough experiences of the object's survival of aggressive attacks, the infant will become able to experience psychic reality as inside and shared reality as outside. The baby perceives the mother as a whole person towards whom feelings of love and hate can be expressed. This is also the state M. Klein has described as the successful outcome of the depressive position.

From then onwards, it is not any longer the failure of the facilitating environment which may constitute illness (environmental deficiency diseases) in later life (Winnicott 1959-64/65). The child may, however, have to encounter traumata throughout his childhood. They are then negotiated by his intrapsychic world. But if the arising intrapsychic conflicts are too overwhelming and the child's relationship to his adult world is poor, then psycho-neurotic disorder may occur then or in later life. During the phallic-oedipal phase, when three cornered relationships have to be accommodated, the child is exposed to the well-known normative intra-psychic conflicts. If he cannot master them then psycho-neurotic disorders may also occur in later life.

I have tried to present Winnicott's concept of the true self (1960/65) by giving a short outline of his concepts of earliest ego integration and object relating. The successful negotiation of this earliest phase by mother and infant alike refers also to the successful rooting of the true self in the infant's intrapsychic world. Failure of earliest development will not root the true self in intrapsychic experience. Instead, it will stay isolated and hidden (split off) and living will be possible by defensive false self structures. The ego can then relate to the outside world only by compliance. The better organised the false self is the more will intrapsychic reality wither (1960/65).

It is my thesis that in our work with patients we inevitably provide a milieu which re-creates what was originally the facilitating environment for the infant. If our patients have reached enough integration so that they present with intrapsychic conflicts and psycho-neurotic problems, then the dependency, which is inherent during the earliest stages, will remain mainly potential. But every good enough therapy will at one time or another reach out to a true self experience which is meaningful to the patient and therapist alike. In its essence it is a non-verbal experience. It is often a very simple happening and the quality of the experience is difficult to describe. Language tends to become banal when we try to do so. But the patient usually has the experience of having been instantly understood by

the therapist. He or she experiences the session as a good feeding. This is in contrast to the perfect interpretation which may be a good feeding but is not necessarily an experience of a good feeding, as Winnicott has pointed out. But for those patients who have not experienced the earliest phase of ego integration and the rooting of the true self successfully, the milieu of the treatment will become its centre in which patients can regress to that early dependency state where the original environment failed to facilitate growth. These patients will present either with well established defensive false self structures and the true self will be hidden, split off, or the false self structures have disintegrated and the patients appear to be in a state of chaos. In a different language, you would find psychotic symptomatology of varying degree. (1960/65). The therapist's handling of this regressed dependency state (W. 1955/58, 1959-64/65) will facilitate that growth process which leads from object relating to the use of the (not-me) object (1969/71). It will also actualize true self experiences which make psychic reality feel real.

I have tried to show how it came about that the concept of self has recently become such an important one in our clinical work and I have given prominence to Winnicott's concept of the true and false self. The true self becomes rooted in the child's intrapsychic world when through environmental facilitation the earliest ego integration and object relating has been successfully negotiated. The false self, in contrast, becomes operative through the ego's need for adaptation to the shared reality world. There are healthy and unhealthy false self structures. The latter come about when the infant's environment fails to facilitate growth. The true self finds expression in emotionally meaningful living. But it stays personal, it is not influenced by experience and it is truly incommunicado. (1963/65).

The concept of self has become a sparkling one. It has been romanticised, it has become idealised and also mythologised. In the early psycho-analytic literature it was erotically loved by Narcissus. It has been Winnicott's achievement that he has taken the concept of self out of its connection with narcissistic phenomena. In his studies, he has given it a rightful place in the psycho-analytic investigations of emotional experience.

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SYMBIOSIS ANXIETY AND DREAD OF DEPENDENCE
A Reading-in Paper

Denise Taylor

The major and recurrent theme in the therapy of Michael, his dread of loss of boundaries, of merger, and of ultimate dependence, is reflected in the title of this paper and provides the focus of the presentation. This falls into three main overlapping sections: the patient and his background, the course of therapy, summary and discussion.

I - THE PATIENT AND HIS BACKGROUND

Michael began three-times weekly psychotherapy having referred himself. He was twenty-eight years old at the time and seemed a likeable young man with a serious and sensitive air about him. He dresses casually, and his faded jeans, slight beard, thin fair hair and pale blue eyes blend in with his rather colourless, flat voice and deliberate way of talking. From time to time, however, as one listens to him, this rather smudgy picture is unexpectedly enlivened by an unusual turn of phrase or a vivid image and one is left with the impression that he chooses his words quite carefully. I knew from the report of his psychiatric interview that he had a fluctuating slight stammer but this was hardly noticeable in my initial interview and as Michael did not mention it, I did not either.

Michael explained that he had not come to therapy on account of any specific reason, but that he felt there was something lacking in his personality. Most of the time he seemed to be just playing a role to fit in with others' expectations. He felt he generally lacked decisiveness, although he assured me that this did not apply in a specifically sexual sense for he had only just parted from a girl with whom he had had an intimate relationship for nearly two years. She had just begun individual psychotherapy herself and perhaps that was an additional reason, although he had been thinking about it for quite some time. He explained that they had broken off because both wanted to be independent. He thought that in some ways they were too compatible. "We didn't want anyone else more than we wanted each other, but I have a thing about dependence and how much it's right to expect from someone you want to live with." He had always found it difficult to make close relationships.

EDUCATION AND WORK

Michael was coached for his 11+ examination by his mother, and remembers this as an unpleasant experience. He feels that it was only as a teacher that his mother gave him any of her personal attention. There was no gratification even when he had learnt something - just an attitude of "Right, on to the next thing!" No-one expected him to pass, but he did, and this was repeated at the O-level stage. His father was then sixty. Contemplating retirement he implied that he

might not be able to keep Michael on into the sixth form. This determined Michael to continue with his education. His first ambition was to become a cameraman with a film company but he was rejected by relevant companies where he had applied for technical training. Generally discouraged, he also failed his A-levels. However, by the time the results came through he had discovered psychology, decided to read that subject at University, and passed his A-levels the following year. He again failed his exams at the end of his first year at College and had to repeat the year but finally graduated after five years.

During this time Michael lived a rather isolated life in lodgings. He was uncertain what to do next and took up an opportunity which presented itself to work in a residential Adolescent Unit as a Nursing Assistant. This was an important formative period for him which he found helpful both personally and professionally. After eighteen months he decided he did not want to be a psychologist, as this seemed to be too remote and clinical and he felt he wanted something more practical which would bring him into closer contact with people. He took a training course in Youth Work, seeing this as a challenge to develop skills in social relationships. After taking some time off to work in a children's camp in the States he eventually started work in a London Youth Club.

II - THE COURSE OF THERAPY

I would like to begin this account with a vignette of our first session which foreshadows a number of features which were to become important in our subsequent work.

Michael arrived eight minutes late and decided after a moment's hesitation to take off his boots before lying down awkwardly on the couch. The feeling engendered in me by this manoeuvre, of being a person whose houseproud standards had to be complied with, was re-inforced by his opening remark. Had I anything to add to any instructions as to what he should do now? I reiterated that he should feel free to say what came to his mind. Michael volunteered that he had been thinking over the week-end about what he should say, and another pause ensued. When this became to feel rather uncomfortable I said that it was a bit daunting: anything might pop into one's mind. At this Michael took off for several sentences talking in an abstract generalised way which I eventually understood to mean that he did not really want to prepare what he should say because he felt he shouldn't. On the other hand he did not want to talk about just "happenings" either. I pondered his dilemma for a while and then acknowledged his serious intent: he did not want to talk about trivialities, but about what was important. If he talked about whatever popped into his mind it might not seem important. Now it was Michael's turn to be thoughtful. Finally he said, "Of course, I may not be able to judge what is and what is not important."

He once more went on at some length, but more comprehensibly, to explain how he liked to take thought, plan and be in control of what he is doing. He likes to observe himself as he is acting, "Not that this results in a more efficient performance, but I want to know how I make out."

"So you like to keep a critical eye on yourself," I said.

"No", said Michael, "I just don't like to fail."

Presently Michael said he had forgotten to tell me something. He had suffered from a stutter since childhood which came to worry him a lot in adolescence. He had thought about it all the time and it interfered with his life because it kept him "on the edge of things". Later, when he forgot about it, he found he did not stutter and it does not bother him much at all now. But at that time he was very self-conscious and kept observing himself and had difficulty in "letting go".

"Rather like here?", I suggested.

"No", he contradicted again. "What I was afraid of when I talked of letting go was losing myself in another person or situation. Here I have created the situation, - I cannot get lost in myself!"

On considering this session it seemed a positive sign that Michael would use what I happened to be able to put in his way even if he often had to contradict first. He himself made the statement that he might not be able to judge what was important and this safeguarded his autonomy in the face of his denied fear of losing himself in another or that I would dismiss what he brought of himself as unimportant. He was also able, in spite of denying its relevance, to associate to my remark about keeping a critical eye on himself by telling me about his stutter and, in fact, confirming it, by saying that his stutter improved when he stopped keeping a critical eye on it.

In his final statement quoted above Michael found a formula which allowed him to express his dread of losing himself in another by denying its possibility. That this was mere whistling in the dark was soon to become apparent. His fear of literally losing himself, that is his sense of identity as a separate individual, has been central to the therapy. It was a particularly acute issue in the early months, irrupted regularly at times of particular stress such as breaks and separations and in its corollaries and permutations, which I hope to elaborate on, and has been the continuous thread linking together the various themes and phases of our joint work.

Trying to understand these has led me to explore the literature especially on early personality development and borderline phenomena. Since this has been a process running parallel to the therapy I propose in this paper to interrupt

the presentation of clinical material from time to time with some theoretical comments. Stoller (1977) integrates a number of inter-connected ideas in his term "Symbiosis Anxiety" which seemed to lend itself particularly well to serve as an organising concept when considering Michael's material. The term "symbiosis" was borrowed from biology and used metaphorically by M. Mahler (1975) to designate a developmental stage which begins as soon as an infant becomes dimly aware of a need-satisfying object. The essential feature of symbiosis is that it is based on an illusion. The infant has the subjective experience of omnipotent fusion with the mother when in reality there are two physically separate individuals.

Although there is argument between various schools of thought as to whether this state is already present at birth or develops gradually in the subsequent weeks there is a consensus of opinion as to the hallucinatory and omnipotent character of this stage and its vital importance in laying the foundations for subsequent development. Winnicott's vivid evocations of "the good-enough mother" who can facilitate this illusion, Balint's description of "primary love" and the "harmonious inter-penetrating mix-up" are just two examples of writers who have described this stage. An optimal symbiotic experience establishes what Erikson has termed "basic trust", Bowlby "the safe base" and Mahler the "safe anchorage" from which further development and growth are possible. This takes place through a gradual "hatching" process in the course of which the infant comes to differentiate his self-representations from the symbiotic fused self-plus-object representations. This is the beginning of the separation - individualization process which proceeds through various sub-phases for the next two or three years. In a parallel movement the relationship to the object changes from a level of need gratification or part-object relationship to what Hartmann calls "object constancy", that is a state where the cathexis of the object is retained regardless of the state of need and has been invested with libido, or in other words becomes the first love object. This constancy of self and object representations has other consequences: the previous tendency to splitting into good and bad is reduced; ambivalence becomes possible and identity building can take place on these more solid foundations as separation-individuation proceeds.

It is here that Stoller's term "Symbiosis Anxiety" is relevant. Stoller defines symbiosis anxiety as "the fear that one will not be able to remain separate from mother". It serves as a crucial barrier against the "tendency to regress into mother's embrace".

Given adequate symbiosis and a successfully negotiated separation-individuation the individual is well on the road to establishing himself as a separate individual and would only experience symbiosis anxiety when under exceptional stress. In Michael's case one can assume that he experienced a good-enough symbiotic stage but that difficulties

arose during the separation-individuation process.

With this basic hypothesis in mind I will now return to Michael's material.

