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CONTENTS

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BULLETIN

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EDITORIAL

Psychological Counselling

The past year has seen the Association greatly occupied with problems of the definition of Psychological Counselling and of training workers in this discipline. An attempt is made here to review our work so far.

Our past seminars have shown that Social workers of all kinds are constantly called upon to deal with clients whose problems they feel do not yield to the resources that the caseworker possesses. Psychotherapists have this experience too, but they believe that they possess techniques which are capable of development and expansion and which potentially offer some hope of ultimate success.

Social workers look towards these techniques and anticipate that they can learn from them and so increase their own skills. They do not wish to become psychotherapists but they believe that they can gain something, perhaps some applied aspect of the general theory of Psychotherapy and use it in a limited way on problems which do not demand the full resources of a psychotherapist. These applied skills come under the general heading of Psychological Counselling.

Our purpose here is to examine what is understood by Psychological Counselling and to attempt to come to terms with its definition and use. It is written from the viewpoint of a psychotherapist and is the outcome of considerable discussion in professional seminars and with social workers from various spheres.

The most widely accepted definition of Psychological Counselling springs from the non-directive techniques of Carl Rogers. The non-directive element is the most widely known. Rogers himself, however, places the techniques of counselling within a framework of controlled relationship between Counsellor and client. He says, in essence, that the Counsellor must be able to enter into an empathetic relationship with the client and to be keenly in touch with the emotional life that pervades him and which is manifest in the interview. The client, Rogers maintains, will sense this empathy, although the fact that it exists may not become explicit. Over and above this the Counsellor's attitudes to the client must contain the conviction that the client has the potentia-

lity of growth towards the solution of his problems, and that the Counsellor's role is to remove obstacles to that growth and—and here is the non-directive element—not to offer solutions openly or in a disguised form. Rogers emphasises the fact that the Counsellor cannot really control the client's life or solve his problems for him in any lasting way, so whatever the Counsellor may feel about this or be driven to try and do, the only really effective working arrangement that he enters into with his client is a non-directive one.

Rigorous application of the non-directive principle coupled to the hypothesis that the client has within him the potentialities to solve his own problems, leads to the rule that the Counsellor should add nothing to the material of the Session which the client has not already made manifest. This means that the Counsellor does not interpret. He can rephrase and feed back to the client the material that the client has supplied. He does not introduce fresh ideas based upon his understanding of the unconscious content of the client's material or from a frame of reference from psycho-analytic or other theory. This offers difficulties to psychotherapists who wish to operate in the strict Rogerian manner.

Rogers maintains that transference problems can be dealt with in the same way as any other material that the client produces. The feelings that the client has towards the Counsellor can be made manifest where need be and directed back into the situation. Rogers holds that extreme transference situations are not common in Counselling. He feels that this is because, unlike Psychotherapy, Counselling does not encourage attitudes of client dependency and emphasises that the client and the Counsellor are co-workers on the problem that the client produces.

Rogers does not define the limits of suitability for Counselling. He says it has been applied to a wide range of cases with a wide degree of disturbance. He admits, without being precise, that it may not be suitable for all cases but implies that it should be helpful in most. The bulk of his writing, however, seems to be based upon his experiences with American college students, and the presenting problems are often those of social adjustment. There are none of what might be called self-contained symptoms such as obsessional manifestations, phobias and so on. It seems unlikely that this type of symptom emerging from tightly rooted unconscious processes could be vitally affected by Counselling techniques. It is, of course, possible that the support that Counselling gives may reduce the tension in the client's life and so reduce such symptoms. We need to accumulate experience on this.

We can now turn to Counselling as practised by some psychotherapists. This is largely an unformulated set of techniques derived from psychoanalytical psychotherapy, but which do not

insist upon the formal aspects of psychotherapy such as free association, dream interpretation, placing the client on a couch and so on. The Counsellor and client situation is more or less unstructured and the Counsellor feels himself free to react to the client as the totality of the situation demands. The Counsellor is aware of the transference and of the unconscious content of what transpires. This will play a large part in determining his responses. He may consciously manipulate these or the session may take the form of spontaneous interaction between Counsellor and client —the content of the spontaneity being more or less kept in the Counsellor's conscious awareness but not necessarily in that of the client's.

On the whole the Counsellor does not offer the client advice or if he does it is not with the expectation that it should necessarily be followed. Advice may serve as a background against which the client may formulate his own opinions.

Interpretation is also offered, but largely of the here and now sort, i.e., throwing into emphasis the relationship processes between client and Counsellor and avoiding ideas and hypothesis not contained within the situation.

It is claimed that this type of Counselling can be widely and effectively used. It demands, however, a considerable background of knowledge and experience. From the Counsellor's viewpoint it does not emphasise the restraint demanded by non-directive techniques. It presupposes, however, that the Counsellor is keenly aware of his own attitudes and how he uses his personality. It demands self honesty and a capacity for detachment within the involvement. It is generally held that a personal analysis and long experience in therapy are essential for this type of counselling.

From time to time one comes across what might be called "intuitive Counsellors" who use their personalities in this way without being consciously aware of the processes involved. Their responses to clients and the checks necessary operate at an unconscious level. These people are often highly successful, but their practice can have limitations which they do not perceive. They are also unable to communicate to their colleagues how they achieve their results and they tend to remain rugged individualists.

Counselling of this relationship sort is claimed to have a wide application. It makes high demands for empathy and lacking a formal structure to contain the Counsellor-client relationship, it can create considerable stress for the Counsellor. Observation seems to suggest that its practitioners restrict themselves to short termed treatment. Strong transference manifestations do not usually occur but when they do they are apt to present difficulties for both therapist and client. Those that practise this form of counselling often enjoy it and find that it offers spontaneous

enrichment to their personalities. Its results can be most impressive.

For completeness some mention must be made of the Behaviourist approach, although work on this has been limited and perhaps hardly comes within the definition of Counselling. In essentials the Behaviourist sets out to decondition or recondition a presenting symptom so that instead of causing discomfort it is neutralised. There are two main approaches to this. The first utilises the principle of retroactive inhibition. For instance a sufferer from a facial tic can be directed to consciously practise the tic in front of a mirror until he becomes highly fatigued and can do no more, i.e., the tic becomes inhibited. In favourable cases it is found that the inhibition influences the involuntary tic and it diminishes.

The second approach is largely that of building up pleasing associations to a displeasing symptom. For example, a girl suffering from obsessional symptoms was relaxed under mild hypnosis. Her symptoms were induced by suggestion and when she displayed them her arm was stroked and the words " calm, calm " were spoken. She enjoyed this. When subsequent involuntary attacks occurred she was taught to stroke her own arm—say " calm, calm," i.e., form a conditional link between the unpleasant and subsequently pleasant experiences. She was able to gain considerable relief from this technique.

Those who are sceptical of the Behaviouristic approach say that even at its face value its therapeutic possibilities are limited and not adequately demonstrated. They go on to say that in all probability such effects as are reported are dependent upon strong transference reactions which, it is maintained, are apparent from the descriptions of the cases treated. However, for the purposes of this paper we can only note the existence of the theory and its claimed potentialities. There appears as yet to be no direct applications we can make.

We are now confronted with the problem of what model of Psychological Counselling do we accept and thus how may we best train for it.

Observation suggests that attempts to operate on strictly Rogerian lines with personnel who are trained, but relatively unsophisticated in other respects, introduces considerable strain for the Counsellor. The non-directive technique tends to destroy the spontaneity in the client relationship without giving anything sufficiently rewarding to take its place. The Counsellor tends to distrust his spontaneous reaction and his response becomes stereotyped and limited. On the other hand the unhibited and uninformed response, although less stressful to the Counsellor, is self defeating. It seems therefore, initially at least, that some adherence to non-directive techniques is essential and training

must aim at this. At the same time as the Counsellor's knowledge and experience grows so more and more of the therapeutic aspect of his personality should be brought into play. The second facet to training is, therefore, a long-term programme which aims at increased self knowledge of how the Counsellor uses his personality in the counselling situation. All this, of course, must rest on a solid grounding of casework experience and knowledge of psychopathology.

So far the Association has attempted to translate this framework into practice by offering a series of seminars on general aspects of personality and interpersonal techniques.

Students are drawn from a wide range of social workers, probation officers, hospital almoners, after-care officers and psychiatric social workers. Experience and qualification in their respective fields is demanded for admission.

At the conclusion of the Seminars, students are offered the opportunity of joining a small group of about eight members with one or two psychotherapists who help them to understand the attitudes and involvements which they as workers bring to their cases. The form of group proceedings is designed to suit the needs of the members.

After a year of such experience we are now contemplating offering students a further stage in which they would be expected to acquire a more formal knowledge of relevant literature plus extensive supervised practice.

P. U. DE BERKER.

ACTIVITIES OF THE YEAR

Psychological Counselling Seminars

At the time this Bulletin goes to press we are embarking upon our second series of training seminars for Psychological Counsellors. Twenty-two social workers, drawn from a wide variety of fields, attended the eight seminars on various aspects of client relationship, in which members of the association spoke. Dr. Robert Andry, Ph.D., acted as course tutor throughout. About half the members of these seminars have proceeded to Part II, namely intensive work in a small group under the guidance of Dr. Mary Swainson, Ph.D., and Mrs. Rowena Phillips.

The response to these courses has been such that we feel we should make every effort to make this a regular yearly feature of the Association's activities.

Internal Seminars for Members.

Earlier this year we conducted a series of seminars to examine aspects of Freudian and Jungian theory and practice. Dr. R. A. Macdonald chaired the Freudian papers and Dr. Murray Jackson

the Jungian. The difficulties that those of the Freudian discipline have in accepting such concepts as "archetype" and in clarifying the Jungian definitions of personality emerged at an early stage. It would be true to say that these problems remain. There is, however, little disagreement amongst experienced therapists of either school when it comes to the practical side of handling a case. It appears, in fact, that the patient indicates the treatment needed if the therapist is wise enough to be aware of this.

Later in the year we held a further course of seminars in order to clarify our ideas on the definition and content of Psychological Counselling. These were most valuable in providing a baseline from which to consider a training programme and to consider critically the theoretical concepts involved.

Annual General Meeting

The Annual General Meeting was held at 36, Queen Anne Street, on March 11th. Dr. J. Reid was in the chair. The meeting welcomed the news that the Association of Psychotherapists had now divided itself into the Association and the Society for Psychotherapy, the division having been necessitated by the conditions governing the establishment of a charitable trust. The Association continues as a meeting place and professional organisation for its members, while the Society is concerned with the furthering of the understanding and practice of Psychotherapy and as such can attract donations or Covenants under the rule that governs charities.