The initial sessions caused Michael a good deal of anxiety, which kept him awake at night and threw him into temporary panics but were relieved while he was with me. I suggested that it was difficult to "let go" because of the uncertainty of where this might lead him and this made it a rather risky business. He associated his feelings with an experience at college where he first became involved with a girl. Although it was a "talking relationship" only, as he put it, he became infatuated and was totally pre-occupied as if "possessed" by her. It is interesting to note that she was living with an older student in the same house as himself, who did not object to the relationship, a situation similar to that in his own family where father always took up an aloof position. He realised that he must get free or he would be lost and finally managed to tell her that their relationship must end. However, she would not accept this and made a terrible scene. He had to avoid her for years afterwards for fear she would re-open the issue. I acknowledged the validity of his feelings that the same might happen with me. In the light of these feelings we could understand his efforts to keep in control of the situation in various ways, such as for example by coming late. This left the decision of how long the session was to last to him rather than to me. I pointed out that he felt better when he was actually with me because he then had the concrete evidence that he could share his thoughts and it was possible to get close without having the feeling of being swept away. This was more difficult in the gaps between sessions. I was certainly very aware of the strain our sessions put on him, and the strength of the symbiotic longings against which he had to defend himself. I noticed that after leaving he would sit in his car for a while before driving off, but it wasn't until much later that he told me that he could not trust himself to drive straight away and needed to allow some time to "recover".

I felt it was important to establish a climate which would reduce the opportunity for the projection of symbiotic wishes onto me and enable Michael himself to get in touch with his wish for closeness. I tried to do this by accepting Michael's defensive manoeuvres in a positive light with the underlying implication that he would be able to relax these when he was more sure about the nature of psychotherapy and of our relationship.

When the anxiety between sessions lessened Michael became more painfully aware of the spaces between them and was liable to become depressed at these times, especially at week-ends. He realised for the first time how lonely he really was and came to feel that his relationships even with friends were superficial. Then he would fear that there was nothing worth while in him, rather like a dark cellar that

contained only rubbish or, more frightening still, nothing at all. He complained that he could not remember what had gone on in sessions and it was not until he could acknowledge some of his sense of loss during gaps and his anger about this that he was able to link one session with another.

He told me more about his relationships with women. He had had two sexual relationships before the one with Alison, the girl-friend from whom he had parted just before starting therapy. Both these had lasted only a month or so and had not been satisfactory. He had found both girls much too passive for his liking. They seemed to depend totally on his taking the initiative both in and out of bed. Alison was more like himself in intellectual and other interests but their sexual relationship had not been satisfactory either. Her being in many respects so like himself attracted him to her but when it came to sex he wished she were more feminine. He used to blame her lack of confidence as a woman for their difficulties and she also had difficulties adjusting to the pill. However, recently he had wondered whether he had not also contributed. He expected her to be always available when he wanted her and objected if her friends or other activities intruded. He would not so much complain in a loud way but withdraw and she would realise that she was not giving him "what he wanted". She complained that he would not allow her to be independent and he felt she did not give enough time and attention to him. They finally broke off after she had become pregnant and had to have an abortion. She became upset when he was not at all pleased with the news. She wanted to talk of nothing else, while he felt there was nothing to talk about and she would just have to get rid of it. He described the actual abortion as a 'non-event'. Alison, however, became pre-occupied with herself and would not listen to him talk about his troubles at the club. Soon afterwards she started psychotherapy, and they decided to part for a trial period. He declared that Alison had become too dependent on him and saw this as being swamped by the needs of another person, which meant that his own individuality would get lost as he would have to fit in with the other person rather than do what he wanted. He illustrated this with further examples from the youth club where he fended off boys who tried to attach themselves to him. The woman in charge of the club told him at a review-meeting that she feared he would never make a Youth worker because of his distant and disengaged attitude, but that there had been a very slight change recently which gave some grounds for hope.

At this point I experienced a chilling sense of alarm and an urgent feeling of Michael's vulnerability and great neediness - he never seemed to have experienced a satisfactory attachment, had not yet come to a stage of development where he could feel concern and had a very shaky sense of identity. This neediness made a powerful appeal to my maternal feelings and I realized that Michael would want me to be an

object without any needs of my own. In time my counter-transference feelings in this respect helped me to help Michael to realize how he was controlling me and Alison by his needy dependence. This has had to be worked through again and again in his various relationships and he has come to understand that he often uses this quite deliberately to "get what he wants" from people, to use his expression. Michael declared he wanted love, not pity, but sadly remarked that perhaps he would not recognise love when it was offered. He came to realize that he typically interacts with others by evoking sympathy or, more rarely, by being an "entertainer", which he could sometimes achieve when with a group of friends.

The situation with Alison seemed to be a kind of emotional see-saw. You were either up or down. In the up position the other listened to you, saw to your needs and this meant that you were in control. But this never lasted as the other's needs came to predominate and made you sink down again. Yet Michael needed the distance between himself and the other and could not move nearer to the centre where a balance might be achieved because then both would be the same and difference would be obliterated. I drew the parallel to our own situation by pointing out that this was also a warning to me to keep the right distance in our relationship.

In his childhood his brother Jeremy and his sister took the centre of the stage and he himself felt relegated to the wings, needy for his mother's attention without ever being able to make his voice heard and his desires known. He always felt his separateness keenly. He sadly remarked that he could recall little kindness and gentleness from his childhood and recounted incidents illustrating the distance between members of the family and his hatred and envy of Jeremy whom he wished dead.

His brother and sister were always brilliant at school and University whereas he himself knows he is bound to lose in any competitive situation. He never seemed to be able to achieve anything which pleased and impressed his parents. The successes he did achieve were completely taken for granted. He once jumped out of an upstairs window to impress his mother but he fractured a bone in his foot as a result and his mother was not at all pleased. I was impressed with the strength of his desire for recognition and the desperate quality underlying his attempt to achieve it. He remembers his rage against Jeremy but that this could never be openly talked about or expressed. Jeremy, according to his mother, would never let Michael say anything and would try to drown his words with his own flow, thus contributing greatly to Michael's stutter which developed with his speech. His father to this day tends to deny all difficulties and his mother, although more aware, does not know how to deel with feelings and copes by avoidance and a retreat into helplessness. The best she could do was to keep Jeremy and him apart as far as

possible. In the squabbles with Jeremy Michael usually felt helpless himself and would easily dissolve into tears which he remembers continued until Jeremy left home for University when Michael was thirteen years old.

As time went on it became clear to us that Michael identifies sometimes with one and at other times with the other of his parents. Michael usually only spoke of his father in order to dismiss him. He did not seem to be a figure of importance in the family and when at home usually retreated to his pottery shed where he was wrapped up in his work. I initially imagined him to be a silent onlooker relegated to the wings rather like Michael himself. However, this picture was corrected as time went on and as Michael reported on his occasional visits home. Father also began to appear as a potentially overpowering personality as the following incident will illustrate: Michael, like his father, is skilful with his hands, liked to model and construct as a child and has continued an interest in pottery and painting into adulthood. But instead of being able to meet his father in a pleasurable way over this common ground this became another area where the child and even the adult Michael did not have his needs met. When he asked his father for help or advice he would soon be made to feel clumsy and inadequate and it always ended with his father taking over and doing the job himself. For example when he went home on a recent visit he wanted to throw a certain shape of pot on the wheel. His father started to tell him how to go about it but inevitably took over and made the pot himself. After that Michael did not feel much like trying himself. It seems, therefore, that Michael could not obtain for himself additional support from his father who was often not available and when he was, showed little respect for his autonomy or ability to encourage a sense of achievement and mastery in his son.

Michael described a constant struggle going on inside him between two opposing voices: one belonged to his impulsive, spontaneous self, and the other to the "guard" - a parental voice with the characteristics of a traffic warden - "someone who only took an interest in your affairs in order to stop you from getting on with them." His stutter was an example of the struggle between these two voices - one wanting to express something genuinely felt, mostly his rage and angry protests, the other opposing this with disapproval. One way out of the resulting impasse was to remain silent, as he most often did in adolescence when he became acutely self-conscious about his stutter. At home and at school no-one took any notice of his silence, or of his stutter, which was never referred to, or of his tearful battles with Jeremy.

Meanwhile, Michael found it convenient to use Alison as a vehicle for his transference feelings for his therapist which he could not express directly. In spite of the trial separation agreement Michael continued to meet Alison every two or three weeks and even to sleep with her. One day he

arrived to announce his ideal solution: "a relationship without commitment". He felt that he had achieved this with Alison, and also with me. Nevertheless, he resented Alison having other relationships, because that meant that she wasn't always free for him when he wanted her. This did not apply to me because I was always there for his sessions. As the summer holidays were not far off this was obviously one of the times when Michael identified with his father in denying unpalatable reality.

Michael resorted to ever more lengthy and abstruse abstract intellectualisations until I had to admit I was lost. Michael likened these to a scaffold and himself to a crumbling building in need of repair and support. This was certainly a vivid picture describing the use of the intellect as a prop to a weak ego. This scaffold also served to control me and keep me at a distance by which he tried to ensure that he would not get lost. Typically he would take one bold and usually aggressive step into the open only to scuttle back under the protection of some scaffold as soon as he could. Then he would complain that we were going round in circles returning to the same issues again and again and he dreamt that he was floundering in an uncharted void in a spaceship which he had to bring under control.

The looming holiday could no longer be ignored and Michael said he was really looking forward to it. He had felt terrible ever since he started with me and needed a break and a rest. At this stage, Michael's own holiday plans were suddenly foiled when a friend he was going away with let him down. We ranged through possible alternatives, with a forlorn Michael being unenthusiastic about any. Without any explanation Michael missed the next session and I realised that I had come too near to being the controlling parent. After considerable deliberation I decided to write to Michael rather than risk not having another session before the holiday by waiting. My own anxiety about the separation no doubt contributed to my strong feeling that I would rather have him exasperated with me than doubting that I cared.

Michael returned and gave vent to his anger. However, this had the comfort of familiarity. It was as if both he and I knew what this was really about - a defensive skirmish to guard against a far greater threat - to the autonomous existence of a hardly defined self. We also understood better the reasons for his general unwillingness to let me in on his everyday affairs for fear I would become too interested and "take him over"; he felt again that we were stuck in a groove and going round in circles returning to the same themes of control, dependence and fear of being taken over. Wasn't I supposed to discover things about him, he demanded angrily? This led to some useful clarification of our respective roles and his general expectations from therapy. He could not tolerate pity, Michael declared. When I pointed out that he was equating concern with pity, Michael realized with sadness that he was depriving himself

of the very thing he wanted. Michael remembered a tutor telling him he had an "undernourished" personality, which again demonstrated the appeal he made by appearing "starved". He was not used to rich food and it was no wonder he had to spit out what he was not accustomed to.

Since then we have been able to understand the manipulative aspects of Michael's behaviour. He impresses people with his neediness and when they respond he rejects their advances as being intrusive. This is not without considerable gratification to himself. By this manoeuvre he at one and the same time assures himself that supplies are available and repeats in reverse the rejection that he feels he experienced in childhood. He could now also understand better why he needed to adopt as the ideal solution to his relationship difficulties the formula of a "close relationship without commitment", which to me certainly seemed a contradiction in terms. This seemed to be the consequence of an unsatisfactory early relationship with his mother which was either too close or not close enough, or too suddenly broken. Michael himself is sure that it was not too close and is convinced that the change from a "nurturing home" to a "teaching household", as he describes it, came quite suddenly and arbitrarily. Certainly he was ill-prepared for it.

Michael returned after the three week summer break declaring that he had enjoyed himself until he became anxious again when the time to begin again drew near. He had not missed his sessions. However, he had been hurt by Alison's behaviour. She did not seem to have missed him at all, enjoying all kinds of relationships - sleeping with his best friend, he would not be surprised! He was angry with her, but as he guessed that this was precisely what she wanted him to feel he was certainly not going to show it. Here Michael was demonstrating some defensive reactions which were typical of him. Instead of admitting his feelings for his therapist, he distances himself by projecting them onto his girl friend; instead of allowing himself to feel the pain of separation he becomes angry, thereby warding off feelings of loss and helplessness; and instead of expressing his defensive anger in a straightforward way he resorts to negativism to salvage for himself a spurious sense of being in control. Michael admitted freely that he was "in duty bound" to do the opposite when he became aware that someone wanted him to react in certain ways. When I helped him to discover that he was therefore just as much controlled by the other as if he had conformed in the first place he was deeply struck and has worked since at becoming more aware of how he uses his negativism destructively to others and himself.

We had not long resumed our sessions in the autumn when there occurred one of these "special events" described by Stanley Weiss (1975) as providing an opportunity for breeching defences and illuminating the transference. My father was first taken seriously ill, seemed to stabilize,

but then died. I had to cancel sessions first for two weeks, and after a short interval for another week, while I went abroad. Michael guessed that this was on account of some family crisis although I did not enlarge on this. He described his anger as a huge reservoir of water which, if he had let it overflow, would have brought destruction to everything within sight. He remembered how at home anger was always dealt with by isolation or withdrawal. It could not be talked about or legitimately discharged. When I likened the water in the reservoir to all the tears stored up in him he was able to express the painful sadness he had felt during my absence as well as feelings of abandonment and hopelessness of ever being able to pick up the threads again. It was the absence of sessions that made him aware of their value to him. This was different from holiday arrangements which he saw as only arbitrary impositions on my part. Unlike these this absence was caused by events outside his or my control. It led us to consider that for his mother, too, the change from a nurturing figure to a teacher, which he felt so keenly as an arbitrary change, might have been beyond her control.

A mood of tranquility, reflection and mellow sadness pervaded many sessions. He re-experienced an adolescent phantasy where he was alone in a beautiful, empty desert. There he could be himself uncontaminated by the presence of others. Being in therapy was like that. There were no harsh impingements from others so that he could "find what there really was of him".

The "special event" had brought about a lessening of the transfer of symbiotic omnipotence onto the therapist which helped the treatment alliance to become more firmly established and I felt more sure of being able to strike the right balance in dealing with Michael's sensibilities. I felt this marked the end of the beginning phase of the therapy.

The transference relationship had so far been distinguished by an either/or quality which made compromise difficult. I was either a critical school mistress mother who could never be satisfied or a kind of Circe, an enchantress who was out to ensnare him and who knew what went on inside him without being told. As father in the transference I posed a similar sinister threat of "taking over" or being invisible and absent, leaving Michael helplessly exposed to the two faces of mother. Masterson (1976), writing on "Psychotherapy of the Borderline Adult" emphasises the important role of the father in normal separation-individuation (p. 34 f.). He sees him as serving "as an object uncontaminated by symbiotic cathexis, to draw and attract a child into the real world of things and people" and as a parental love object to counteract the regressive pull to the mother, thus laying the foundations for the oedipal involvement. The evidence is that Michael's father was not able to fulfil these needs and help his son at that stage of his development.

Michael's constant fear of losing himself and his dread of dependence led to a defensive stance of independence which emerged as his most rigid character feature and prevented him from becoming intimate even with those close to him because of his fear that this would lead to a breakdown of his separate identity. Winnicott's dictum that "the breakdown that is feared is the breakdown that has happened" (1974) opens up another train of thought. Does Michael fear losing himself because he was "lost" by his mother at a time when he was too young and unformed as an individual to manage comfortably for himself? This would have thrown him back on his own resources and we have already heard of his need for a "scaffold" in the shape of premature cognitive development to enable him to cope.

Anna Freud in her paper "About Losing and Being Lost" (1953) makes the point that children only feel lost, or actually get lost, when they are not sufficiently cathected by their mothers whose feelings at the time are either too ambivalent or too ineffective or centered on something else. This may have been the case with Michael's mother when he was passing through the clinging stage in what Mahler (1975) has described as the "Rapprochement" phase of separation-individuation. Although we have no evidence of any external traumatic event occurring at this time, we do know that his mother found it difficult to tolerate the clinging behaviour of her first child, Joan, which one can surmise might itself have been a reaction to the mother's ambivalence. She evidently felt differently about Jeremy, her first male child, who might also have contributed by his own more robust disposition to his happier relationship with his mother, at any rate until the birth of Michael.

When Michael was "lost" by his mother he was confronted by the vigorous aggression of Jeremy from which his mother was helpless to protect him. The fear, frustration and rage caused by this could well, as his mother maintains, have affected his speech which was just developing at that time. Being "lost" by mother before he was ready for that amount of separateness also deprived Michael of mother's mirroring function and this became the main task that seemed to be required of his therapist for the next six months or so. I do not mean to imply that there were no other interventions, nor that the need for mirroring disappeared thereafter, but only that it assumed a position of priority.

By "mirroring" I am not referring to the classical mirror model of Freud's but to the mother's - and therapist's - function as a mirror to her child symbolized by the child's confrontation with himself in a mirror as elaborated by Lacan (1949). In this "mirror stage" the mother identifies and confirms for her child his needs and feelings and gives them as it were a "habitation and a name" so that gradually the child's image of himself "takes shape" and acquires a structure and identity. Thus Michael's repeated wish to speak of important matters expressed his need to be confirmed by his therapist in what was important for him. As

Michael expressed it, "I need someone to help me be more myself than I am."

A dream may be illustrative at this point: He dreamt that Alison and he were lying close together and it suddenly seemed as if the two figures were like pieces in a puzzle with only a think line between them which faded as you looked at it. In the dream he turned over so that the pieces would not fit any more and each had its distinct shape.

Increasingly Michael felt that the two opposing forces of impulse versus restraint were pervading every aspect of his life, and he compared them to two wrestlers locked in combat. The result, too often, was a state of stasis, of inactivity. This proved an impediment to decision-making as it did to committing himself in speech and leading to his stutter. Just as in the transference he wanted a close relationship without commitment so he avoided committing himself in other situations. The two wrestlers seemed to stand for an idealised self struggling with an internalised harsh, disapproving parent figure. On the one hand he wished to refuse to follow its dictates, on the other he was afraid of rejection if he followed his impulse.

He recounted sadly how he would have liked to be like his friend, Robin, who would have openly expressed his views on particular political issues of the day but he himself was afraid of what others might think of him. I said that at least he knew what his ideals were and was not in a haze about that. He recalled a period in adolescence when he was reduced to total passivity - he couldn't even decide whether to have a biscuit or not! Other examples from the past as well as the present all proclaimed the same message: Michael wanted to have his cake and eat it. He could not give up one alternative in order to gain another.

In a burst of self-assertion Michael went along to show his sympathy at a meeting, and he related with pride how he could now stand up and show frankly which side he was on. He went on from there to clarify long-standing titillating relationships to two girl friends who both had steady boy friends. He was attracted to both girls and wanted to sleep with them but he also feared that he "might get more than he bargained for" and they might become dependent on him. Their boy friends seemed to be too passive to ensure against this. He went on to establish a men's discussion group and struggled with feelings of resentment that the others "depended" on him and expected him to take some responsibility. However, when his resentment was seen in a different light, as a wish to promote a democratic setting where creative exploration might be possible, he was able to take on some caretaking functions to get the group off the ground and found that he wasn't even anxious about stuttering which he usually is when speaking in a group. These were real, hard-won achievements.

Another cycle of pre-occupation with breaks as Christmas drew near was ushered in by an unnerving experience, when he thought he saw me go off in my car "on holiday" just as he was arriving for his session, which we saw as a repetition of the trauma of my own and perhaps also his mother's leaving him too suddenly. He spent a night with a girl, a relative stranger, as a piece of acting out, as if to prove to me that it was possible to have closeness without commitment. He became depressed again, could not sleep properly and felt it was useless to go on coming if there were only a couple of weeks left. Again he expressed his transference feelings in terms of his girl friend. He felt more positive towards Alison, but he had no hope that she would ever feel that way about him. He wondered if it would not be better to make a complete break and start afresh with someone new - not caught up in all these emotional entanglements!

Earlier in the autumn Michael had told me that he would have to stop the week before Christmas as he was going away. When his plans again broke down at the last moment and it would have been possible for him to come for the last two sessions, he decided against it. "You've had enough turns of leaving me - it's my turn to leave you." Whenever Michael felt the pull of attachment it evoked in him the dread of dependence and he had vehemently to repudiate any feelings of regret or pain at the separation.

Michael returned after the Christmas break to report a dream he had had that morning. In the dream I telephoned to cancel the session. His brother Jeremy took the call and only gave him the message as Michael was leaving the house. He was furious with Jeremy for not calling him to the phone and for coming between us, as Jeremy had always come between him and his mother. He was both relieved and disappointed at the cancelled session. This dream, reflecting the original rivalry situation with his brother over the love and attention of his mother, as well as his ambivalence about the desired relationship, was to set the theme of the work of the next few months.

I learnt from Michael that on the day of our last session before Christmas he had asked out Kay, a girl in his dancing class, tried to sleep with her, but found himself impotent. A couple of weeks later he tried again with the same result. Kay was the kind of girl he greatly admired, with an independent outlook and a critical and demanding attitude to the world and towards himself. Kay became a substitute for his therapist, whom he had just relinquished for the holidays; and, by way of the transference onto the therapist of attributes which stood for his mother, Kay also became a substitute for her. At one level these substitutions came too close to the mark at the crucial moment and proved an impediment to his potency. When we looked at this more closely, however, the incestuous wish was not the major threat; behind it lay the dread of passive surrender in the act of intercourse, which symbolised a return to the womb and symbiotic fusion with the mother. Symbiosis anxiety

would intervene, produce impotence, and thereby ensure that the dangerous situation was averted.

Stoller, in fact, came to develop his concept of symbiosis anxiety in the context of studying disturbances in male identity and functioning. He argues that in males heterosexuality is an achievement, being dependent on the successful separation-individuation of the infant boy into masculinity. At the symbiotic stage he has not yet distinguished his body and psyche from that of his mother, which is feminine. The boy's success in "disidentifying from mother", as Greenson (1968) describes the process in a paper with that title, will determine the degree of success of his later identification with his father. A boy, therefore, needs the help of a mother who approves of and encourages masculinity and who can draw on support from her husband to reinforce this. We know that Michael's father provided a model of masculinity where aloofness and withdrawal alternated with having "to do it all himself", two modes of behaviour which were very evident in Michael.

Stoller (1977) suggests that some of the very characteristics of masculinity such as forcefulness, fierceness and strength, owe their force to a reaction against the unacceptable temptation towards femininity. "Masculinity... does not exist without the component of continuous pushing away from mother." Symbiosis anxiety therefore can be a contributory cause to a homosexual orientation or, as in Michael's case, failures in potency. Anna Freud (1952) similarly points out that the symptom of impotence in such patients paradoxically serves to preserve their masculinity. She further makes a connection between dread of dependence or "emotional surrender" and negativism, which has been such a prominent feature in Michael. Negativism is a reaction formation against an individual's fear of regression "in terms of dissolution of the personality" which causes him to defend himself against it by a "complete rejection of all objects, i.e. negativism."

Michael felt now able to talk more frankly than he had as yet about the role of sex in his life, which, he maintained, had so far been a minor one as far as he was concerned. He masturbates without phantasies and likes "to get things over with quickly." He has had trouble with potency on other occasions and feels he performs best when personal relationships do not get in the way of sexual intercourse. Socially, he had always been attracted to women who seemed competent and had a mind of their own - in fact, rather reminiscent of the schoolmistress mother. In bed, however, he liked them to be feminine, and "to meet him more than halfway". He said he had never been attracted by another male, although now he had one good friend, Robin, whom he had already talked about. In adolescence he just went along with the crowd. I thought that at the time when he withdrew and spent long periods in his room brooding over his stutter he might also be concerned about masturbation and sexual matters but he denied that masturbation was a major pre-

occupation. His stutter, therefore, seemed to me to be a kind of "displacement upward", as well as serving the function of negativism, although I did not interpret the former.

After this session, which he later described as the "ultimate" leaving nothing further to be revealed, Michael succumbed to flu and was away for a week. Again it seemed as if he felt we had come too close for comfort and he felt it necessary to put some distance between us.

The two months after Easter saw an apparently dramatic change in Michael's life situation. He moved from his flat to a house which he shared with another man and two girls and to his astonishment and delight quickly established himself as the undisputed leader of the household. He found both women eager to sleep with him. When the first made some demands for commitment on his part he withdrew from her in favour of the other girl, Rita. With her he was able to establish yet again a relationship which repeated the old triangle with his mother and brother, as Rita had a boy friend already. He did not press her to give him up but opted for a "sharing arrangement" with the implication that this was a civilised way of settling things. At work, too, Michael earned compliments from his superior. He did all the repairs in the house, and, when a similar house became available next door, he prevailed upon the man responsible for finding tenants to give Alison a room. From having spent all his life so far "in the wings" he was now taking the centre of the stage - he even acted in a play at the Youth Club dismissing the possibility that he might stutter.

Michael now seemed to be in a grandiose state of mind reminiscent of the "grandiose self" described by H. Kohut (1971) as being revived in the "mirror transference". He advises that these infantile phantasies of exhibitionistic grandeur must be gradually assimilated to allow the traumatic loss of the narcissistically experienced object to be made good and integrated by "transmuting internalisations".