The meeting went on to listen to a report of the year's activities as mentioned above and fully to discuss ways and means of launching an appeal for funds. It was decided to set up a small ways and means committee, which was thereupon elected from those present.

This committee has drawn up the appeal which went into the hands of members last month.

In the afternoon, Mr. Lyward, of Finchden Manor, addressed members and their friends on the work of his school and the philosophy that he applies to it. A penetrating discussion followed.

The committee ask all members to contribute articles and notes for the *Bulletin*. They should be sent to the Secretary, Mrs. A. P. de Berker, 411, Upper Richmond Road, London, S.W.15.

REVIEW

NERVES AND THEIR CURE

By C. E. Barker

ALLEN AND UNWIN, 1961.

Our colleague Mr. Barker's book "Nerves and their Cure" is of real value to that ever widening circle of people who want to know what psychotherapy is all about and whether it could do anything for them.

It has a quality of brilliance in that it explains causes of illness and methods of cure in such a way that is both comprehensible to the uninitiate and not boring to ex-patients and practitioners. Without trying to do this oneself it may be difficult to appreciate the skill whereby complicated psychodynamics are made understandable to those who have given little time to studying mental processes.

The book is thorough yet until one looks it through after having read it one scarcely notices the wealth of cases illustrating with vividness and simplicity well-known psychoanalytic findings. It reads as easily as fiction but the suffering of the real life situations are not overdrawn nor are the growing pains of the healing work underestimated.

Clearly what the author most hopes for from the book is to set on their way towards self help people who cannot, for some reason, manage to procure proper psychotherapy from a therapist. Their desperate need of relief from neurotic symptoms and unhappiness speaks to us all from the pages he writes.

Can this relief come through reading? Personally I believe there are some who, with the aid of the right guide book can explore the maze of unconscious desires and defences and thereby come to some understanding of themselves. Obviously the likelihood of their gaining help is increased if they stumble upon a case history which runs closely parallel to their own.

If any writing can be the right guide for such a persevering person then Mr. Barker's is the book. The second part is clearly designed for those unable to reach a psychotherapist. For those patients already in treatment the whole book can provide excellent material for comparison with themselves.

ANALYTIC WORK WITH LSD 25

By Margot Cutner, Ph.D.

A. Theoretical Remarks

1.—Introductory Explanations

The following paper is an attempt at evaluating the use of LSD 25 as an aid to deep analysis. It is solely concerned with the psychotherapeutic aspect of work with the drug and the way in which it can be integrated into general analytical procedure. In addition, some theoretical inferences will be drawn, as it seems that analytical work with the drug can help to throw some light on the dynamics of psychological processes generally.

The trade name "LSD" stands for lysergisch-saures Diathylamid (lysergic acid diethylamide). It is a synthetic preparation of a substance (d-lysergic acid) originally extracted from the ergot fungus, which was first prepared by Stoll and Hoffman in 1938. In 1947 and 1949 Stoll reported " . . . in detail the chemistry and pharmacology of the drug and considered that the symptoms produced by LSD 25 in the normal subject were the expression of an acute exogenous psychosis analogous to that produced by alcohol, opium, cocaine, hashish, mescaline and the amphetamines."

The main feature that has struck everyone who has concerned himself with the psychological effects of LSD is their unpredictability. In spite of certain typical reaction patterns, no two LSD sessions are ever alike—either in different people or in one and the same person. To an analyst, this is not surprising, as the main psychological feature of the drug is a facilitation of the emergence of unconscious material, which, though it follows its own psychological laws, may appear to anyone but an analyst to be completely arbitrary. Thus the experiences of persons under LSD have much in common with dreams or visions or images of the active imagination, but they also include actual hallucinations, alterations of the body-image or drastic changes of mood to the point of actually inducing psychotic behaviour, such as violence, often coupled with paranoid states, severe depressions to the point of actual attempts at suicide, phenomena of depersonalization, and phenomena of altered or distorted perception of the outer world.

With all such possible reactions, even in normal persons, it is obvious that it would not be safe to give the drug without adequate supervision to anyone who was not on fairly good terms with his own unconscious. Such supervision, if possible, should be inside a hospital.

The way to deal with patients under LSD varies from analyst to analyst about as much as analysis itself. The writer's aim has always been to use it as sparingly as possible and to keep the main accent on the analysis itself. The writer has had patients who, in two years of analysis, had only two or three sessions with LSD. With others it was found helpful to give the drug weekly, fortnightly or at intervals of a few weeks for certain periods during the analysis, and then perhaps have long periods without it. It is obvious that the drug is resorted to when the patient's material is not coming forth sufficiently for the work to proceed.

This, of course, brings up the question whether it is justifiable to break through what appear to be resistances on the patient's part by using the weapon of a drug. Should not resistances be worked through in patient analytical work; is there perhaps an obstacle in the transference situation which prevents the progress of the analysis; or are there perhaps times of seeming barrenness which in truth may be periods of incubation or assimilation in the unconscious, the rhythm of which should not be disturbed by violent action? Or is it perhaps a simple insufficiency on the part of the analyst that causes the analysis to come to a standstill?

The writer believes that it is very important for any analyst to remain awake to these problems when working with LSD or indeed with any kind of "short cut" in analysis.

It seems to the writer that it is no good denying that there are a great number of cases who, for various reasons, would either, not at all, or only extremely slowly, respond to pure analysis, however skilled and well integrated the analyst himself may be, but who, with the help of certain auxiliary means—such as for instance, this drug—can still be helped.

Because of the drastic nature of some LSD experiences, most analysts now spend several periods during the treatment day with their patients. Each of these periods may last for an hour or more. The writer herself has, on occasions, spent up to two hours at a stretch with a patient, when she felt the need for it. Between the analyst's visits, many patients feel the need for the reassuring presence of a nurse, or at least of a friend. In neurotic patients there is usually a clear awareness that their experiences are produced by a drug; and, with part of themselves, they can maintain the roles of onlookers.

The closer to a psychosis a patient is, the more he will naturally tend to identify himself with, and become absorbed by, his visions or hallucinations; and the more necessary is the presence of an outsider to keep him "sane" or prevent him from "acting out," e.g., becoming violent or suicidal.

In the early stages of experimentation, patients were sometimes allowed to take the drug home and have it by themselves. This

had, in a number of cases, an almost traumatic effect. Nowadays most analysts (the writer would think) would be inclined to interpret the drug-induced phenomena while they are staying with the patient and taking part in his experiences. However, the writer finds that it is best to communicate a minimum of interpretation at the time, so as not to interrupt or influence by suggestion the natural flow of the inner events. More detailed interpretation can be given in subsequent interviews, as the patient usually remembers his LSD experiences in almost all details.

In the cases described in this paper, the drug was given orally, and the usual dosages varied between ¼ and 4 cc., according to the individual patient's response. The patient spent "LSD-day" in bed. The drug was given in the morning; and the effects of it reached their peak from two to three hours after ingestion, and usually wore off toward late afternoon. In most cases, nembutal was given at the end of the day to counteract the more drastic effects of the LSD. Special precautions were taken to insure supervision of patients in the (rare) cases of spontaneous recurrence of the "LSD shakes," a day (or even longer) after administration.

2. Observations on Effects of the Drug and its Interaction with the General Analytical Processes

In this paper, the writer is trying first, to consider the great variety of experiences from one particular angle, through which may be discovered one guiding principle behind the variety and seeming arbitrariness of experiences; second, to present some ideas relating to questions of transference in the use of the drug.

Complementary Character of Material Found to Emerge under LSD.

During three years of work with LSD 25 at a mental hospital with both in-patients and out-patients, the writer noticed, more often than would be due to pure chance, that the material emerging under LSD, far from being chaotic, reveals, on the contrary, a definite relationship to the psychological needs of the patient at the moment of his taking the drug.

If one believes with Jung that the activities of the unconscious are to a great extent complementary to those of consciousness, it is not surprising to find that unconscious activity observed under the influence of the drug reveals its compensatory character —in a similar way to that observable in dreams, visions (including active imagination) and other manifestations of the unconscious in general.

On the other hand, the writer does not believe it to be begging the question to say that the phenomena observable under LSD seem to confirm, even more clearly than those observed in general

analysis, Jung's idea of the psyche as a self-regulating system, in the service of a striving toward wholeness. The teleological factor introduced by Jung into the conception of the unconscious seems to become more obvious when one has the chance of observing reactions to LSD in a fairly large number of patients for several years. Looking at the material obtained in this way, it appears as if something like an autonomous selective process is at work, determining the sequence of the emerging material in a purposive way—as if whatever emerges is just what is "needed" for any particular patient at any particular time, as a factor complementing the conscious personality.

The following categories are meant to serve as a guiding principle for grouping clinical material according to the idea of complementation and compensation. In grouping it, a number of Jung's conceptions are made use of, as it appears that, with their help, a certain amount of system can be brought into the seeming chaos and arbitrariness of LSD experiences.

Categories of Typical LSD Experiences with Special Regard to Their Complementary Tendencies.

1. Drastic experiences through sudden activation of one or more inferior functions, for example vivid experiences of sound, colour and other sensations, also experiences in the form of synesthesia in intuitive or thinking types of personality. Also, reversal of attitudes (introversion—extroversion).

2. Emergence of repressed material of the personal unconscious —childhood memories and traumata (including possibly genuine birth traumata)—experienced not only as memories but with the corresponding physical sensations.

3. Alterations of the body image, by bringing into prominence bodily regions of which the patient previously has been too little aware. (Physical sensations of shrinking frequently accompany childhood memories.)

4. Activation of archetypal (healing) symbolism, particularly in connection with archetypal aspects of transference phenomena (again, experienced not only as fantasy but accompanied by physical sensation).

5. Experiences which seem to resemble those of a mystical or cosmic character, something like an ultimate unity of all creation.

If one accepts Jung's theory of functions at all, Point 1 of the categories is of a complementary nature by definition. Point 2 would be complementary in as far as the neglected or underdeveloped function is largely bound up with and "stored" in (repressed) childhood experiences. This shows most clearly in many of the experiences relating to alterations of the body image (Point 3). For Point 3, see the illustration from clinical material.

The complementary aspect of experiences of archetypal character (Point 4) is inherent in the very conception of an archetype (Animus, Anima, the Good and Bad Parent archetypes, etc.). As for those experiences, which have been compared to mystical experiences, these are usually not only synaethetic but also contain a sudden new awareness of "meaning." It would seem that here too, a successful complementation, through the momentary experience of "wholeness"—or to put it into more strictly Jungian terms, that in such experiences the archetype of the Self is, if only momentarily so, being realised.

As in general analysis, transference phenomena under LSD vary widely in range and intensity, and the handling of the transference varies from analyst to analyst and from session to session. The analyst may be the almost entirely objective observer who, during any one session, passively accepts projections, or he may enter into a relationship with the patient and either "incarnate" or interpret projected contents.

As, however, under LSD, the ego-threshold is rather suddenly lowered and the patient's defences against the impact of emotional and instinctual or archetypal contents are suddenly weakened, a greater amount of anxiety may be engendered than is usual in general analysis. Due to this, there is much greater need for reassurance which, just because of the relative absence of rational ego-forces, can at times only be satisfied by the most direct and elementary comforting contact, that is, physical touch.

As the drug is instrumental in producing a state of regression to a phase of development before the ego was strong enough to cope with the id-forces, it is obvious that the *contact by touch*, the only thing the patient can understand at such times, revives and represents (as *pars pro toto*) his first experiences of security in the physical embrace of the mother (if not, indeed, his experience inside the womb), thus reviving the experience of the "primal temenos" in a more direct way than is usual in general analysis.

At the same time—because of the proximity to the archetypal sphere—it is precisely at such moments that the transition from the personal to the archetypal (healing) experience can take place.

To obtain needed reassurance it is, at times, not even enough for the patient to feel the analyst's hand touching him, but he himself may have to touch the analyst, or his clothes, etc. In the regressed state into which he has been plunged by the drug, he has a new chance of experiencing the processes of co-ordinating sense impressions (including touch and the sensual experiences of his own body) with his emotional experiences (both old and new ones). In this way, a reorientation in his object relationships can take place on a level more archaic than that of language.

Because of the retention of part of the patient's adult consciousness, integration may take place almost simultaneously. On the other hand, experiences of a predominantly archaic character may persist for a certain length of time : it is, in the main, the task of the analyst to find the right moment for breaking the archaic experience and integrating it, by interpretation or action, into the patient's consciousness.

Obviously not all reassurance through contact is representative of the mother-relationship ; other early relationships, too, may be revived or re-experienced in a new light in this direct way (by skin contact), as will be seen from later illustrations.

The matter of *frequency* of giving of the drug is sometimes experienced as the giving or withholding of parental affection. This, too, can become a valuable tool in itself in the handling of the transference connected with problems of feeding and weaning. Giving and denying are thus experienced in a very direct and physical way.

The general problem about the use of the drug is that of the value or lack of value of introducing physical experiences as " short-cuts " into the process of pure analysis and the interrelationship between them. The same problem is inherent in a previous paper of the author on the inclusion of " body experiments " in the analysis. It appears to the writer, from clinical experiences, that all these short cuts, if used in the right way (that is, if consciously integrated into the analytic process as a whole), are not only permissible but may be even necessary, not only in view of the urgency of the problem of treatment of neuroses, but also because of those cases which would otherwise be regarded as " inaccessible " to analytic treatment.

Resistances and Defence Mechanisms Revealed in Patient's Reaction to Drug.

It is usually possible for a patient to resist, to a certain extent, the effect of small doses of LSD. The writer believes that the amount of resistance put up and the form which resistance takes can be revealing with regard to the patient's psychopathology, as well as to the transference situation. It seems, therefore, possible to use the study of amount and form in the analysis of the patient's defence mechanisms and resistances in general. For instance, many patients will not surrender to the effects of the drug unless or until the analyst is present. In fighting the drug, defence mechanisms, which play a part in the patient's make-up anyway, seem usually to become reinforced and thus made more clearly distinguishable for the analyst, and if interpreted, for the patient as well.

In this way, the hysteric tendency to escape from unconscious

conflict situations into physical symptoms (by conversion or substitution); or the schizoid reaction of libido withdrawal, can often be demonstrated particularly clearly in resistance against the impact of unconscious drives activated by the drug.

The most straightforward form of resistance seems to be that of the obsessive. In his case, the defensive character of his symptom seems to have undergone less transformation than in cases of schizophrenia or hysteria. This is probably the reason why, as has been observed before, obsessions respond particularly well to treatment with LSD. It almost appears as if there were not only a more direct connection in this case between the defensive function of the symptom and the warded-off tendencies, but also a greater readiness for the defences to "burst" and allow the unconscious—and complementary—activities to come into consciousness. The reason for this may be that in obsessional cases a more closely circumscribed part of the personality is affected than in other disorders.

As for phobic states and anxiety cases, they would appear to be related to hysteria rather than to any other forms of neurosis in their reactions to LSD. However, more clinical observation would be needed to substantiate these tentative ideas.

B.—Illustrations from Case Material.

In selecting the following samples of case material to illustrate the preceding ideas, there has been an attempt to group them as far as possible according to the different aspects of the complementary factors involved in LSD experiences, which have been discussed. As, however, most of the examples given exemplify a *variety* of aspects it is difficult to adhere rigidly to this kind of grouping, without referring at the same time to the other aspects involved, as well as to problems of transference.

Examples of Inferior Functions and Attitudes Coming into Prominence.

One of the most frequently observed features in LSD experiences is the vividness of sense impressions. To the writer it would appear that this feature is particularly dominant in subjects who normally have rather poor perception (that is, persons who, in Jung's sense, have an "inferior" or "undifferentiated" sensation function).

Characteristic of this, was the experience of a professional man —an intellectual and intuitive type (or, in Jung's terms: a man with thinking and intuition as main functions)—who, during his first LSD session, was struck by the *sensual* impact of things in his everyday surroundings. Colours, especially yellow, appeared "unbelievably bright."

Similarly Huxley, in describing a mescalin experience*, after stating that he had always been a "poor visualiser," gives many pages of description of the most vivid and detailed sensual impressions. He, too, in looking at everyday objects and works of art with this newly awakened capacity for receiving sense impressions, obtains through the senses a new understanding of the *meaning* of the picture or the intentions of the artist.

In a similar way the "meaning" of dance and movement as a "language of the body," equivalent to word language, had become apparent for the first time, to a professional woman whose main difficulties in her relationships with other people, particularly with men, had been her too exclusive reliance on word-language. Under LSD, she saw visions of dancing women (of various European cultures, in addition to Oriental); their movements partly resembled ceremonial activities, and partly expressed shades and nuances of human relationships which, as she realised for the first time, could never have been expressed as perfectly in any other medium.

As has been observed, sexual neuroses (perversions and obsessions) respond particularly well to treatment with LSD, partly because the drug frequently heightens the awareness of sexual urges. This in itself may have biochemical causes, but it seems that the particular form of the sexual experiences—or the fight against these—is determined by the "Type" of the patient and the stage of his psychological development. Just as external sense impressions are experienced with so much greater vividness under LSD, so those of the body itself are frequently experienced with an amazing degree of differentiation by subjects who normally have only small relationship to their own bodies.

Connections between Superior Functions and Sexual Drives in Two Compulsive Patients.

A rather sedate, middle-aged man, an introverted type, suffered from various compulsions, such as a need for checking and counter-checking (inability to close a book for fear of having left something in it, searching the floor for possibly lost objects, and so on). Further, he had an almost fetishistic fascination for women's shoes and provocative underwear, to the point where it had begun to wreck his marriage. He was shy and retiring, with a slight stammer. Thinking was his main function—his Sensation was rather poor.

The typical pattern of his LSD experiences was this: A strong activation of the sexual urge, coupled with visions of sex as the primal mover on all planes of life (expressed in images of a largely archetypal character), was followed (usually toward afternoon)

* Huxley: *The Doors of Perception.*

by speculation and attempts at integrating his visions and sensations into his conscious system of philosophical ideas and moral values. With regard to the transference, the main function of the analyst was to help him in the process of integration through understanding the symbolism of his visions, apart, of course, from the reassurance given by the "good mother" during the revival of up-to-then repressed sexual and masturbatory urges and activities. As will be seen, his experience can be viewed as the coming to life of his inferior functions (sensation and intuition). In this case, sensation was particularly closely linked with sexual repressions. Under LSD, they burst together into consciousness. Here are some of his reports of his experiences :

"Among the first reactions was one of shrinking to a smaller size. . . . It was as though I was trying to draw myself up into as small a compass as possible. . . . My breath was coming in long deep draughts as though I was undergoing great physical exertion. My bones felt supple and pliable, and I was perspiring. The next feeling was one of savage intensity. I felt like a wild animal with fangs bared, breathing heavily, snarling, ferocious and untamed. My arms felt like the front paws of a wild beast with claws. I had the feeling that here were the laws of the Jungle . . . the survival of the fittest as it were. It was as though I could sense, all at once, the whole of the primitive forces of nature. The fight for life itself and the continuance of it in procreation, with all the elements involved in this, the fight for survival against enemies ; the fight for food ; the fight for a mate and the protection of her and her young. . . .

"Then there appeared a lot of female forms, swaying in a rhythmic, sensual way. Next the rather savage animal form returned. This time it was directly connected with sexual feelings. It was the feeling of a male animal, something like a stag, with a large herd of female animals, and one by one these female animals were held down with the front legs while the sexual act was performed. There was a rhythmic movement of the loins accompanying these feelings. This then changed to human form and I became aware of my own sexual organs in realising that I wanted to pass water. There was again a completion of the sexual act with the female form clasped tightly to me in a rather savage, passionate way."

On a later occasion, this patient again had similar sexual experiences in the course of which he suddenly realised that his usual way of sexual intercourse with his wife was unsatisfactory (due to what he then felt to be the wrong position) and that he would have to reverse the position in order to experience the satisfaction characteristic for the male partner. This completely spontaneous discovery which had come to him with great force in that particular session, was, at the same time, linked up with

the general problem of self-assertion. It crystallized itself in the following picture :

" I saw myself as a little cell on the ground. The whole world seemed to be trampling over me, and at one stage I was almost pushed down a sewer by the throng hurrying overhead. I clung precariously to the side of the abyss (a kind of grid it seemed), just managing to hold on as it were from total extinction, and my thoughts began to turn to considering what lay inside that little cell, I knew that if only it was allowed to open up and expand and take its rightful place in the world, there lay inside a wonderful power, a living mind with all the ingredients to enjoy life and participate in all its facets. . . . "

It was after these experiences that not only did the patient's relationship to his wife change considerably, but his capacity for self-assertion in general was freed to an extent which, the writer believes, would without the drug have taken many months to achieve.