Michael's heady state of omnipotence was rudely disturbed by a dream: he was in the company of his boss and colleague when, to his great embarrassment, he shit in his pants. Here he was shown to be like the toddler who feels he is in control of his world only to find he is not in control of himself. This kind of dream alternated with others reinforcing his newly discovered powers - such as the dream where he found himself sleeping with his mother while actually in bed with Rita. In commenting on the implications of these dreams and events Michael again experienced me as the critical, never-satisfied schoolmistress mother, in a family where affection was never openly expressed and the price of approval was to be seen and not heard.

Michael was becoming increasingly aware of his feelings of rivalry with regard to Rita and her boy friend, as well as Alison and a man in her house with whom she had become intimate. He felt he was not getting his fair share of attention from the girls. Here again was a replication of the past. It was now possible to demonstrate to Michael how he himself engineered these situations by setting up triangular relationships where the presence of a rival protected him from a too intimate closeness. However, such a situation left him unsatisfied and disappointed, just as when as a child his brother and father were his rivals for his mother's attention. These conflicting feelings were mirrored in his dreams and in the transference where he created a safety net for himself by assuming that I was being taken care of by my husband to whom he ascribed the footsteps he could hear outside the consulting room. Once more we had arrived at a point where Michael, in wishing for a close relationship without commitment, was introducing barriers to the closeness he feared yet also longer for. For the time being, at any rate, Michael had come down from the heights and was feeling depressed.

By last autumn work at the youth club did not seem to be very satisfactory any more and he began thinking about his future career and looking for other jobs, possibly abroad. This would mean ending therapy, which appeared to Michael like an examination that he must pass. He would repeatedly demand that I tell him whether some attitude or feeling of his was right or wrong. He assured me that he was now no longer afraid of closeness and losing himself in another and spoke as if the degree of closeness was related to high marks. He felt that his social relationships and competence had vastly improved and that he felt much more confident in "going it alone".

Meanwhile he had briefly got to know Jessie who had spent a night or two in the house on her way to Italy to take up a teaching job. They were alone for part of the day and she had given him all her attention. At the time he thought of this as rather stifling, but she had said how much she "enjoyed him". Whenever he remembered it it seemed to work like "magic". They corresponded and when she returned to England for the Christmas holidays they spent a fortnight together and it was marvellous. He returned to announce that he was going to Italy at Easter to stay with Jessie and that he might as well leave his job then and take some months off to travel. This would mean he would be leaving therapy and although he felt he would return he did not know when that would be.

Jessie had obviously become for him the idealised mother who makes no personal demands and loves and admires her baby without any effort on his part. Michael emphasised that what attracted him about these plans was the possibility of trying himself out against different backgrounds to see what difference this would make - rather like the colour pink might look different when seen against a white or a blue

background. It would tell him more about himself and what belonged essentially to him. In Italy he planned to paint, while Jessie would supply admiring support. I saw Jessie as fulfilling the role of the mother whose enjoyment of her child confirms his existence, a role one might say I had predominantly played until Michael's flight into grandiosity, when it became necessary for me to strike a more cautious note as a counterbalance.

Michael had a dream at this stage where he was in danger of having a confrontation with a teenager at the club who kept throwing a football at his head. This dream became very important for him and we discussed every facet of it over the next few weeks. I saw it as a warning to me that we might easily become caught up in a win-lose situation in the therapy. I spoke of Michael's plans as an extended holiday rather than an indefinite break. I pointed out that Michael, although he complained bitterly that I - like his parents - was sure to disapprove, would also have rather enjoyed a confrontation with me. Then I would have fitted his picture of a controlling, critical parent; on the other hand if I did not demur at his leaving therapy he would feel that I did not care. This made it impossible for me to do the right thing and it would be difficult to find an acceptable compromise. I pointed out the regressive and repetitive features of his plans and he himself had already begun to consider whether he might not once more be displacing onto a girl what really belonged in the therapy.

My countertransference feelings of being left high and dry, prematurely, helped me to understand that Michael was repeating by acting out actively what he must have had to endure passively at the time of separating out from mother, when he was probably left prematurely to fend for himself without mother's support. He now projected his negative feelings onto me to ease his own conflict and doubts: I was like a parent issuing dire warnings: "Once you leave school (i.e. therapy) you'll never be educated!" He believed that life educated, too, not only school or therapy, and this was what he was out to get. I pointed out that there were nevertheless differences in what could be learnt from life and in school, and Michael triumphantly claimed that we had had our confrontation. He was not ready to listen to interpretations designed to show that in therapy he felt that he was learning from me, his teacher, rather than on his own; whereas in life it was easier for him to think that he was learning by himself when he was really dependent on circumstances and on a variety of other people.

Continuing to work on the confrontation dream Michael gradually changed his perceptions. He abandoned his extreme either/or view of leaving with no thought of the morrow or not going at all, which signified enslavement to the therapist. He began to view his going more as a holiday, an interval, before resuming work. He volunteered that at first he "had not wanted to move his ideas even a little in case they slid an awful lot". This demonstrated to us both

most vividly how his insecurity drove him to adopt extreme positions.

He said that he had begun to realise that a relationship without commitment was not really possible but what he objected to was a "compulsory commitment". As he had often complained before, the therapeutic relationship was tilted too far in my direction. For example, I set holiday dates, and even if these coincided with his, this was mere coincidence and did not alter the fact that I would not change my plans to fit in with him but he was expected to change his to fit in with me. I agreed that this was so, although it was also true that it had not stopped him from staying away when he had wanted. These arrangements had to do with the fact that they related to my livelihood and there had to be some structure and regularity about that. But what he really seemed to be objecting to was that he actually had come to miss me and our sessions when I wasn't there and the best way of showing me what that felt like was to let me experience it. That he had done before. Now he wanted to put the idea of a "compulsory commitment" to the test. Would I let him go and explore on his own and still be there when he came back?

Michael was completely taken aback. He said he had taken it for granted that I would. He was not side-stepping therapy, but just carrying on on his own for a while. What we had worked out in therapy he wanted to try in life. At this point he had another dream. He was part of an expeditionary force landing on an island. A group of people, himself among them, proceeded in single file over rocky terrain in worsening weather when, to his consternation, he realised that he would have to pass through an inlet from the sea which would engulf him and go right over his head. He could see the guide emerge on the other side and finally decided to take the risk. He was amazed to find on scrambling out on the other side that the weather had changed and the landscape had become sunny and springlike. We wondered whether this dream signified the course of the therapy as an exploration of an island, i.e. himself. If only he could risk its dangers and particularly the hazard of engulfment he might emerge to a sunnier brighter world. Had he done this already and did Italy and Jessie stand for the sunnier side of life? Or was Italy just a small detour, an excursion on the way, to relieve the hardship of the exploration?

His ideas of what he would do in Italy remained vague, apart from wanting to paint. I realised more and more that Jessie hardly figured as a person. She would just be there to provide for his needs, practical as well as emotional. As the time for leaving drew near, however, Michael began to wonder whether the relationship would "come up to expectations" or whether it might become too "stifling" - in which case two months would seem an "awfully long time". Thinking of doing without his sessions gave him a "hollow" feeling, and he was taking precautions to bolster his scaffold, like writing out addresses and taking his diaries with him. We finally made

arrangements that he would write to me in June to let me know his plans.

III - SUMMARY AND DISCUSSION

The picture that emerges after 22 months of psychotherapy with Michael is of a young man "in a state of becoming". Not only is this true of him when viewed from an external, worldly point of view, in that he has not yet found himself the kind of work and career or the sexual partner to which he can seriously commit himself. Intra-psychically too he has not yet achieved a sense of self or identity which would make him capable of commitment. This makes him very dependent on his environment, either passively in falling in with other people's expectations and ideas, or actively in taking an oppositional stance and resorting to negativism. In either case his autonomy, his freedom to make choices, is impaired. Whether from the wings or from the centre of the stage, to use his own metaphor, he is constrained to be constantly playing to his audience. One could say that this is the groove where he is stuck fast and of which he complains. Being fixated to a narcissistic "state of becoming" he has not been able to become a person, a firmly defined individual with a boundary between the "me" and the "not me". His symbiosis anxiety and dread of dependence serve as signals to alert him to the danger of getting lost should he stray too close to that boundary. A "state of becoming", as Giovacchini (197) suggests, in itself helps to establish an identity, by giving a purpose to life which society accepts, mistaking it for growth.

Developmentally Michael's critical pathogenic period, or, to use Balint's (1968) more apt description, the "level of his Basic Fault", most probably occurred in the course of his second year. We have already noted that this for the most part coincides with Mahler's "Rapprochement" subphase of the Separation-Individuation process. This is the time when the child has gradually to relinquish his state of omnipotence with the help of a mother who, by occasionally "failing", will little by little allow disillusionment to do its work, a continuation of a process begun with weaning (Winnicott, 1971).

Michael did not experience this as a gradual process but as a premature sudden abandonment, a trauma which he has been struggling with in and out of therapy. The planned breaks in therapy had the same meaning for him, appearing as a deliberate rejection and withdrawal on my part for which he tried to pay me back in kind by missing sessions. His present interruption in therapy can be seen as a repetition of the trauma but this time with himself in the active role. Just as he left Alison when she made demands on him by becoming pregnant, so he discarded me when he felt the pull towards greater commitment. My role as the idealised mother was now assigned to Jessie. However, he also needs to be able to take his therapist for granted in a way that he had not been able to do with his mother, who had not been available to him at the appropriate time and so he expects

me to be there and available to him.

For the child in the second year anality, speech development, motility and identity formation are all in the ascendant. The trauma, or rather cumulative traumata, constituting the basic fault in this patient have left their mark on the development of each of these and been affected by them in turn. Like the child at the anal stage Michael is pre-occupied with issues relating to autonomy, power and authority. He is sensitive about encroachments on his independence and wants to do it all himself, an urge which might well have contributed to his interruption of therapy in a kind of negative therapeutic reaction (Khan, 1971). He is easily roused to anger which often turns to passivity as a reaction formation. He is plagued by conflicts of impulse versus control, to give or withhold, to do or not to do. This conflict still shows itself overtly in his stutter, which also serves as a means of expressing aggression without having to take personal responsibility for it, by making the other person suffer in listening to him. In a similar way his occasional impotence has an aggressive as well as a defensive function. It is interesting that Michael has observed that his stutter is far less in evidence at times when he feels depressed, i.e. when the aggression is turned in on himself. At the anal-sadistic stage words are omnipotent, and Michael may well have felt that his words could kill his brother.

Michael's tenacious persistence in his attempts to achieve a sense of mastery, the earnestness of his desire to produce something important and valued and to do it himself, already evident in the first session, are impressive. There is an intensity about these urges in him as there is about his needy wants which make a powerful appeal. These latter become sublimated to some extent in his endeavours to be creative. Whether in working with clay to produce ceramics or in painting pictures in oils or by means of words, which for him become an almost palpable medium, these endeavours bear witness to the roots of his creativity in this phase of development (Heimann, 1962).

This is also the stage when action is the predominant mode of expression. Michael has shown himself prone not so much to acting out as to resort to "enactment", that is he uses a concrete way of externalising conflict rather than doing so symbolically in words. His setting up triangular situations re-enacting the original situation of rivalry with no less than five girl friends is a vivid example of this. The re-enactment each time set out to prove that this time it would be possible to have a "relationship without commitment". This was always doomed to failure, without any learning taking place until interpretations had provided some insight. These triangles at first sight have the appearance of oedipal situations, but on further exploration they emerge as little more than oedipal precursors being played out in the context of two-person relationships, that is, at the level of the Basic Fault. The other man in the triangle

hardly impinges as a rival invested with ambivalent feelings. In fact his presence is a necessary safeguard so that the relationship can develop without arousing Symbiosis Anxiety.

We have already seen that Michael was handicapped in identity formation by what he subjectively seems to have experienced as mother's sudden emotional withdrawal when he began to separate. At this stage gender identification comes to rely more heavily on the father as a positive model. Michael's father proved inadequate in this respect which has brought about some degree of gender confusion. As a little boy Michael seems to have had little opportunity to identify with a contrasting figure of a father as the more powerful parent who would re-inforce his striving for mastery and provide a counterbalance to the pull towards mother. This situation is similar to one I have observed in one-parent families where a sibling will provide a rival for the mother, but on account of his own immaturity cannot provide the same experience of mature masculinity as a father is able to. The result is an uncertain masculine identity and a difficulty in disidentifying from mother.