At another session he relived early shocks after some secret masturbatory activities when his fear of having been discovered by possible traces left behind caused him years of anxiety. The vividness of these relived memories by far exceeded those experienced in general analysis as the body-sensations of those past experiences had a quasi-hallucinatory character : The patient felt himself shrinking to the size of a baby or a small child and re-experienced the world as if with the body and the senses of the adolescent, just as he had experienced the Male within himself to the extent of actually " becoming " the stag or the male wild beast.

After these experiences, he spontaneously connected his obsessional need for " checking " with his sexual fears : that of not being able to hold his sexual forces in check, and his fears of leaving traces of masturbatory activities behind. He also recognised his stammer as a form of " checking " and holding back, again a symbolic attempt at coping with his sexual problem, though this particular symptom was—perhaps even more so than the others—overdetermined. It would go too far to inquire into all the determining factors here.

His attitude of " holding back " had, in fact, permeated the whole of his character. He could not let go in any way, and his fear of being " discovered " had caused a general vagueness in his way of talking, a habitual avoidance of the pronoun " I " (by which he would have committed *himself*) and substitution for it of a vague and general " one " or " a person "—padded by many little expressions to safeguard himself, like an unnecessary " perhaps " or " as you might say."

All this was analysed in connection with his LSD experiences. His inability to " let go " was overcome at one session when he

discovered the following connections: His fear of not being able to keep his sexual forces in check, had, at an early age, linked itself with a fear of bedwetting, urination at that point probably having been stimulated by, and partly substituted for, masturbation. The fear of his inability to check either sex or bedwetting seems to have led to a repression which had become so complete that, as a reaction formation, a fear of sexual insufficiency had ensued. It was this which he felt had to be overcome by the extra stimulus provided by high heels and especially provocative clothes. This whole complex became clear to him, mainly in the experiences of one particular LSD session.

The question arises whether the accident of bedwetting that occurred under LSD could be regarded as an act of abreaction. To the writer, it does not seem that it was only the abreaction in the "temenos" of the transference, together with the understanding of the meaning and inter-connection of his symptoms through interpretation which had the beneficial effect, but that it was the direct experience through the body—which was complementary to the patient's habitual way of experiencing life "in the head"—which gave an impact rarely felt in general analysis to the experience.

By way of contrast to this case, the second to be discussed is that of a very severe washing compulsion. In this case the differentiated function was sensation and the prevailing attitude extraversion. In the course of her analysis, and particularly under LSD, the patient was led into a greater introversion, and her thinking function became more conscious.

The patient was a young married woman with children, whose life and that of her family had become unbearable through her fear of contaminating others, mainly after touching anything that might have been in—direct or indirect—contact with lavatories, faeces, or certain parts of the body. In this case, religious problems and sexual guilt feelings, social inferiority and the problems of death, old age and decay, had all been mixed up. There had also been incidents of infantile sex play and adolescent sexual curiosity—all of which had never been sorted out or understood by the patient, who had been a vivacious girl with rather strong sexual urges.

Under LSD, she had, on various occasions, seen images of writing projected on to the wall of the room. Parts of these writings contained either passages or half-sentences from the Bible, other parts were reminiscent of the rather cheap sexy literature she had indulged in as an adolescent girl. Under LSD, too, a good many childhood experiences had been revived, most of which centred around the clash between her mother's extremely narrow-minded moral outlook and her own sexual fantasies and activities. Physical sensations, stimulated by the drug and in conflict with

her spiritual and moral problems, caused a great deal of anxiety. (This, she had managed to ignore before, by an exaggerated extraversion.) This anxiety, caused by the simultaneous experience of conflicting opposites (accompanied by physical sensations), subsided when her thinking function (symbolised as "writings") became activated, and she began to reconsider and to analyse her ideas and values. The role of the analyst in this case was that of the permissive mother, as well as that of the interpreter strengthening the inferior (thinking) function. The symptoms began to disappear when the patient understood them in their symbolical meaning (washing as attempt at *moral* cleanliness, and so on).

Alteration of Body-Image Transference.

The next example illustrates how, through transference experiences as well as through the capacity of the drug to elicit early memories "stored" in the body, the body image may be altered, which, in turn, helps to "unfreeze" formerly repressed parts of the personality.

The case was that of a young man with severe symptoms of depression; depersonalisation; attacks of mental blankness; mild claustrophobia; and a general muscular rigidity, which showed among other things in a—literally—stiff upper lip (which caused his speech to be almost inaudible at times). Further, he complained of headaches and a "dead" feeling of the whole of his left side, particularly of the left side of his face. He had spent his early years with a psychopathic father who, in the end, had committed suicide. After that, the patient had gone back to his mother, a hard and very extraverted woman who, after her separation from her husband, had dreaded that her children might turn out like their father and freely gave expression to that dread.

The patient looked like his father. He was an introverted child who, after an unsuccessful period during which he had made an attempt at adaptation in an extraverted way, had begun to go into a schizoid withdrawal when he came for treatment. His mother's repeated statements that he was "just like his father" had eventually caused an unconscious identification with his father, so that his attempts to blot out his father within himself resulted in unconscious attempts to blot himself out as well (depersonalisation symptoms and suicidal tendencies). His "dead" left side, as well as his general muscular rigidity, was expressive of his deadened emotional life. His functions of feeling and sensation had remained undifferentiated, as he had almost exclusively relied on thinking (mainly in the form of speculation) for access to life. This, however, had naturally

reinforced his sense of isolation and thus, probably, aggravated his depersonalisation symptoms.

His first LSD experiences were almost exclusively concerned with reliving the years spent with his father and the horrors attached to some of the events of those years. These had largely been repressed. After this, his relationship with his mother came more and more into prominence under LSD, as well as during the analysis in general, preceded by a brief spell during which his relationship with his sister was in the foreground. These periods culminated in sessions in which suddenly, through the transference, a violent breakthrough of emotion and sense perception occurred, which seemed to melt, within a few hours, the rigidity of years' standing. During the first of those sessions, the following happened :

He wanted most desperately to hold the writer's hand. When it was given to him, there were, first, all the signs of relief; then he began to feel the hand shrinking until it was the hand of a small child about three years old. In fact, it was to him the hand of his little sister from whom he had become separated when she was about three. When they were re-united, the sister was about seven and they had, in the meantime, led very different lives. Since that first separation, he had carried around with him the dreadful secret of his life with his father, about which he had not been able to talk before his analysis. At the moment when he held the writer's—this is, his little sister's—hand, he was able to pour it all out as he had wanted for years to pour it out to her and to share it with her. It was through the pressure of the writer's hand that he recaptured the memories of his early mental *and bodily contact* with this little girl who was his sister, whom he had loved and lost, and to whom, what he poured out to the writer at that moment, was in reality addressed.

On the morning after that session, he brought one of those little folded paper airplanes which, as he said, he used to make in numbers when he was at the age to which the LSD experiences referred. He told the writer that all through those years he had forgotten how to make them, but that, after feeling the writer's hand and talking to her as if she were his sister, the memory of how to make those airplanes had suddenly come back into his hands.

At the end of that session he wanted to hold the writer's other hand as well. For some minutes he held his hands, with the writer's inside them, on both sides of his head, so that a circle, like a closed circuit, was formed of his arms with the writer's. During those few moments he experienced a feeling of complete peace and unification of his left and his right sides which ordinarily he felt were split up by a dividing line right down his middle.

It was only after this that he dared, in the two following sessions, to let go enough to permit the projection of a mother-anima image to come into consciousness. Here are parts of his reports :

" Dr. C. comes in, she looks a bit stern—feel I've got to tell her what's going on but it's a great effort. Wish I could pull her inside me. When I can get myself to look at her she seems after a while to look very beautiful in a wise and understanding way. Am looking at every line and feature of her face. . . . Want to tell her how beautiful she looks but feel very foolish. She smiles and seems to understand this. . . . Wish she was my mother—I look away and see or rather feel what my mother is like—indrawn features, and always gesticulating . . begin to cry. . . Remember girl friends and women—looking into them and seeing for a tiny instant the simplicity and love which is behind them. . . Dr. C.'s face changes as I look at it—she's younger and I see her as a girl. . . Can see a broad bright background to her. It's like looking into a bright light. . . . "
(This was followed by fantasies of killing his own mother.)

The next report starts with descriptions of experiences of dances and colours ; it continues : " When you came in my first reaction was to try and cover up these fantasies. This sort of thing happened anyway in real life, when I would be scared stiff that someone outside myself could read my thoughts . . , I looked across at you sitting by the bed and you seemed to be doing all sorts of things. First you'd float away in a yellow sea . . . then frowning at me, then laughing at me and I was thinking ' Damn, you've got this drug in me, and I'm completely at your mercy ! ' I wanted to pull out of it so I could get you under conscious control again. Then I began to think ' What's the use of that sort of thought—get her inside with you,' and with a bit of effort I stretched out my hand and you took it and sat on the bed.

" Immediately it changed. You looked friendly and I wanted to laugh. Suddenly I remembered lots of occasions when I've been with girls and my imagination used to take wings. . . . Suddenly I wanted to laugh and say anything. I felt full of energy and wanted to take you and rush out on the sand and sea that I could see in my mind's eye. To go leaping all over the place and have a really abandoned time—the sort of thing I never experienced with either my father or my mother . . . because there was always this problem. Suddenly I wanted no longer to feel ashamed or guilty for being me . . . I just wanted to like being me and revel in being me, with no one to stop me being me . . . it felt fine. . . . "

With regard to the first part of this report : the patient had, in fact, been staring at me for a number of minutes, with wide-

open eyes and the expression of a child scrutinising and studying a new person for the first time, wondering whether it was safe to trust. He kept scrutinising every corner and every line of expression on my face, and I felt I had to present myself as it were without any protection or defence to his judgment. If I had contracted out of the direct encounter at that moment and hidden behind the mask of The Analyst, it would probably have defeated the whole process. As it was, I had to allow a mental "photograph" of my personal face to be taken by the patient and I could only hope that what it expressed might be "sufficient" to serve as the reassuring mother he was searching for. This does, of course, not mean that the personal face would not be permeated in the patient's experience with archetypal features, yet there was at this moment, through nothing but the medium of facial expression, a directness of "question" and "answer," which, due to the more deeply regressed state of the patient, was more intensive than that usually experienced in pure analysis.

After this, there followed a period during which he alternately looked at me and stared at a vision of his own mother—obviously also with archetypal projections. Whenever he stared at that image his face tensed up and showed an expression of pain and even horror. Groans and exclamations of despair alternated with outbursts of hate and fantasies of killing her. Then back to my face again and renewed studying of every feature, with the liberating of little laughs and relaxing of his whole body.

This instance, especially the detail of the "interpenetrating gaze," resembled that cited by Moodie in his paper on counter-transference (which, however, came to my knowledge only long after this incident had occurred). It is perhaps also characteristic that my case was that of a deeply regressed patient in whom processes were at work similar to those in children, who as Moodie also remarks "encourage the spontaneity of the analyst . . . " In this case too, it was probably the fact that I had "offered" myself for judgment without any defence, and with a good deal of doubt whether my face would be found "sufficient," which reassured the patient enough to lead him to come out of his reserve and to free himself from the grip of his negative mother image (expressed in a loosening of his muscular rigidity). I had to look back at him and allow my face to express exactly what I felt at the moment which, if put into words, might have been something like this: "Yes—this is me—I can only hope that it will suffice, all the same, to represent a human face that can be trusted. . . . "

It was after those two sessions that his left side came to life. It stayed alive for several weeks; but it was very obvious how, in the daily contact with his mother, he gradually became tense again. However, with continued analysis and some more LSD

experiences of a similar, though less intensive, character, his mother-anima problem gradually solved itself. With that, his left side had finally come to life, and he felt free and relaxed.

Projection of Archetypal Images and Transference.

Symbolism indicating the transition from the personal to the collective sphere. An interesting phenomenon which the writer has observed on various occasions is the sudden projected appearance of an archetypal image behind a personal memory which itself had been recaptured and relived in the more or less hallucinatory way characteristic of the LSD experiences.

Here is an example. The case is one of an unmarried woman in her early 30's who had come to the hospital with severe depression. In the course of the treatment, strong paranoid tendencies had become apparent. The transference was strongly ambivalent, and during its negative phases it was usually coupled with paranoid reactions. During such phases the patient became wildly hostile and aggressive. She distorted and misinterpreted what was being said or done. During her "sane" periods she was extremely "sane," and nobody would have suspected psychotic tendencies. Facts from her history: a possessive mother, a rather weak father, sibling rivalries—in particular with one brother who, in fact, had had many privileges over the patient. Accordingly, there was an ambivalent relationship of the patient to her mother who, even in earliest dreams has appeared as a monstrous crab and someone who constantly stood between her and the men's world. Under LSD, religious experiences, which left the patient elated, alternated with experiences of utter misery. Often there was a quick succession of the two types of experience, even in one session.

One morning, about an hour after she had taken the drug, the writer found her in a room out of which she had thrown all the bedding and all furniture with the exception of one chair. She was sitting on her bare bed, trembling, with a face distorted with fear, hatred and horror, begging me to leave the room as otherwise she was sure she would strangle me. She also kept repeating, as she often did under LSD, that she must take her own life. She then fell to the floor and said the floor boards were sloping. Mixed up with a genuine hallucinatory experience there was some hysterical exaggeration which, however, disappeared after interpretation.

Here is part of her report:

It began by my feeling myself growing smaller. I was in a small strange room, I did not know where. Then I felt I wanted to strangle someone, and when the nurse came in I wanted to put my hands round her throat and squeeze the life out of her. Next I wanted to strangle myself. After she had gone, I strongly

felt I must tear everything up. I got a blanket but could not tear it. Then I had the idea I must get rid of all the things in the room, so I threw out the bedclothes and all the things I could move. I could not even bear to see the flowers on the dressing-table, and I wanted to tear up the calendar and the picture of the dog. I just had to get it all out of my sight. I wanted to go into the office and tear everything up. Somehow, a chair was left in the room . . . suddenly I was so furious that I caught hold of the chair and threw it. I wanted to smash it. Then Dr. C. came, and while she was talking I noticed that the floor boards were slanting. I remembered that the floor boards in the small bedroom in the cottage (her childhood home) slanted.

Then the chair began to change and I saw that it was the one that my father had cut down for my mother to nurse my brothers in. I also remembered it used to stand in the corner in the boys' room where I kept my toys, and I used to be frightened of it because I thought a witch used to sit in it. I afterwards felt I wanted to smash everything, and again later I wanted to tear things up and I prayed that nurse would come and bring some papers so that I could just tear and tear. It is certainly an enlightenment to me to realise that a little child could feel all these things and keep them hidden inside himself, but it was also a great shock to me when I threw the chair, but I realised that I had indeed felt this dreadful anger as a little girl but had never really known about it and certainly not let it out.

The following quotations from some of her reports exemplify how certain archetypal images changed their meaning for the patient during an LSD session through the impact of the transference, so that, within seconds, images assumed a positive instead of a negative character.

"I began to feel that I was lying at the bottom of a pit. I felt that rubbish was being thrown in on top of me and I had to fight my way out."

I suggested that she should stop fighting and I reminded her of the story of Joseph, thrown into a pit. She then relaxed and again experienced a feeling of growing small. Then she heard the ringing of a sawmill saw, and then remembered that she was born near a sawmill. "As I lay, I had the growing conviction that I was going to be born and that it was absolutely essential that Dr. C. should be with me." She then felt she was "attached to something by a cord, and I could feel my limbs beginning to swell, then I began to feel that life was flowing into me and that I was fed by this cord. I was not actually born, but the feeling I had was that, if I could retain this feeling, I could ultimately break away from my mother . . . and that people would have to accept me and my ideas instead of my always trying to conform to theirs."

Contrary to the first examples given, the external world, in her case, became unimportant under LSD and served almost exclusively as a "screen" on to which to project her inner images. Colours, too, were attached practically exclusively to inner images and became immediately meaningful to her for their symbolic value.

LSD, by reinforcing introversion (initiated through analysis anyway), brought her up not only against her own, previously unconscious aggression, hate and jealousy stemming from childhood experiences; but it also evolved archetypal healing symbolism through which her psychotic tendencies could be overcome.

Another feature mentioned previously, which was particularly striking in this patient, though the writer has found it in others as well, was the fact that the drug was unconsciously experienced by the patient as equivalent to "mother's milk." Consequently, frequent sessions with the drug were felt by her as proofs of love; weeks without the drug were felt as deprivation which, on various occasions, produced reactions of strong hate and of paranoic constructions. This too, was used as material for analysis. In this way the drug, more or less inadvertently, served a secondary purpose, in that it became an additional means for the patient to experience her own infantile reactions to gratification and deprivation, as well as her own, gradually growing, frustration-tolerance.

Crises like those mentioned demonstrate again that the main value of the drug lies not so much in its capacity to facilitate abreaction as in its capacity to produce more varied and more drastically experienced unconscious material for analysis.

While, during the first part of her analysis, personal memories and archetypal experiences were predominant, it was only at a later stage that the patient could begin to realise her deficient relationship to her body as one of her major problems. This, of course, was closely linked with her sexual problems and her deficient relationship to her mother, resulting in a deficient relationship to herself *as a woman*. In this process, too, LSD assisted in bringing complementary forces into play, partly by sensitising regions of the body which, before, had been "dead," but also by allowing easier access of unconscious symbolic imagery into consciousness. During several of her first LSD sessions she had seen an image of a woman's face, the right side of which was very beautiful, whereas the left was a dead and shapeless mass without a mouth, an eye or a proper outline. As her awareness of her body grew, the left side of that face, in another vision, had been moulded into shape. (Also, see the previous case.) At the same time she experienced, also under LSD, a sudden sensation of "unity between head and body,"

upper and lower half, a problem which her analysis had touched upon, on various occasions before, but to which there had been an extraordinary resistance.

Physical sensation and symbolic vision elicited by the drug, together with analysis and "body experiments," seemed to prove particularly helpful in this case—as indeed they seem to be in all cases where the sensation function is far removed from consciousness.

Transference, Resistance and Acting Out (with Special Consideration of Hysterical Mechanisms).

As was mentioned before, it appears that, under LSD, the tendency of the hysteric to evade attempts at consciously facing his problems, by producing or magnifying physical symptoms, becomes particularly obvious. Physical effects produced by the drug, and largely ignored by *some* types of patients may become almost the only experience the hysteric realises, overshadowing all psychological changes, and serving, in this way, as a particularly suitable means of expressing resistances. The writer found, for example, that headaches, feelings of nausea, restlessness, etc., which frequently accompany early LSD reactions anyway made LSD sessions almost useless with a number of hysterical patients, unless or until, through persistent analysis, the patient could accept his reactions as resistances and work through those. The writer seems to have found these reactions so consistently in hysterics, that it almost appears possible to use LSD for diagnostic purposes (for example a differential diagnosis between hysteria and schizophrenia).

The following case may illustrate some aspects of hysterical mechanisms as shown under LSD.

The patient was a middle-aged married woman whose main symptoms had been sporadic depressions, various fears and uncontrollable tempers; she also suffered from frequent headaches and psychogenic fatigue, and there were marriage difficulties, mainly due to her partial frigidity. When she began her analysis, one of the most striking features of her personality was a certain lifelessness, dryness and lack of spontaneity. During interviews, she found it difficult to talk; her usual reaction was: "There is nothing to talk about." Whether this was due to flattened affect or to tension was not easy to decide at first.

The main "theme" of her analysis was conveyed, in a characteristic way, in one of her initial dreams, in which running water was being installed in her room. Yet it was only after a good deal of work with pure analysis, LSD and "body experiments" that the potentiality anticipated in her dream became reality; that is, that her personality became "free-flowing" and "alive."

She was one of those patients with whom, under LSD, headaches, feelings of nausea and restlessness became the predominant experiences whenever unconscious aggressions, resentments or infantile impulses of one kind or another were approaching the threshold of consciousness. These experiences were usually closely linked with the transference. They served as a means to get the doctor or analyst to her bedside, and served as an expression of resentment when she considered the intervals between the analyst's visits to be too long. These symptoms usually subsided quickly as a result of interpretation. (This was that the analyst's absence was felt as a sign of rejection and neglect, reviving early childhood experiences of—presumed—rejection and neglect and so on.)

However, even during some of the first of her LSD sessions, her usual "flatness" and lifelessness gave way to very violent feelings of hate, love and despair, expressed in sobbing and a sudden pouring-out of her troubles in the form typical of abreactions. It turned out that her feelings for both her parents, as well as for her brother and husband, were highly ambivalent. Of course, the transference was also, though the positive trend was the stronger one throughout; this, too, seems to be characteristic for hysterical patients—as distinguished, for example, from paranoid ones.