As far as object relations are concerned Michael cannot be said to have achieved object constancy. In Kleinian terms, he occasionally approaches the depressive position (as when I was unexpectedly called away and therapy was interrupted) only to back away again. For him one object is readily exchanged for another which will meet his needs. He cannot recognise and accept the needs or self-interest of the other person, making empathy and compromise very difficult, if not impossible. His narcissistic personality organisation, however, ensures him a certain "stable instability" of functioning (Schmideberg, 1947).

All these features which became evident in the course of therapy are an implicit consequence of Michael's developmental arrest on the brink of separation-individuation. He cannot achieve integration because of the constant pull in two opposite directions: magical, blissful yet obliterating closeness, as against a separate and independent life of his own which, however, cannot as yet be imagined because it has yet to be experienced and therefore holds the dread of the unknown. We have seen the extent to which Michael was dominated by this paradox, a paradox which had to be allowed for and tolerated and which is not to be re-solved but will, if all goes well, be grown-out-of, as Winnicott (1971) has pointed out.

When considering prognosis Balint's concept of a Basic Fault is helpful, both in setting realistic treatment goals and in indicating therapeutic approaches. A Basic Fault skews all subsequent development and after-effects are only partly reversible. However, by helping the patient to get in touch with the original trauma and to express the pain, anger and regret connected with it, the wound can be encouraged to heal, leaving a scar it is true, but one that can be

recognised, understood, allowed for and lived with. I realize, that if this is to happen with Michael should he choose to resume therapy, it will take a long commitment on the part of both of us. He will need to come to trust me sufficiently to allow himself to become dependent so that from there he can emerge in his own time to make a new beginning.

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PSYCHOTHERAPY WITH A HAEMOPHILIAC
A Reading-in Paper

Penelope Jaques

'Without sickness and anxiety I should be like a ship without a rudder - I tread the narrow road'
Edward Munch 1863-1944

INTRODUCTION

I first met Mr. F in the autumn of 1978. He had been referred by an old friend of his who was also a college counsellor. Before we met I knew only that he was 34, married with 3 children and suffered from haemophilia; that his childhood was rigid and repressed and he had become increasingly anxious in the previous 2 years.

At our first meeting I was impressed by Mr. F's thoughtfulness and intelligence and his firm resolve to get help after years of struggling with his difficulties on his own. He is a short, pale, sad-looking man and walks with a pronounced limp. There is something wistful and appealing about him, and I was aware from the first moments that he could elicit maternal concern just by his bearing. He was dressed scruffily in tweed trousers and a baggy sweater and smelled of pipe tobacco. His shoe laces were often undone in the early weeks and I was disconcerted to see how he lifted his legs vertically from the couch to tie them. In contrast to his external appearance his mind seemed alert and I was impressed by his easy way with words and found it hard to believe he had had so little formal education and had for some time been too anxious to read. He was clearly a very intelligent man. It was some time before I began to see how his ability to intellectualise was used so defensively, and much longer before he termed his apparently interesting thoughts, dreams and associations as 'rubbish'. Anna Freud, writing about the defense of isolation says, "The obsessional patient does not fall silent, he speaks even when in a state of resistance. But he severs the links between his associations and isolates ideas from affects when he is speaking, so that his associations seem as meaningless on a small scale as his obsessional symptoms on a large scale." (Freud, 1937).

The history that emerged in our first meeting is an extraordinary one. His maternal grandfather was the only boy out of 6 who all had haemophilia who survived into adult life. The illness then reappeared in Mr. F. He has one sister, Elizabeth, 2½ years older. Mr. F's father had been married previously, his first wife leaving him and subsequently committing suicide with her lover. Mr. F's father had represented the UK in the 1924 Olympics, but by the time Mr. F was born his father was a broken man who subsequently became a badtempered recluse and an alcoholic - something Mr. F did not understand until he was about 15 years old. The parent's marriage was unhappy. The father owned and

edited an electronics magazine. He had an office in the house and put the magazine before wife and children. They lived in a large house deep in the country outside Oxford and with no car available Mr. F led an almost completely restricted life. When I asked about hospitalisation he shrugged the question off, saying he supposed he had been in once or twice but had no clear memories. At age 5 he attended a small private Dame school where he was happy. At 8 he became the only day pupil at what he describes as a "ghastly appalling" boys preparatory school. He was so unhappy there that his mother took a job helping in the dining room but he continued to be miserable. He was moved to a larger school for one year but serious complications after chickenpox kept him at home from aged 10 to 12 years, during which time he had two different male tutors and achieved some 'O' level exams by 13. He then attended a Public school part-time but never felt part of the school life and by 14 he was so obsessed with worries about his sexuality that he ceased to cope academically and fell behind so badly that he left school. Through the help of a family friend he was apprenticed to an aeronautical factory near his home but a bad fall with serious complications put an end to that. He stayed at home and at 20 met his wife who was then 16. They had 3 children who in November 1978 were aged 9 (Helen), 7 (Benjamin) and 2 (Sophie). He told me he loved his daughters but hated his son. In 1973 he began working for his father. In 1976 he was terrified he was going mad and unburdened himself to his GP. He felt so much relief that he never took the prescribed medication, and for the first time spoke to his wife about his anxieties. In December 1976 his father became ill and then died, and Mr. F took over the running of the magazine, the capital being held by his mother who lives in East Anglia.

Mr. F knew from an early age that he had haemophilia. He told me he has the lowest bloodcount of anyone surviving and that he was the second person in the country to be put on home treatments. He keeps supplies of Factor 8 in his deep freeze and injects himself when necessary, keeping a detailed record which is checked by the specialist at a London teaching hospital.

Mr. F told me at our first meeting that he had suffered from obsessional symptoms of varying degrees of severity from the age of 10 when he had developed a washing ritual which he overcame by reasoning out how stupid it was. At 14 he began to have wet dreams and was so appalled and terrified that he tried to stay awake all night to avoid sexual dreams, and used compulsive reading to control the urge to masturbate. He could talk to no-one about these worries but at 18 bought a book called "Teach Yourself Sex" which came as a great relief. He described his sexual relationship with his wife as mutually satisfying and expressed surprise about this, saying that his penis seemed the only part of him that haemophilia had not affected.

Mr. F was eager for therapy and we arranged for sessions 3 times a week at 7.10 a.m. In 2 years he has only missed one session through illness although he has frequently been in pain with bruised and stiff joints. Missed sessions have had other meanings; leaving me before I can leave him and getting me out of my bed and leaving me stranded waiting just as he has spent so much of his life - waiting and stranded.

THE BEGINNING OF TREATMENT

Looking back across 2 years I am impressed by the way Mr. F raised in the first session the crucial themes of his treatment. I am also interested to see the note I wrote to myself after the first session - "he is fascinating but I fear for myself in the transference." I will give some detail of this session.

When he went to lie on the couch he hesitated, worried that his shoes might mess the couch, and then said his mind had become quite empty. He spoke of his wish to be sure of himself in relation to his wife and how different she is from his mother, whom he called "a secular saint". In a cool, dispassionate voice he said "My mother has always disliked the male of the species - people - dogs - cats - I suppose it's because of the nasty male things they do all the time - but of course she was a wonderful person - she had no love in her at all, she has always been dishonest." He spoke of his father's death and how terrified he had always been of him and yet felt that somewhere his father had loved him. How his father had never had a chance, being sent to boarding school at 7, of his father's arrogant and dominating manner - his alcoholism and filthy tempers. Mr. F had believed they were a 'nice' family but recently had begun to reassess the whole picture. He said he hardly knew his sister and that she was not yet ready to face how really awful it had all been. When I took up his wish to reassess it all and get it understood he said he had to get on with it quickly and was annoyed with what he felt I was implying, that this might not be possible. He said he had so little time left - life was running out - he had fought and survived this far and was not going to give in now. When I wondered what 'give in' might mean, he said 'kill myself'. He said that once or twice in the recent past he might have shot himself if he'd had a gun. He then spoke of his wish to get back to a time before 8 years when he feels he was worth something - "You see - I have this feeling I am so bad - cosmic guilt". He said he was curious about everything being good and bad - two black lumps joined by a thread. He said he had been over and over the session before he came as if talking to me, and knew he could tell me things, but here he was silent, and stuck. I made a comment about the frustration of this and he returned to the subject of his wife and her relationship with a close friend of theirs and he wondered if this man was in love with her.

Even allowing for the fact that I missed numerous opportunities to make links and transference interpretations (it was my first session with my first training patient) I could see the important themes emerging. Firstly his dirty anal wishes which could mess the couch, the isolation of affect - so that quite powerful thoughts and feelings were spoken of in a matter of fact way. His hatred for his castrating mother coupled with a longing to return to a time before 8 when he was almost exclusively in her care. His terror of his father and the wish to find the loving feelings in his relationship with him. His wish and fear of re-evaluating all his early relationships, of facing how awful his early life had been. His feeling that life is running out and in spite of suicidal thoughts a powerful urge to hold on to life at all costs. The ambivalence in all these ideas was symbolised in the two 'lumps' and his difficulty in making connections was represented by the thread only just joining them. The longing to communicate and the feeling that paradoxically he could only do so on his own. Also hints about the problems of triangular relationships.

He had told me how stuck he was and yet the words flowed out and I came away from the early sessions impressed by the richness of the material - I kept forgetting the warnings I had read and heard about working with obsessional patients. Fenichel says "The danger is that due to the isolation of ideational content from the corresponding emotions there may be only an intellectual understanding which is useless unless understood as a resistance against emotional experience." (Fenichel, 1946). Mr. F put this clearly in his fourth session when he said "If I have control over my thoughts I am safe - that's how I survived - by isolating myself with my thoughts." He went on to warn me how he is his own best therapist just as his mother had repeatedly told him "you are your own best medicine." Many sessions have been reporting sessions - Mr. F only allowing himself to think more freely when alone in his office - speaking to me in absentia - so severing the links between us.

Having spoken of his recently discovered hatred for his mother, he soon spoke of his fear of her seductiveness and how she excited and disgusted him when he was a boy. In this early phase of therapy I did not interpret his sexual longing for her but rather his need for her care and attention. My efforts to help him to get in touch with feelings about a long weekend break from me led to him giving a vivid and feeling account of his first day at prep school at 8 years. He had seen the headmaster beating a boy, which terrified and no doubt excited him. He recalled his terror of and hatred for the staff and his physical and emotional separation from the boys. He was often in a wheelchair unable and unwilling to mix. He compounded his difficulties by being a clever 'know-all'.

Bergman, writing of ill children, says "certain ego skills such as speech may undergo an accelerated development to compensate for motor restriction of limbs" (Bergman, 1945). This seems to have been the case with Mr. F.

A few weeks after starting treatment Mr. F went with his wife to a theatrical performance in which there were nude actors. He was surprised and alarmed to find himself being sexually excited by a nude man and made a conscious decision to allow whatever thoughts and feelings there were to surface. Having allowed them in he was no longer afraid and later in the play found himself much more interested in the woman. This event led to him being able to tell me of his terror about sex from age 14. The lengths to which he went in order to avoid touching or looking at his penis. He had tried to ask his mother for information about sex when he was about 10 but she refused to discuss anything and suggested he ask the GP, which he was unable to do. He remained ignorant and terrified until he was 18. Between 14 and 16 he would think of killing himself to avoid sexual thoughts and tried not to sleep to keep sexual dreams under control.

I thought it significant that Mr. F never mentioned hospitalizations. When I tried to raise this he ignored my comments or made some sort of dismissive remark so that I almost lost sight of the distress which I knew must have been associated with those traumatic separations. Then one day he told me "just for information" that he had indeed been in hospital at 6 months and at 2, 3, 5 and 7 years. I knew we would come back to this later on.

In the second month with me he announced that he had decided to allow himself to dream again. He said he had picked up that I saw nothing wrong in him owning his dreams and so after a year of no dreams they had returned. Jung writes about the significance of the Initial Dream "It frequently happens at the very beginning of treatment that a dream will reveal in broad perspective the whole programme of the unconscious" (Jung, 1960). Mr. F told me of this dream a few minutes before the end of a Friday session. He was in bed with Jane (wife of Pete, who was in reality having some sort of relationship with Mr. F's wife, Maria). Opposite them, in separate beds, were Maria and Pete. Mr. F and Jane were making love in the manner he always dreams about i.e. he is completely passive while she makes love to him. At the point of waking he could see either Pete or Marie trying to persuade the other into bed without success - he hoped it was Maria refusing. In the session he left neither himself nor me time to think or comment meaningfully about the dream. I said something about his conflict over passivity and linked to his expressed fear of passivity on the couch. Thinking about this dream later on I could see it was full of oedipal longing; his wish to have mother always with him, ministering to his needs, and his wish to keep the couple (mother and father) in separate beds. No doubt this was also linked to the weekend and fantasies about what I would be doing. As he left that session he said he wished

he could come every day.