One of the main outbursts occurred when she remembered that the only thing she was noted for as a child was "being intelligent." She also was always "good," in contrast to her brother who always "got his own way." But she had hated both being "good" and being "intelligent." When asked what she would have wished for instead, she said, "Being cuddled." Revived memories under LSD brought out her strong mother fixation, her guilt feelings because of early sex play, with resulting ambivalence towards sex, her craving for satisfaction of her intellectual needs, which her husband did not understand ("he never talks to me"), as well as her repressed emotionality and sensuality.

With this set of circumstances, it was not surprising that the transference should be rather violent, with a strong urge on her part for physical contact and acting-out generally. When her claims on the analyst were not immediately and completely satisfied, she reacted in either of two ways: she either went into a flat numbness or went into violent and often extremely histrionic outbursts. She would "want to kill" me, actually putting her hands around my neck, and trying to order me about: "Don't leave the room—if you do I shall come with you!—Don't leave me—you *are* my mummy, aren't you? Do you love me?—I want to see your ring—give it me! (What if I don't?) Then I shall jump out of the window."

On one of these occasions—during an LSD session when she had commanded me, first, to give her my ring, then to let her handle my skirt (criticising its cut and material) then to pick up a few things she had dropped and to fetch a few others—I asked jokingly, "Any more orders, Madam?" At that she broke down in desperate sobbing followed by a deep sulk. No more material was produced for the next two weeks, but instead the whole series of physical symptoms appeared.

During most of the next LSD session she was lying in a half-sleep, and at one of the following sessions she developed what might have appeared to be an aphasia but was in fact a histrionic exaggeration of a numb feeling around the jaws, a common reaction to the drug. At one session I found her jumping up and down on her bed like a two-year-old child. She said she enjoyed that and was keen on my watching her.

At another session, she suddenly declared she wanted to dance. She got out of bed and began first to sway in all directions, then to swirl around in circular movements in a mixture of self-display and gradually increasing absorption. In the end, she let herself fall to the ground. Here is her report of that session. It began like this:

"I feel so sick. I wish they would stop making that noise. My head is being pulled from my body. I have no use in my hands. Something is pulling me around. What the hell is happening? . . . I'm not writing this, someone else is. Where is Dr. C.? I feel so sick. . . . I seem to be emerging from something. I feel very sick. My head. . . . Why do I always feel so sick? Where the hell is everyone? I feel cold and hot. What am I talking about? What am I waiting for anyway? Why should I be in here like this? Where is everybody? I can't stand it. Why doesn't someone come? I must go home. What a lot of rot. I feel sick."

The interpretation seems obvious. Most of the sensations mentioned are rather frequent experiences under LSD due to physical changes in the organism. As a rule, they are more or less ignored by patients. In this case, however, as in other cases of hysteria, they received the main emphasis. Their close link-up with feelings of anger, neglect and desertion (as shown in the patient's report) colours the whole experience, so that the physical symptoms appear to become more than just physical phenomena carefully registered. They appear to become an expression of the accompanying emotions themselves: feeling cold with neglect; hot with anger; sick of the whole business and of herself in her neurotic state. Headaches (one of her usual symptoms) again become emphasised as a result of anger at being left alone. There seems also to be a dim awareness of the spuriousness of her feelings in expressions like "a lot of rot." "Wanting to

go home " would imply " to a better mummy " and so forth. It appears that here one can observe, as it were in miniature, the mechanisms behind conversion symptoms generally.

It appears possible to conceive of hysterical mechanisms (conversions as well as histrionic behaviour) as unsuccessful attempts of the repressed infantile personality to break through a false and unsufficiently adapted adult " persona." Overdramatisation of aches and pains, as well as of emotional states, are appeals for help by the infant who, due to experiences of guilt and rejection, had imprisoned himself behind the protective walls of pseudo-adaptation, in this case combined with " flatness." As in all forms of neuroses, the initially protective wall is being increasingly felt as a bar against the loved object. Whereas the schizophrenic seems to have given up the attempts at breaking through the wall, and the phobic feels threatened by it, the hysteric seems to try to break through by force, realising at the same time the inadequacy of his means. The more he feels that his actions lack conviction, the more dramatic he has to become in his search for contact with the barred-off love object, but the more (falsely) dramatic he becomes, the less he will be believed.

Again, as in the previously mentioned case, it seems to the writer that physical contact in a state of intensively experienced regression—under LSD this patient frequently spoke in a kind of " baby language "—can be of great help, provided it is used in connection with interpretation. This patient seems to have gained immediate help from feeling my ring, my clothes, my hand, and from partly acting out her aggressive as well as her love impulses before she could understand them rationally. In her dance, she achieved three things : First, she encircled the analyst (mother), making sure of her presence ; Second, she began to circle around her own centre. In that way, for the first time, she made the step from histrionic self-display to self-collection (an attempt at mandala). Third, in falling to the floor she experienced an attitude of surrender and of giving up the violent attempts at " breaking through."

It might be worth mentioning that the dance-experience had been preceded, also under LSD, by experiences of " being born," " learning to walk," and slipping through small openings in walled-off rooms on a number of occasions. The attempt at " surrender " too, had had an unsuccessful forerunner in a pretended suicide attempt, in which she had taken a very small dose of drugs but pretended to have taken a large one. It seems, again, to have been the direct experience in the acting-out of unconscious infantile content through the senses—in connection with analysis—which had at least speeded up the process of recovery.

The capacity of the drug to bring out particularly relevant compensatory factors was apparent in this case, in the emergence of violent feelings of love and hate, as well as of a repressed but very strong sensation-function, in a patient who had been " too intelligent " and " too good a child."

Some Remarks on Counter-Transference.

The question which inevitably arises is this : Just how far should the analyst permit " acting out " under LSD ? Compared with general analysis, where is the difference ? Also, might patients not use the drug as a conscious or unconscious " excuse " for assaulting the analyst or nursing staff, possibly even to the point of danger ? For an example, what if a patient should try to embrace the analyst or proceed to attack him or her sexually ? Patients, particularly if they have previously heard about the effects of the drug, may easily either deceive themselves or get the impression that they are not only allowed, but almost expected, while under the drug, to give way to their urges, as otherwise no curative purpose would be achieved.

It appears to the writer that the answer to these obviously controversial questions may be this : Because of the regressed state of the patient under the drug, a greater amount of " acting out " than in general analysis seems not only permissible but therapeutically desirable. It is comparable in some respects to play therapy in the analysis of children. On the other hand, it usually seems possible, even while the patient is under the drug, to lead him to realise the " reality " of the situation without feeling rejected.

Thus the process of the patient's gradual acceptance of " denial " inherent in the analysis of the transference, but normally spread out over a longish period in general analysis, may be experienced in more condensed form in LSD treatment. Of course it is necessary to work through such experiences in subsequent analytic interviews. However, it appears that, in working with the drug, an awareness of the counter-transference is particularly necessary. It seems especially important here for the analyst to " listen with the third ear " and to be guided by his own intuition. Being aware of the complexities of questions of transference and counter-transference, the writer wonders whether, without gross oversimplification, it might be said that, in trying to steer the right course between denial (due to the reality principle) and gratification of the patient's needs, something like a compass at the disposal of the analyst may be found in his own feeling of what is " genuine "—in the patient's demands as well as in his own response. It seems to the writer that, especially in critical situations under LSD, by genuinely responding to the genuine in the patient, the analyst responds not only

to the previously repressed " child " in the adult patient but also evokes the (maturer) adult in that " child," i.e., in the regressed or fixated adult.

Example of a " Cosmic " Experience.

To conclude, here is an account of the experiences of a professional woman, who under LSD discovered the world of the non-verbal or pre-rational and who, in describing her experiences, was acutely aware of the difficulty of putting them into the form of language. The non-verbal world, that is, the world of pure imagery, and the world of language were felt to be two completely different systems which were not only mutually exclusive but which also largely invalidated one another. Looked at from the system of language, the other system appeared as " just an interesting state of mind " artificially induced by a drug, the characteristic feature of which was an altered and slightly " psychotoic " mode of experiencing the world.

However, from the point of view of the pre-rational system, the one of language and rational thought appeared as an unbelievably shallow, superficial and one-sided mode of experiencing the world, superimposed on, but missing the essential factors of life. Truth, so it seemed, could only be found inside the non-verbal system, whereas the system of language and scientific thought appeared from that point of view to be an incredibly poor and deceptive attempt at understanding the essential.

The most impressive feature in the experience of the non-rational system was the disappearance of all boundaries between individual entities or indeed the disappearance of individuality as such. Instead identity and correspondences were the dominating features. In the way the meanings of certain musical phenomena (rhythms, intervals, etc.) were felt to have their exact equivalents in certain tensions or experiences of pressure, movement or position of certain parts of the body ; but the body would also have a complete correspondence to colours or moods, or landscapes, or plants, or animals. The feeling was as if certain (definite) parts of the body had the same character as certain (definite) landscapes, or continents, or kinds of vegetation, whereas other regions of the body would " correspond to " or " represent " other geographical or biological spheres, or historical periods.

The act of intercourse was, in its essence, the same as (not like) a musical chord. There was an overwhelming experience of what the patient called the infinite number of " facets " of the Universe, all of which were alike and different at the same time.

At another stage she saw people talking, but the contents of talk appeared at that time entirely unimportant ; instead she

felt able to a degree unknown to her in her "normal" state to "know" in a direct and immediate way what the other persons felt or by what they were motivated. A smile, a movement, or a certain line in a face became all-important, so did a silence; talk or even discussion appeared as almost ridiculously shallow. Last there were experiences of the impersonal (archetypal) aspect of herself as a mother ("I am all mothers"—"I feel the feelings of all mothers"), or an experience of getting old ("I am all old women—I am the anonymous earth from which things have grown," etc.). There were periods under LSD when there had been nothing but an experience of rhythmic tension and relaxation, in which rhythm had been felt to be the only reality of life—rhythm of breath, of heartbeat, of music and of orgasm—rhythm of movement of all creation—it was all ultimately the same, and the only thing that seemed to matter was to fall in with the rhythm required at each particular moment, and to play one's part in maintaining it.

As in the previous illustrations, the drug had brought out complementary factors. A woman with a predominant thinking function had momentarily experienced life through her less differentiated functions (sensation, intuition and feeling), with the resulting experience of "wholeness."

SUMMARY

In this paper, work with LSD 25 as an aid to analysis has been described. Of particular interest has been the seeming unpredictability and arbitrariness of experiences elicited by the drug, and an attempt has been made at finding the determining factor in emerging material. This appears to be the selection of complementary and compensatory unconscious contents; selected in accordance with Jung's idea of the psyche as a self-regulating system, "striving" towards "wholeness."

Clinical material has been grouped in five categories, in which different aspects of complementation are illustrated. Some questions of transference and resistance in connection with LSD treatment have been discussed; and ideas about typical mechanisms in certain categories of neuroses, as suggested by the patient's response to the drug, have been put forward.

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AN APPRECIATION OF W. RONALD D. FAIRBAIRN

HIS THEORIES OF OBJECT RELATIONSHIPS AND ENDOPSYCHIC STRUCTURE

C. Edward Barker

It seems strange that in "Freud and the Post-Freudians"—(1961, Penguin)—a recent and excellent survey by J. A. C. Brown—there is no mention of the work of W. Ronald D. Fairbairn. If I were to say who had helped me most in an understanding of the unconscious mind I would have no hesitation in saying first, Sigmund Freud, second Otto Fenichel and third—last but by no means least—W. Ronald D. Fairbairn.

The most formative and productive experiences of Fairbairn's career appear to have arisen out of analytic work with schizoid patients and considerable practice with victims of war neurosis, and a period when his duties included the frequent examination of delinquent and problem children. It was Fairbairn who, more than anyone else, recognised the far reaching theoretical implications of Melanie Klein's findings concerning the pre-genital phases in infancy and her emphasis on object-relationships. These findings, along with his own discoveries with schizoid patients, stimulated his thought very deeply in two directions: (a) He was brought to re-cast Freud's libido theory in terms of a theory of ego and its object-relationships; and (b) He came to emphasise the primacy of the first year of life as the psychogenic root of the neuroses rather than the oedipal period.

Freud gave us a psychology of impulse—the libido theory—and this sprang largely from his work with hysterical patients. It was only from the later 1920's that he more specifically gave his attention to the place of the ego. Thus in "The Ego and the Id"[7]—he superimposed a psychology of the ego upon an already established psychology of impulse. "This is a situation which I have come to regard as most regrettable," said Fairbairn[2]. "Libido is essentially object seeking"[4]—not merely pleasure seeking. As a consequence Fairbairn was led to concentrate attention on the *object* toward which impulse is directed. The ground had already been prepared for such a development of thought by the work of Melanie Klein on internalised objects [8, 9, 10] but Klein herself did not clearly see the theoretical implications of her findings. Moreover, it is due both to Klein and Fairbairn that we learn that "what are repressed are neither intolerable guilty impulses nor intolerable unpleasant memories, but intolerably bad internalised objects."[2]

Let us now look at the very interesting psychopathology of Fairbairn's scheme. "The pristine personality of the child consists of a unitary dynamic ego," said Fairbairn[5]. The ego must not be taken here merely in the Freudian sense of a function of adjustment. Freud laid most stress on the *adaptive* function of the ego, but the ego also performs *integrative* functions such as the integration of perceptions of reality and the integration of behaviour. The infant does not start his life "lived by the It," as Groddeck would say, but for Fairbairn, the ego includes the concept of the id, and the two are psychologically indistinguishable[3]. Remembering this, it is necessary to remind ourselves that the child is an ego from the very beginning and his libidinal impulses are not primarily seeking "pleasure" but "an object," and the first object of his libidinal seeking is the mother's breast.

This relationship with the breast in the first few months of life is best described as a relationship involving *identification* with (and incorporation of) the object. The baby is only complete when he is one with the breast-mother and he is unconditionally dependent on this identification.

Maturity in adult relationships is reached as this relationship involving identity with the object is gradually replaced by a relationship based on differentiation with the object. "It is when identification persists at the expense of differentiation that a markedly compulsive element enters into the individual's attitude toward his object. This is well seen in the infatuations of schizoid individuals. It may also be observed in the almost uncontrollable impulse so commonly experienced by schizoid and depressive soldiers in wartime to return to their wives or their homes when separated from them owing to military necessities. **The abandonment of infantile dependence involves an abandonment of relationships based upon primary identification in favour of relationships with differentiated objects."**[1]

But to come back to the first relationship of the child with his object. If the breast-mother is protectively and sensually satisfying, if the breast is good, if the baby is assured by the mother that he is wanted and loved, and if the baby has assurance that his own love and need is accepted and good, then all is well. The baby has a good object relationship and is satisfied and so is able, in due time, to move from a state of dependence by identification, gradually to a state of mature dependence involving a relationship between two independent individuals who are completely differentiated from one another as mutual objects.

Often, however, the baby is quite unable to make a good relationship of identification with his object—the breast-mother. The mother may be afraid of the far-reaching emotional and sensual involvements of the breast relationship and may flinch

at the nature of this intimate contact. The baby may, secretly, be unwanted, and for various reasons the mother may not be able to satisfy the baby's basic need :—an assurance that the breast-mother loves him whole-heartedly and that his own love is good. If such assurance is missing a trauma of the first order is precipitated. The situation to the baby is quite unendurable and he is threatened with a total disintegration of his universe. In this critical situation (a situation he is powerless to control and one in which the breast will not yield) **" he does his best to transfer the traumatic factor in the situation to the field of inner reality."**[3] In other words, he internalises the intolerable aspect of his mother as a " bad object." So now he has a relationship with two objects, a tolerable object in external reality and a bad, intolerable object in the sphere of inner reality.

This, however, is by no means the end of the matter. We must follow further the fate of this intolerably bad object which is now internalised. This " bad " object, representing as it does the intolerable aspects of the breast-mother, has two distinct facets. (i) It frustrates and rejects ; and (ii) it tempts and allures, but refuses to satisfy. Both these qualities are retained in his inner world. " After internalising the unsatisfying object, accordingly, the infant finds himself in the quandary of 'out of the frying pan into the fire.' In his attempts to control the unsatisfying object, he has introduced into the inner economy of his mind an object which not only continues to frustrate his need, but also continues to whet it. He thus finds himself confronted with another intolerable situation—this time an internal one. How does he seek to deal with it ? As we have seen, in his attempt to deal with the intolerable external situation with which he was originally faced his technique was to split the maternal object into two objects, (a) the 'good' and (b) the 'bad,' and then proceed to internalise the bad object. And in his attempt to deal with the intolerable internal situation which subsequently arises, he adopts a technique which is not altogether dissimilar. He splits the internal bad object into two objects (i) the needed or exciting object and (ii) the frustrating or rejecting object ; and then he represses both these objects (employing aggression, of course, as the dynamic of repression)."[3]

I feel like asking the reader to pause here for breath. This revision of Freud's psychopathology is incisive. It may be well, before we go further, briefly to recapitulate. The object has been split—with a consequence as far-reaching for the unity of his infant world as the split of the atom in the world of nations. Then, as we have seen, the inner bad object is split yet again into the exciting object and the rejecting object. Now, the further point is this : those parts of the *ego* that have been attached to the internalised objects by strong libidinal ties can

no longer stay in the unity of the pristine ego. The ego itself, therefore, is split, and those parts of the ego that are identified with the two aspects of the bad object are themselves internalised. The consequence of this is that the libidinal ego is internalised and remains attached to its exciting object, and the anti-libidinal ego, now internalised, remains attached to the rejecting object.

Turning back, then, to the situation in the world of external reality, the infant is left with a mother he can now accept, and the situation would appear to have a possibility of being tolerable again. The mother he knows now in the external world is a kind of idealised version of his mother shorn to some extent of the dangers that devastated him. By internalising the intolerable aspects of his breast-mother he has attempted to remove himself from the possibility of intolerable emotional upheaval. It is an attempt that does not succeed.

But the breast-mother is the first object in his universe. She is the prototype of all succeeding relationships in his world. In his attempt to make life tolerable he has had to decapitate from his relationship with the breast-mother his violent emotions, and this he has done by internalising the bad object, involving, as it does, the splitting of his ego. But because his relationship with his mother is a prototype of all succeeding relationships with objects, so it comes about that as he grows up his contacts with other people are stilted and unnatural. He cannot give a natural expression to his emotions. This is a situation we find both in the schizoid and in the depressive patient.

For a moment let us summarise the situation in the infant's inner universe. There is the libidinal ego attached to the exciting (but frustrating) object, and there is the anti-libidinal ego (a kind of saboteur) attached to the rejecting object. This anti-libidinal ego acts as an unremitting, sadistic "super-ego," attacking the exciting object and the libidinal ego in an unceasing hostility. Here is the basic endopsychic structure as it emerges —not in the oedipal period—but in the first year of life. Here is the source of the inner conflict in all schizoid and depressive states. This is not to say, by any means, that schizoid or depressive states are the first to emerge in adult life when the personality shows signs of emotional stress. Rather the reverse. The states which do emerge, in the first case, are anxiety states, hysteria, phobic and paranoid states, obsessive and compulsive states; but, says Fairbairn, beneath all these there is this basic endopsychic situation and the psychoneuroses appear really as a defence whose purpose is to ward off the original schizoid dilemma. In support of this view Fairbairn reminds us that nearly all schizoid patients have a history of obsessions and other nervous symptoms behind them.

Before I comment on the psychoneuroses as viewed from the

standpoint of object relationships and Fairbairn's endopsychic structure, I would like to carry to a further point what we have already described concerning the endopsychic structure. Although the baby, faced with an unendurable mother object, has split the unendurable part of that object from the acceptable part with all the ramifications of a split, too, in the ego, the baby is still left with the danger of emotional outbursts towards his parents. Though the " split " and repression have to some extent alleviated the infant's problem, he is still left with a sorry plight in which he dare not express either (i) his love ; or (ii) his hate.

(i) He must not express his love. In the ordinary way his love would be expressed in the only way a baby knows, that of sensual need, and yet his sensual need is revived with every new day that comes. He dare not express his love because, to do so, would be to discharge his emotions—as it were—into a vacuum, and the effect of this would be the threat of a complete loss of libido. During early years the growing infant feels this danger frequently and in such circumstances experiences acute inferiority, humiliation, worthlessness, destitution. The intensity of this experience is at its greatest in the oral stage. The experience is so terrible as to make the baby feel he is on the verge of complete disintegration, of imminent psychical death. (Ernest Jones uses the term " aphanisis " to describe a similar concept.) It is the threat of such imminent psychical death in the young baby that sets the stage for the schizoid reaction to operate in later life. The offer of his love will meet with such a fatal rebuff that he simply must not offer it. His love is lethal. His love means destruction. As a consequence, libidinised life is, as it were, taboo and life becomes futile. Now " futility " is the characteristic affect of the schizoid state with its complete lack of interest. and its withdrawal from life. The patient's preoccupation with the world of inner reality, his pursuits designed to steer him away from personal and emotional contact, proclaim the fact that he is re-enacting in later life the great problem of his earliest days—that his love is bad. It is lethal ; his libidinal seekings are completely forbidden and he is left with an experience of utter futility.