The actual situation of his wife seeing Pete I found quite difficult to deal with. In the first place something (I assumed of a sexual nature) was going on which my patient as an adult married man had to face and deal with. Secondly, I felt sure that this triangular relationship re-awakened in my patient unresolved oedipal difficulties which had in their original form brought about a regression to the earlier level of functioning and led ultimately to the obsessional symptoms from which he still suffered. There was also the evidence that Pete was carrying the transference to my patient's father and the attendant conflict, hating Pete (father) for being with Maria (mother) and at a deeper level longing for Pete (father) for himself.

In the second dream he reported could be seen his longing to be close to father and the fear of this closeness becoming sexual. After this dream he began to look at these conflicting feelings towards Pete and father.

At the point where I began to understand the regression that my patient had made in the face of these intolerable conflicts he at last felt able to tell me he had recently had a recurrence of a fantasy he often had between 9 and 10. He recalled wanting a baby to cut up - to really hurt, to bend and break its limbs. At 9 and 10 he was quite nasty to the family pets, throwing them downstairs and out of windows. Telling me of this he seemed to be closer to the feelings with his heart pounding and a feeling of fear in the session. He said the baby was six months old and always a boy. I recalled his first hospital admission had been at six months and then he told me how terrified he had been at age 7 while in hospital. He felt his life was being taken away and that he would never get out of hospital. He spoke with feeling of the terrible pain at age 11 when he had been on morphia for a time. At the end of the session he commented that maybe the fantasy was one way of coping with an impossible situation. Anna Freud writes "a child in pain is a child maltreated, harmed, punished, persecuted or threatened by annihilation....young children react to pain not only with anxiety but with other aspects appropriate to the content of the unconscious fantasies i.e. on the one hand with anger, rage and revenge feelings and on the other with masochistic submission, guilt or depression (Freud, 1969).

Shortly after sharing his sadistic fantasy he was very frightened that he might be developing anti-bodies to the Factor 8. He told me of his last hospital admission at age 22 for a kidney haemorrhage. "I was actually bleeding to death but at the last moment I won the battle." Whatever happened he was determined to keep out of hospital "nameless people all around - I'll be lost." He recalled his mother laughing and talking to other children in hospital leaving him feeling he was in no way special to her. I was then ill and cancelled two sessions. He arrived quite calm but reported that between the sessions he had felt quite out-

raged. I had no damned right to be ill. To his surprise and bafflement words appeared as if on ticker tape in his mind and he read them out to me A.N.G.E.R and F.U.R.Y but could allow the messages no real life while he was with me. I interpreted his terror that if he allowed the anger towards me then I might disappear and abandon him just as he feared his mother would do.

At this time I became aware of his need to be seen as a sexually desirable person. He was concentrating at work now and dressing smartly and spoke with pride of his large and 'flashy' car. He brought his feelings about his children into the sessions. Sophie (aged 2) so open in her feelings of love and hate helped him to feel safer with his feelings. Benjamin (aged 7) of whom Mr. F was very envious had said 'I hate you Daddy' and Mr. F said to me "Keeping ordinary thoughts like that out of my mind used up all my energy".

Mr. F then despatched Pete. After that he dared to look at the homosexual implications - the wish for closeness with father and the terror (seen in a dream) of loving feelings leading to sexual activity. The following session he reported a dream about homosexual men and woke terrified with a feeling of pressure in his rectum and a fear and urge to mess himself. The next day he allowed himself to have a fantasy of sex with Pete which led to masturbation and a sense of relief. He said he realised how tightly he had "held down the lid" all his life. It seemed he was now experiencing in fantasy what he had forbidden himself when it would have been appropriate i.e. in adolescence. He was also reassured to discover that there was a line between fact and fantasy for when he bumped into Pete the next day he had no homosexual feelings towards him.

THE SECOND PHASE

After Easter he came back resolved to look at his feelings about haemophilia. He stated one of the difficulties like this: "I am angry about being different when I want to be the same as others and, curiously, I am angry at the thought of being the same when I want to be different." He admitted that he had always used his illness to control people and avoid taking responsibility for himself. He never knew his mother's feelings about haemophilia. Was he, he wondered, the whole reason for her living or, given a chance, would she have abandoned him forever in the hospital? Was he the possessed or the possessor? This of course came up in the relationship with me, for he began to question whether he had decided to come or was he forced in order to satisfy my needs rather than his [He knew about my training from the man who referred him.] In all this was the idea of being unique and special, someone's life work, 'a wonder boy', too wonderful to allow the violent fantasies that he described as "undiluted butchery" in which he saw me, mother, his wife and children hacked to pieces. Significantly there was always a lot of blood in his violent fantasies and 'bloody' is his most often used adjective.

Mr. F, like patients described by Reich, talked openly of incest and violent rape and murder but remained entirely unmoved. I found Reich's writings on Obsessional Character relevant here (Reich, 1950). He makes the point that because the affects are disassociated from the ideas it becomes possible for highly censorable ideas to appear in consciousness. I would hear the words and frequently be amazed that I was not more upset or alarmed by them. I felt much more under attack when towards the end of a session he calmly announced that he had German measles. I felt a lack of concern for my welfare and guessed at his wish that I should not be pregnant. At the time I was not fully aware of my anger over this but then found that I overcharged him for that month, a fact which he used to rail against me in an attempt to deal with his guilt about his treatment of me over the German measles. In trying to understand this he was able to tell me of his guilt that he was not paying me enough. He often spoke of his feeling that the world owes him a living and that I should see him for nothing, but at the same time he longed for me not to make allowances, to treat him like a man and charge him appropriately.

Maria was pregnant again and caught German measles, and after a worrying few days she miscarried. From the start of this pregnancy Mr. F had identified with the baby - he was sure it was a boy and he felt he could care for it even if it was handicapped. Marie was upset, but relieved by the miscarriage and not able to be in touch with her husband's distress. He felt she had wished the damaged infant dead and the implications of this in terms of his mother and himself were unavoidable. It came alive in the transference when he felt I might be looking forward to getting rid of him during the coming summer holiday. One day he thought I looked sad and so felt unable to express any angry feelings to me. At such times I felt how it must have been for his mother and him together; Mr. F never being sure how she felt, trying to work out from the smallest signals her true feelings. In his paper "Reparation in respect of mother's organised defense" Winnicott says "An individual's reparation urge may be related less to the personal guilt sense than to the guilt sense or depressed mood of a parent" (Winnicott, 1958). From what Mr. F told me about his mother as well as in my strong counter transference feelings I came to understand something of his mother's difficulty in allowing her angry feelings to emerge. I think she defended against them by a massive reaction formation. She was always described as a 'saint' and the opposite of a saint would be someone too awful to imagine. In supervision I could see how I, too, got caught up in this 'saintly' defense against my anger. Putting up Mr. F's fees felt a cruel act, even though I knew he was paying too little. I had a lot of difficulty allowing my own anger, feeling moved and sometimes overwhelmed by the awfulness of his illness. If I had not worked through these feelings he would have remained helpless and dependent. In the process I gained some understanding of his mother's difficulties, and I also felt how he used his illness to manipulate me and others.

Anna Freud wrote "It is only when parental feelings are ineffective or too ambivalent, or when their aggression is more effective than their love that children not only feel lost, but in fact get lost" (Freud, 1969). As the summer break came nearer the thought of being lost by me reawakened the terror of being abandoned in hospital and his always unexpressed longing to be at home. At 7 he carefully altered the weights on his traction apparatus to get home more quickly. He admitted that in the recent past he had falsified his records to avoid the possibility of hospital admission. I was encouraged to see that Mr. F was beginning to allow some of the feelings to come alive in the sessions. After sharing more of the terrors he spoke of his love for objects that work well. His tool kit, his car, his first pedal car - his experience of flying, of being inside and in control of a powerful well-functioning machine. He recalled his collection of Dinky cars describing how he put himself into them for safe keeping, which led to him wrapping each one in tissue and packing them in a box before going into hospital, he would not unwrap them until he was back at home, an insurance against death and abandonment. He could not play away from home, and now found his favourite hobby - flying - too exciting and anxiety provoking to follow. As a teenager he used the book by the disabled Douglas Bader 'Reach for the Sky' to distract himself from sexual thoughts, and flying had become closely associated with sexual fantasies and a wish to expose himself so that it was too dangerous to attempt at present.

His fear of his father's retaliation for his sexual wishes was vividly re-enacted with me when he asked at the start of a session if his car was sticking out too far, and then said he had seen a man in the house and wondered if he was lurking just outside ready to come bursting in if Mr. F had sexual wishes towards me. He felt sure his father was just waiting for an excuse to get rid of him - it was preferable to remain sick, helpless and passive. At this and other moments in my work with Mr. F I have been surprised that he is not a homosexual, he seems to have had the perfect breeding ground for such development; constant illness with the attendant passivity, castration shocks particularly when hospitalised, and an unavailable father who was felt as frightening and dangerous in retaliation for Mr. F's close relationship with his dominating mother. Perhaps he is an example of what Anna Freud terms 'homosexual manquees' in whom the reaction formations against anality, especially disgust, effectively block the path to homosexuality (Freud, 1966). He was deprived of the opportunity to experiment in relationships and moved directly from life with his parents into an early marriage. It has been important for him in his therapy to experiment in fantasy, if not in reality, - an attempt to make up a little of the lost ground.

With much difficulty Mr. F began to dare to step off the "narrow road" which involved him in admitting that I might have other people in my life. He was then able to widen his own horizons to include his own children and also his sister, who had been noticeable by her absence up to this stage of therapy. He admitted having had sexual dreams about her when he was an adolescent, and when he spoke of this time I was reminded of his total lack of a normal social life at this time in his life. His mother and sister were the only people available as sexual objects. He began to speak of his envy of his sister's freedom and health and his pleasure in her distress when she went away to weekly boarding school. This intense envy had transferred to Benjamin his son and by now Mr. F felt his relationship with Benjamin had changed profoundly and was the only really good thing to have come out of therapy. Now he could dare to tell me, with the appropriate feeling, of his hatred of Benjamin from the minute of his birth, when he cursed inside and handled him roughly and enjoyed making him cry. Benjamin had become the baby of his childhood sadistic fantasies. Now he could look on Benjamin's health and vitality and robust masculinity with pride and pleasure and not destructive envy. He watched him kick or stamp when angry and told me how such an action would have resulted in weeks of pain for him - he had no normal physical outlet for his aggressive feelings and had had to try and deal with them all in his mind - an impossible task.

These sadistic fantasies and acts were understandable as Mr. F's attempt to turn passive into active. As Freud says "In passing from the passivity of experience to the activity of play the child applies to his playfellow the unpleasant occurences that befell himself and so avenges himself on the person of this proxy" (Freud, 1920). This seems to have been the case with Mr. F but all this activity increased his guilt and anxiety.

The worrying question of homosexuality came up again in a dream in which Mr. F was sitting on a disc with a vibrating rod pressing into his anus. He awoke near orgasm confused and baffled and took what he described as a huge risk and put his finger into his anus. After feeling anxiety and guilt he attained a sense of peace that he had discovered a new part of his own body and given himself permission to touch it. He then recalled how the G.P. often carried out rectal examinations which had been "not totally unpleasant". In his associations to the dream he recalled the nurses in hospital getting cross if he asked for a bottle between rounds. He then said that two days earlier he had a spontaneous gut haemorrhage "That's when I shit blood and it frightens me." In the face of real physical illness such as this he felt sure he could exert psychological control over it - from very young he shifted the pain and fear into his mind and tried to master it there. The ultimate dread was of a brain haemorrhage but he knew there was no protection from this. He is quite often afraid that this has occurred and after a recent dizzy spell Menieres disease was diag-

nosed. He feels strongly that this and his migraines are triggered by unexpressed angry feelings and while I have no reason to disagree I have always to keep in touch with the physical reality of the haemophilia as something over which his mind cannot gain control. It is the uncertainty of it which is its cruellest feature. It can strike with no apparent cause and from minute to minute the patient can never be sure how he is.