We have seen then, that in spite of the fact that the infant in distress has internalised his bad objects, he still has difficulty in his relationships with his parents and his world in general because he still dare not express his love. Such is the nature of the original schizoid dilemma.

(ii) Now we come to the other difficulty that emerges in the *later* oral (ambivalent) phase. The infant discovers not only that he must refrain from expressing his love, but also aggression or hate. He not only sucks, he bites and protests and soon finds that his hate, too, is bad. His bitings and screams tend to threaten

him just as his love did, but for a different reason. Whereas his love endangered his libido and his life, his hate constitutes a threat to the continuity of his object. This appeared strikingly in the phantasy of one of my patients. She felt herself—as a baby in arms—to be screaming rebellion at her unloved state. The mother was walking about with her in her bedroom, unable to pacify the infant, when suddenly the mother's patience came to an end. The baby felt herself to be shaken with incredible violence by her mother and then hurled on to the bed where she bounced up and down with the feeling that her last moment had come. She stopped screaming. She had learned her lesson. She had discovered that if she continued to express her hate she would lose her mother. This problem—concerned with the expression of one's hate—is the problem of the depressive patient. It is so well known to the psychotherapist that I need not enlarge upon it further here.

Our present concern is to ask what measures the infant takes when he can neither express his love nor his hate. If he expresses his love he is in danger of losing his libido and of life becoming a vacuum. If he expresses his hate he is in danger of losing his object, his mother.

To circumvent these appalling dangers, when his need to express his affect (emotion) is uncontrollable, he "uses a maximum of his aggression to subdue a maximum of his libidinal need."[3] In this way he circumvents the problem of outward expression of his love and hate by turning it inward to the world of internalised object relationships. His libidinal ego becomes increasingly libidinised, and his anti-libidinal ego becomes increasingly aggressive, and the fight between these two egos (and their corresponding internalised objects) goes on with more severe intensity.

We have observed that the development of Fairbairn's revised psychopathology has, as its basis, the internalising of the bad object in the oral period, i.e., the period when the baby's relationship with the mother is one of identification and incorporation.

Now the growth of a baby from birth to maturity is, as I have already mentioned, a process of maturation in which the baby's dependence on his objects characterised by primary identification, is gradually yielded up in favour of a relationship with his objects characterised by differentiation. The baby state, then, is one of helpless identity with (and incorporation of) the breast-mother, and a state of psychological maturity is one in which the person is capable of co-operative relationships in which there is a measure of freedom, and the capacity to give as well as to take.

The process between the state of baby indentification and

incorporation and the state of maturity may be spoken of as the *transitional* stage. Very roughly Fairbairn's stage of primary identification corresponds in Abraham's scheme to the oral periods, and Fairbairn's transitional stage corresponds to Abraham's secondary narcissistic, anal and genital stages. If there have been difficulties during the stage of primary indentification, resulting in splits in the ego, then trouble may well be expected in the stage of transition, but these difficulties have their source in the problems the infant has experienced at the earliest stage of life.

The transitional stage provides the aetiology of the neuroses, and it does so partly in virtue of the fact that infantile dependence does not only involve indentification with the object, but the incorporation of it too.

The great conflicts of the transitional stage arise out of a struggle between a progressive urge to surrender the infant attitude of identity and incorporation, and a regressive urge to maintain this infantile attitude. The struggle owes its intensity to the situation that had its origin in the oral period, a situation that has remained unresolved.

The infant desperately wants to break the ties of identification with the mother, and equally desperately insists on "returning home." This kind of oscillation in infancy is re-enacted in adult life and is seen most clearly in the patient suffering from *phobias*. His symptoms—agoraphobic, fear of heights, or fear of enclosed spaces, fear of fire or of food, are all symbolic expressions of the struggle between the desperate necessity to escape from the prison of infant identity with mother, and the equally desperate necessity to return from the void of separation in order to cling to her. The conflict is between flight from the object and return to the object.

At the moment a patient of my own presenting phobic symptoms shows this very clearly indeed. She is terrified of enclosed spaces, and cannot bear to be caged in; but the thought of having to make her way on foot to a bus or train by herself, sends her into complete panic.

But the significance of the conflict is recognised when we realise that the object the person is fleeing from is the rejecting internalised object, whereas the object the person is seeking to return to is the accepted object.

For the phobic patient then, the conflict presents itself as a fight between infant identification with the object and flight or separation from the object.

In the *obsessive neuroses* we find the same kind of conflict but with a different emphasis. As has already been said, the oral stage is not only one of identification with the object, but one of incorporation of the object, too. If the object that is

incorporated (and also internalised) is *bad* and yet libidinally cathected, then there comes to be a conflict concerning what is incorporated in terms of *contents*. As the object has been incorporated, there is an urge to expel the contents, and an urge to retain them. The urge to expel contents is accompanied by the fear of being utterly emptied and drained, whereas the urge to retain contents is accompanied by a fear of bursting or of being poisoned or of contracting a malignant growth.

So we see that the phobic and obsessional modes of expression are concerned with a similar kind of conflict but with differing emphases. In the case of the phobic person the basic conflict is between flight from and return to the object. In the case of the obsessive person the object is experienced as "contents" and the conflict is one between expelling contents or retaining them. (Here, by the way, is an additional reason why the obsessive patient usually has trouble with constipation.)

It should be mentioned here that the reason why obsessional guilt is so savage and intractable, is not because of the activities of super-ego—a later development—but because the split-off parts of the ego find themselves confronted with internal objects which are not only devoid of moral significance, but also are unconditionally bad from the standpoint of the central ego—internal objects which function equally as internal persecutors whether they present themselves (a) as exciting objects, or (b) as frustrating objects.[4]

In *hysterical states* we find an attempt to deal with the basic conflict in yet another way. This time, the conflict presents itself as a dilemma between the **acceptance and rejection of the object.**

The orthodox Freudian view is that the hysterical state is the product of difficulties arising in the phallic phase and associated with the Oedipus complex. Fairbairn, by contrast, associates hysteria with an acceptance of the externalised object, alongside a rejection of the internalised object.

It is a marked feature with the hysteric that the exciting object is excessively exciting and the rejecting object is excessively rejecting. Probably the reason for this is connected with the fact that the internalised object (rejected) is equated with genitals, and the genitals in hysterics are secretly identified with the breast as the original libidinal object during the period of infantile dependence. Hysterics are extremely oral in character, and "in the case of the hysteric, it is characteristic for genital sexuality to have been prematurely excited."[5] The dissociative phenomena in hysteria represent a rejection of the genitals, and this rejection of genitals in turn represents a rejection of the original part-object (i.e., the breast), now internalised.

The intensity of the hysteric's love relationships, and his over-valuation of people show clearly that his accepted object is an

externalised object. The hysteric accepts people with enthusiasm, but rejects their genitals because their genitals represent the internalised and rejected breast. Thus it is seen that the hysteric's quandary is that he accepts his externalised object but rejects the internalised object.

Quite the reverse is the case when we consider the *paranoid* subject. Whilst the hysterical patient accepts people in his outer world with enthusiasm, the paranoid individual treats everyone with suspicion. An enemy lurks round every corner. Again, whereas the hysteric's trend toward disassociation shows a marked sense of self-depreciation and inability, a contrasting feature of the paranoid person is his high opinion of himself. He is grandiose. He is important.

We have already seen that the characteristic attitude of the hysteric is that he accepts people in the outer world but rejects the representatives of his inner world of objects, the genitals. With the paranoid personality, the opposite appears to take place. He externalises his rejected object and identifies this object with people and their supposed persecutory machinations in his outer world. At the same time he internalises his accepted object and so comes to think well of himself.

Moreover, it is to be noted that for the paranoid subject, the bad object—(externalised but representing the rejected object of his internal world)—is *unconditionally* bad, not necessarily bad in a moral sense. The badness relates to the world of the intolerably bad objects that was internalised in the oral phase, and that is why the paranoid's persecutory ideas are fraught with such intense and irrational terror and venom.

Here, then, we have a brief review of the psycho-neuroses in terms of object relationships. We see them as an outcropping of the original schizoid and depressive dilemmas whose origins are to be found in the oral phase in infancy. The psychoneuroses are techniques of defence designed by the personality to ward off the threat of a wholesale "return of bad objects" and to "control" them by the safety-systems of the neuroses, so that the deeper tragedy of melancholia, and above all, of the schizoid dilemma might be averted.

I know little of Fairbairn's therapeutic techniques, and in any case, this is a paper on his theory rather than on matters of practice. Certain things are clear, however. The object of therapy is to enable the patient to find release from his internalised, repressed bad objects. Originally they were internalised because that seemed to be the only thing the baby could do with them. They were repressed because he could not endure them in the world of recognisable reality.[2]

In therapy, by the usual analytic techniques, he comes to recognise his bad objects, and **the libidinal bonds by which he**

is tied to them, and by which these objects have become secretly indispensable to him. He comes to see that his deepest resistance to therapy is not because he cannot face his bad objects—they are, after all, only phantasms from early life—but because he is tied, hand and foot, libidinally to this way of life, probably because (a) he has known no other, more satisfactory way of living and because (b) as in the schizoid dilemma, he fears the vacuum and emptiness of a life where libido may be lost entirely.

The therapist in his interpretations makes it clear that libidinal strivings are basically good, being dictated by the original "object" love of his nature, and as being capable of greater fulfilment in more mature directions. Even libidinal "badness" is goodness that has remained locked in immaturity. It is a kind of clinging to false gods. As for obsessional guilt, even the most intractable (but irrational) sense of wickedness comes to be seen as a bad-object situation, and with the aid of analytic technique, insights come and guilt is relieved.

The psychotherapist may find the prospect of so much deep work—digging down into such early material—a somewhat frightening task, but I believe that these are problems of technique and have their answer. My own experience suggests that induced phantasy work and directed association provide the clue to this problem.

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