On a hospital visit he got very angry about a poster depicting a small boy and girl walking hand in hand, the caption read "He's a haemophiliac and it's her problem too". He was furious that it implied that the boy was a 'Haemie' and not a human. On the same visit he saw a young child patient being comforted by both parents and felt a longing to have had comfort from his father. He recalled his father coming to his bedside and turning away in the face of Mr. F's suffering.

The final session before the summer break was a moving one. He had been making me feel increasingly useless and bad. I suggested he was attempting to protect himself from the pain of separating by making me bad. He said he felt sad and for the first time wept and through his tears said with much feeling that he was tired of important things happening to him on his own, that he had felt lonely all his life.

THE SECOND YEAR

On his return after the long break there was an additional problem in that his mother-in-law, who had terminal cancer, was spending more and more time in his home, taking his wife's attention and reawakening in him the rivalry he had felt in the triangle with his parents. Her illness and approaching death also brought into focus his fears for his own health.

He now expressed a wish to stop being 'such a good boy' and to his surprise and indignation rude words came floating into his mind - significantly 'bum' and 'toilet'. He said he was annoyed with silly trivial words interfering with the serious work of therapy - but he seemed relieved when I said that perhaps the silly things should be taken seriously, while a lot of the serious things he had already redefined as rubbish.

In the following session he reported a dream in which I was explaining 'it' (id) to him, which he felt was me allowing for baser ideas to be important. He said he felt haemophilia represented the wages of sin. He also felt that he might now be able to become more spontaneous in his sessions and not continue to report on the treatment which he conducted on his own. A constant difficulty for me has been his capacity to distance himself and therefore me from important matters, not just by isolation of the affect, but by allowing several days, or even weeks, to come between his experience and the reporting of it. I have often felt that past

sessions have been invalidated when I learn later that crucial events and feelings were unexpressed at the time. Freud writes: "In endeavouring to prevent associations and connections of thought, the ego is obeying one of the oldest and most fundamental commands of the obsessional neurotic, the taboo on touching....isolation is a method of withdrawing a thing from being touched in any way - when a neurotic isolates an impression or an activity by interpolating and interval, he is letting it be understood symbolically that he will not allow thoughts about that impression or activity to come into associative contact with other thoughts" (Freud, 1926). If I was not very watchful I would get caught up in his defenses so that my supervisor, as the one far enough removed from the feeling to actually experience it, helped put me back in touch with it so I could return to my patient and help him to allow it. Time and time again I would be writing up a session and wonder how it was possible to miss a powerful feeling - this was not an intellectual failure on my part, but rather an indication of the power of the defense of isolation, and my patient's capacity to sever the links between ideas and feelings.

By now he felt half way through his treatment and expressed disappointment that he did not feel more changed. I wondered if he felt I could, if I would, cure him completely of his haemophilia. He told me how when he was small he had suspected that his mother wanted him ill. In the transference I (mother) had made him ill and dependent, so he could blame me (mother) for his situation and take no responsibility or action himself.

It was after this that he decided not to hide behind illness to avoid a potentially frightening situation. He went to run a stall at a trade fair knowing that some readers were critical of his running of the magazine, comparing him unfavourably with his father. He was terrified of the imagined attacks and nearly chose illness. In the event he went and survived and was encouraged to discover that the feared attacks were far worse than the reality.

Soon after this event he came to a session and could not get out of his mind the thought that his car lights were left on. He became increasingly anxious and wanted to ask me to go out and check them while he stayed lying down. He explained that if I took the responsibility for looking after everything and went out to find the lights were off, he would be able to make it all nothing to do with him. If the lights were not checked the batteries would be flat and then he would "be stuck with no-one to push". I said this sounded like being stuck in a wheelchair - this led to a flood of distressing memories of being at school stuck in his wheelchair, going up and down empty corridors while the other boys played games. When his elbows were stiff he was "stuck with no-one to push". It was then he developed what he calls his astonishing and profound bladder and bowel control. He said that until a year ago (when treatment began) he never went to the toilet during the day. He could

see how this was part of his earliest attempts to control his body and its illness - pretending to himself that he was not bleeding - not in pain, cutting off the sensations in his body which led on occasions to feeling out of his body. Now that he was attempting to be more in touch with his feelings so he had to tolerate an increased awareness of pain. He began to tell me when he was in pain in sessions.

Soon after this he was frightened by his medical specialist asking him to go into hospital for a liver biopsy. Some patients on Factor 8 were developing serious liver disease. This was just before the Christmas break and he had to cope with fears that he could perhaps be dying. In fact the holiday went well and he did not feel overwhelmed by anxiety and, to his delight, he had for the first time in two years been able to enjoy reading a book.

Feelings about haemophilia still dominated the work. He shared a fantasy of having intercourse with his mother who was menstruating. This was based on a memory of being about 10 and seeing his mother wearing only a sanitary pad. He finds menstruating women sexually exciting - he feels that through intercourse he can stop their bleeding and gain control over it i.e. his own bleeding. On reflection, I feel this also shows his sexual confusion - he is identified with the woman who bleeds. He then rushed into a series of sexual fantasies with me - as if defending against the identification with the woman and the attendant passive homosexual longings. In the next session he spoke of a wish that I wipe his bottom and this led to memories of mother wiping his bottom until he was 14 during the times when both his elbows were swollen and rigid. At those times he was also unable to feed himself. The conflict over this was clear. His mother doing this had been exciting and pleasurable but at the same time he feared she was taking over his body and making it hers. He recalled her insistence that she roll back his foreskin - he did everything to avoid this. Anna Freud again: "The gradual mastery of various bodily functions such as independent eating, independent bowel and bladder evacuation, the ability to wash, dress and undress etc. mark for the child highly significant stages in ego development as well as advances in detaching his own body from that of the mother and possessing it at least in part. A loss of these abilities when occasioned by the nursing procedure means an equivalent loss in ego control, a pull back toward the earlier and more passive levels of infantile development" (Freud, 1969). Had Mr. F been a healthy child he might well have survived unscathed by his mother's wish to possess him - but his actual physical dependence on her made such escape impossible. His mother was keen on bodily cleanliness and he told me more of his washing obsession at 11. How he feared he would infect himself and die - that he felt so guilty. I interpreted the guilt as being about certain wishes to do with his bottom and he then recalled how just before the washing obsession he had enjoyed anal masturbation using meccano rods, but how guilty and dirty he had felt. He was angry with his mother

for not noticing his compulsive handwashing in spite of his sister calling him 'Mr. Health and Hygiene'. He cured himself by a supreme act of will - he forced himself to suck his fingers and discovered that he did not die.

Father came into the material at this stage in dreams and in the transference when I felt he was looking for a firm strong father in me. When he had not paid me he said quite casually one day that he was going flying. He felt I should indulge him and yet expressed fears that he, like father, was self-centred and demanding. He was relieved when I did not avoid tackling the issue, and it was then that he admitted he paid me entirely from his D.H.S.S. Disability Grant - in effect, he had never paid me himself. This seemed an appropriate time to discuss a fee increase and I felt he was relieved I was treating him as a strong and capable person. The business was by now running well, whereas at the start of treatment he was spending so much time in his office ruminating that the business nearly collapsed.

Mr. F had known for 10 days before he told me that he was going into hospital. He felt he would be overwhelmed by endless tears if he spoke of it to me. He feared that in his absence his wife and Pete would get together and he accepted my interpretation that this was in reality a childhood fear of his parents getting together when he was away in hospital. He then shared a memory of being about 7 and walking into his parents room when they were having intercourse. He found it difficult to allow the idea that there were perhaps good times in their marriage.

The printers' strike brought a real possibility of financial ruin but he was pleased with his capacity to sort out what was real from what was unreal. He did not have the biopsy after all, but was very upset when during a hospital visit he learned that babies with haemophilia are now aborted. He had a dream of finding a baby girl lying in the gutter which he picked up and gave back to mother who was radiant. In the dream he experienced a feeling of great joy. I felt this dream was carrying the wish to have been born a girl without haemophilia whom mother would have loved unconditionally. Boy babies with haemophilia had to be cared for, but nowadays are aborted.

For the first time in his life he enjoyed his birthday, due, he felt, to his having come to terms with the fact that no-one was going to give him the gift of removing haemophilia.

Mr. F continued to struggle with the idea that a three-person relationship was possible. He was not withdrawing as much from the difficult triangle with his wife and mother-in-law. He made reparative moves towards his sister, inviting her to lunch and talking about their shared past. One morning he saw one of my sons in the living room as he walked through. He assumed my son must be ill, otherwise why would he be there? He also assumed my son would be

furious and 'out for his blood' as Mr. F had separated him from me. This linked to his rage with his sister for coming between him and mother. He began to enjoy his contact with his sister and was touched by her telling him she was working for "Riding for the Disabled".

As the second summer break loomed I noticed he had cuts on his head and commented on this. I knew his worst fears were of brain haemorrhage and yet he kept banging his head. I tried to link this to the coming break and he said he felt he could if he tried force me not to go away. "If you're not careful you might have to look after me - I'll make you"; but at the same time he wanted to feel that however difficult and demanding he was I would go - he wanted to discover he was not omnipotent. He missed some sessions before the break - making me feel what it is like in limbo, waiting as he has waited. As he knows I get up early to be with him he was making sure I was not with my husband.

Just before the break something he feared actually happened. His wife (who is often depressed and speaks of suicide) was driving too fast and crashed the car. Neither she nor Sophie was hurt but the car was a write off. It was very difficult to look at the implications of this for Mr. F. It was too terrifying for him to bring the feelings about it into the session - he reacted as if very little had happened and now I was going away I found that I too forgot the accident much too quickly.

I had to cancel a session and he was able to share the fantasy that I was going to be sterilized. He told me that after his birth his mother was sterilized. I interpreted his wish that I should have no more babies/patients and he was then able to tell me that he had just begun to think that I saw other people. With this thought had come the wish to wander round the room and be freer in the sessions. Then he decided to open a box which he had inherited from his father and never dared to open. From documents he learned of two more suicides in father's family which frightened him - he wondered if suicide was inherited like haemophilia. But he reiterated his wish to hold onto life. In the box he found letters between his parents which confirmed his feeling that their relationship had been frought with difficulties but which also made it clear that there had been good times as well, with hints of sexual enjoyment. Mr. F was widening his vision and making discoveries that were not what he expected.

POSTSCRIPT

Mr. F's business is now going well - he feels much freer with his children and better able to dare to move in on situations rather than opting out. He has decided to go to a patients' meeting organised by the hospital - an important step for a man who has struggled all his life against the acceptance of his illness. He was relieved to discover that after two years he was not thrown out by me, and the work

goes on. He has taught me a great deal and I believe he has begun to step off his "narrow road".

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THE CONCEPT OF MANIC DEFENCE AS APPLIED TO THE HANDLING OF ATTEMPTED SUICIDE

Peter Schoenberg

It has been observed that towards the end of the first year of life, there is a period of sadness which corresponds with the child's overt awareness of his mother as a whole person. Melanie Klein conceived of the manic defences as a way of avoiding these depressive anxieties faced by the infant. These anxieties were aroused in her view by the growing awareness of the infant of his sense of dependence on the mother and by his discovery of his own ambivalence towards her, coupled with intense feelings of feared loss and guilt in relation to her.

Manic defences are directed against these feelings of dependence which must either be denied or reversed. In essence the depressive anxieties are concerned with an awareness of an internal world. This internal world is growing in the infant who is in the process of trying to contain valued objects of which the most important is the mother. As Hannah Segal (1964) has said, the manic defences are directed against the experience of psychic reality. Thus they are important in psychiatric practice because they become a means whereby the patient can avoid those depressive anxieties which he may be obliged to face in the therapeutic situation.

The manic relationship to objects is characterised by control, triumph and contempt. This is illustrated by Melanie Klein in her description of the dream of one of her patients who in the dream was flying on a magic carpet over her analyst who was in the form of a cow munching a blanket. In the dream one sees the triumph of the patient in his ascendant position on the carpet flying over the analyst, his contempt for her in representing her as a cow and his omnipotent control over her work with him in representing this totally unreal scene, in which dependence is denied. (Klein, 1945).

The earliest writings on mania, from a psychodynamic point of view, are by Freud and Abraham. Freud wrote that in mania, the ego had got over the loss of the loved object and that whereas in melancholia it had 'succumbed to the complex', in mania it has mastered it and pushed it aside. He spoke of a triumph in mania and of the passing away of the shadow of the object. Abraham wrote at greater length on the subject of mania - he observed how a manic patient might actually laugh at the graveside of the lost person he had loved (Abraham, 1949).

However, in the context of the manic defence, it is Abraham's paper on 'a particular form of neurotic resistance against the psychoanalytic method', written in 1919, which is of especial interest. Here he wrote about those patients whose apparent compliance in the therapeutic situation

masked an unusual degree of defiance - this 'false transference' of which Joan Riviere later spoke, was a hindrance to ongoing treatment. He also wrote of patients who were more overt in their demonstration of this defiance, citing one patient who refused to free associate and often jumped up and went to the opposite corner of the room and expounded his own opinions in a superior way about his neurosis. He described another patient, who said to him that he understood psychoanalysis better than Abraham, because it was he and not Abraham who had the neurosis. After long continued treatment, this same patient said to Abraham, 'I am now beginning to see that you know something about obsessional neurosis'.

The point about the manic defence, as seen in the therapeutic situation, is that this stand which the patient takes in avoiding those crucial issues in his illness, renders impotent his relationship with the therapist, whom he seeks to control by his manic defence.

These examples need not be restricted to analytic practice and I want to describe here a young man who made many interviews with doctors a sterile process. I quote here an extract from an interview that I had with him on the ward. I asked him how he was feeling; he replied, in a haughty way, 'I feel fine'. However, he in fact looked quite depressed, and I pointed this out to him, to which he replied, 'Yes, but you want me to say that I feel fine, and it's easier for me'. This patient had been admitted to the ward because he had threatened to commit suicide. During his stay on the ward, he spent most of the time lying on his bed, refusing to take part in the ward activities, remaining in a state of passive negativism, apart from occasional suicidal gestures and threats. This charade, which masqueraded as depression, was repeated when he was told he would have to leave, by an elated state in which he denied there was anything wrong with him. In both states of being he denied his true sadness as a person, in the one by making us responsible for his welfare, in the other by pretending to be completely well. In both states there was evidence of his own manic defences in full force, with control, triumph and contempt for his therapists. One of his most frequent remarks to me and other doctors, in reply to any question, was 'I anticipated that question, but I don't have an answer'. His manic defences could be usefully seen as a way in which he avoided a real experience of his sadness. He once in fact said during an interview, 'If I really talked to you it would be far too painful for me'.

Various writers have emphasised that the manic defence is not only important as a concept in the therapeutic setting, but also may serve to understand certain ways of living. Joan Riviere has written about Ibsen's "The Master Builder", in which Hilda can be seen as a personification of the manic defence. Here is a person who, as Miss Riviere says, is 'life, youth, vitality, personified, blooming health, above all independence, self assurance and fearless daring. She

comes alone, walkng with a pack from her home miles away, indifferent to ordinary feminine concerns; there is more than a hint of masculinity in her. What she lives for is dangerous excitement; she will defy everything for that. With her entry, two parts of an emotional state become personified in her and the Master Builder; where life offers him only a decline into gloom and danger, she incarnates sunshine, youth and promise; he is uncertain, irascible and full of torment, while she is gay assurance and determination that she can gain her ends. In the heart of Hilda is the vision of her castle in the air, the Princess enthroned over all'. Her ends are achieved, for she above all envies the Master Builder's success, and she triumphs over him at the end of the play, forcing him to climb the tower he has built, and so fall to his death. Hilda's liveliness is dangerous here, in so far as it hinges upon the vulnerability of the Master Builder, which she triumphs over and controls (Riviere, 1955).

Winnicott took a broader view of manic defences, for though he also saw them as a defence against inner reality, as a way of holding depression 'in abeyance', of holding the people of the inner reality in suspended animation, he also saw the manic defences as operating in the disturbed behaviour of children. He had earlier written of the 'common anxious restlesness' which he saw in children in his pediatric clinic, and which he regarded as a form of hypomania. Here there was a mild aggression in the form of untidiness, messiness and irritability with lack of constructive perseverance. In his essay on 'the capacity to be alone', written in 1958, he spoke of the ability of normal children to play and to become excited when playing, without feeling threatened by a physical orgasm of local excitement. He then contrasted this with his observations of the deprived child with manic depressive restlessness, who was unable to enjoy playing because the body became physically involved. These children could not play in the same way as other children, because their relationships with external objects were used in an attempt to decrease the tensions of their inner reality. For the normal child, playing sponsors growth and development, whereas for the deprived child, attempts at play cause only pain to the outside world, so as to defend against the pain of the inside world.

Winnicott also spoke, in his paper on the manic defences, of the possibility of hypochondriasis occurring when these defences broke down, but he did not extend this concept or illustrate it with clinical examples (Winnicott, 1935).

The control in the manic defence has been described as having a magical quality. This has been written about by Joan Riviere in her paper on 'magical regeneration by dancing'. Here she describes a little girl who, in her jealousy of her newly born sister, invited her mother to a small feast at a toy table. When all the food was finished she jumped up and performed an elaborate dance around the table in order as she said 'to make it (the food) grow

again'. This brief description of the little girl makes another point about the manic defences which is not mentioned; as with all defences, they are not always pathological, but may play a valid function in allowing time for growth and being in life. Winnicott himself wrote of dancing 'here is the primal scene, here is exhibitionism, here is masochistic submission to discipline - but sooner or later one adds - here is life!' (Winnicott, 1935).

I have discussed the concept of the manic defence in terms of its value in relation to understanding a certain phase of development in the infant and how this is reflected within the therapeutic situation; also how various writers have used this concept to understand certain aspects of behaviour. However, one aspect of this subject which I have not talked about is the relationship between the manic defence, and the clinical states of mania and melancholia. Winnicott contrasted the aggressive outburst of mania, and the 'common anxious restlessness' of the manic-defence, but apart from this little has been written on this aspect of the manic defence - one may speculate as to theoretical differences contrasting the actual loss of the object in mania, with the threatened loss of the object in the manic defence. Ultimately, however, I think the manic defence refers to a certain position of control that is adopted by the individual, only in the context of an ongong relationship. Mania by contrast occurs outside and independently of the existing relationships. The one state refers to the present state of things, the other reflects those things which have passed.

I have quite deliberately spelt out the concept of manic defence as seen by Winnicott and Klein, because I have found it particularly helpful in dealing with certain character disorders where an enforced liveliness masks a certain inner despair. Nowhere is this more the case than in those border-line patients who attempt suicide.

Current psychiatric practice favours the careful follow-up of these patients, and research has shown that this sort of follow-up is rewarded by a diminished risk of further attempts. The problems presented by this sort of work are that these patients are often looked after in relatively hostile environments, where acute medically ill patients take precedence, and are followed-up in under-staffed clinics. Only a small proportion of these patients presenting as attempted suicides are profoundly depressed or psychotic. The majority are young people who have attempted suicide after some severe disappointment, usually in a relationship. What is striking about them as a group of patients is their apparent indifference to their attempt at death, as if it had not happened, and as if they have no wish to look into their sadness. The attempt was not calculated, but impulsive, and now seems remote from consciousness. Thomas Gunn in his book of poems 'The Sense of Movement' (1957), writes in his poem 'On the Move':

A minute holds them, who have come to go:
The self-defined, astride the created will
They burst away, the towns they travel through
Are home for neither bird nor holiness,
For birds and saints complete their purposes.
At worst, one is in motion; and at best,
Needing no absolute, in which to rest,
One is always nearer by not keeping still.

These people live in movement, not wishing for themselves the intrusion of self, let alone therapist. Therefore therapeutic ventures are hazardous, or often impossible.

Winnicott developed the notion of the holding environment, in which the mother could hold her child and so sponsor growth. This concept has been applied by Shields and others in their handling of delinquents with an anti-social tendency. The same containment can be provided for these young patients who attempt suicide. I am doubtful that long term psychotherapies have a place in their management, but optimistic that careful handling so as to contain them during the crisis of the attempt and its aftermath, can be rewarding.

I wish first to present a case in which suicide was threatened to illustrate the vecu in which the manic defence presents. We are naive if we confuse the manic defence with mania, which is more violent and absolute in its way. These appearances of the manic defence are more subtle.

The first case is a young ex-ballerina in her 30's, now working in theatre design. Supremely intelligent, and her life in the private ruins of a broken marriage and a geographically disconnected past; living on her own. Shortly after starting twice-weekly psychotherapy, she arrives as always looking particularly elegant, with the gestures of a butterfly. For the last two sessions she had explained that she had been sleeping all the time. Today she has started a new job in a Northern town. She is happy, no longer sleeping all the time, and so on. And yet the tone of her voice betrays her mood - it is wistful and lost. She sits astride the chair, triumphant, as one riding. Then, looking out of the window, she says quite delicately: "There is something that I don't want to tell you, but perhaps I should. I'm afraid of what you might do - I am pregnant." "What might I do?" "You might advise me differently. I am going to get a termination." Her eyes fill with tears. "It all makes you very unhappy." "No", she says firmly. "Actually I feel happy - being pregnant makes you happy." She describes how she became pregnant in France, by a man she hardly knows. It is in my opinion a signal of real despair, but all understated - she looks wistfully out of the window. "Well, there's nothing more to say - I don't think I had better come for the next two sessions." "Why?" "Well, I wouldn't want to talk about the pregnancy, which is uppermost in my mind - I want to go." Silence. "What is there to talk about otherwise." "The chimney tops." I point out that she

is in considerable despair, and that I will see her for the next two sessions. I am concerned that she may well attempt suicide.

She was on time for the next session, and cheered me up in her fashion, saying: "Well, you see, I did come." Again, superficially she looked well and her opening words were that she felt well. But then there was a silence, after which she said: "I have this disturbing fantasy. I know I shouldn't have it, but I keep on thinking how nice it would be if Colin and I could have the baby." She berated herself for thinking in this way, and I commented that I was quite concerned that really there was a lot of despair which she could not face, and would have to face when she had the termination. She went on to talk about her ideal lover, who was both exciting and brotherly towards her, and this led to a discussion about her own brother who had gradually distanced himself from her. There was a silence, and then she told me she had telephoned her ex-husband. "It was a crazy conversation. He invited me to act in a film where I jumped off a barge. It seems ridiculous that we should have wasted our time talking like this." She was silent again, and then in a sinister way recalled another fantasy. "There used to be this street in Hamburg, and I didn't like walking up it. I had this strange fantasy that someone was going to shoot me in the back. It's funny because I started to get these thoughts again." I linked this to her despair, but she said: "I feel quite well now. I don't feel I'll ever get depressed again." I said it seemed to me she was really quite a bereft person. She laughed and then I said to her somewhere she was talking to me about her wish to commit suicide. She denied this, but then told me how suicidal she had felt earlier on in the year.

The other case is tougher but less obscure, and by contrast, my interest in this girl is because I failed to recognise her manic defences, and in so doing, landed myself with a nearly successful attempt. This patient was a 20-year old narcotic addict with psychogenic vomiting, a long history of overdoses, self-mutilation, hospitalisations, and an impossible family background in which her father amongst other things, supplied her with narcotics. I took her into twice-weekly psychotherapy more on impulse than on careful consideration, having made my acquaintance with her in the casualty ward of a busy general hospital. Psychotherapy was an ambitious project to say the least, and my therapeutic zeal contained its own form of denial in colluding with this poor girl's militant demand for sameness. However, by six months I consoled myself that though this patient had not changed a jot in response to her anorexic problems, she had at least abandoned her narcotics in favour of phenothiazine.

Whenever this girl came for her sessions, she like my other patient would humour me. However, unlike my other patient she did attempt suicide by cutting a vein in her anticubital fosssa and by taking a massive overdose of diazepam. The hospital where she was admitted wanted her transferred im-

mediately to an in-patient unit, but I in my omnipotence decided that I should see her in the first place. Needless to say she came and persuaded me that she did not need to go into hospital, and I arranged for her to come and see me for an extra session in two days time. Instead of this, she arrived early on the morning of the session and left a small present for me, her favourite bird's nest together with a note thanking me for my help. She then disappeared and was found cyanosed behind one of the bushes in one of London's larger parks, having consumed the better part of 100 barbiturate tablets. She only survived this massive onslaught on herself because of the technology and care of the hospital where I was working. And after this second attempt she was hospitalised. This unfortunate girl's story made me very wary of states of excitement disguised as liveliness. For her the excitement truly misrepresented her deathliness.

If we only consider the notions of manic defence in a psychoanalytic context we miss the possibility for handling these problems when they occur in the raw. Too often these patients fob off attempts to help them by this surprising capacity to feign good health and vigour. They are on the move, but this movement is paradoxically away from life and not towards it. Thus they present a sizeable challenge to therapeutics.

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