THE ASSOCIATION OF PSYCHOTHERAPISTS

BULLETIN No. 8

50p

Marianne Jacoby

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No. 8 1971

CHAIRMAN'S LETTER

The Association is steadily expanding, as Paul de Berker intimated at our last A.G.M.

Last year a Counselling Section was set up, and its pilot course is nearing completion. Additional training will begin this year for those interested in Group Work, and a new committee to hold together the various sections of the Association has been formed. This is called the Affiliated Bodies Committee.

Our liaison work with other organisations continues and several working parties are active, some looking into the structure of departments of our organization and one working on definitions of psychotherapy.

Since our last bulletin there have been some changes of Secretaries. Mrs. Blumenau's work has been taken over by Mrs. Myers and Mrs. Therese Erskine's by Mr. Stewart Cook. Our warm thanks are due to our Secretaries past and present; their work is indispensable to the running of the Association.

We congratulate our senior students, several of whom are now completing their training and becoming Associate Members. A new brochure fully explaining our training scheme is now ready and for the present our Thursday Seminars are open to all student members.

With all good wishes on behalf of the Executive Committee,

ROBERT G. ANDRY.

REPORTS

SEMINARS FOR MEMBERS, 1968 - 70

During 1968 there were 8 meetings with guest speakers. In the Spring term Dr. Esterson spoke on *Family Therapy,* illustrating his talk with tape recordings. Dr. R. D. Laing gave a lecture on *Grandparents and Greatgrandparents* and Dr. Haven gave an account of *The American Scene in Psychotherapy.* In the summer Paul Senft led a discussion on *The First and Last Interviews* and two symposia were arranged. The subjects treated were *The Patient's View of Interpretations* and *Negative Transference Phenomena.* Four of our members participated in these discussions. Three meetings took place during the Autumn term. Dr. Holden on *The Problem of Adolescence,* Professor Allaway on *Bernian Theory* and Dr. Abraham on *Patients Presenting for Termination of Pregnancy.*

In the Spring term of 1969 there were five symposia on *What is Psychotherapy?* Paul de Berker opened the first, and several members contributed. Guest participants in these symposia were Dr. Casson, Dr. Esterton, Dr. Heaton, Professor Mayer and Professor Heimler. In the Summer term Dr. Abraham read extracts from her biography of her father and Miss Schwarz spoke on her research subject *The Concept of Acting-out in Stealing.* In the Autumn Term there were four symposia on *The Self.* Guest speakers in these were Archbishop Anthony Bloom, Mrs. Welch and Dr. Howell. In addition eight members of the Association gave ten minute talks. These were lively meetings, nearly everyone present taking part in the discussion.

Guest speakers in 1970 included Miss Balkanyi on *A Rebellious Student in Analysis* and Mrs. Irvine on *Strategies of Intervention.* Papers were read during the three years by several of our own members, including Miss Rowlands, Dr. Kanter, Lady Balogh and Mrs. Jacoby.

The number of guest lecturers was reduced considerably during 1970, because eight student members read papers with a view to qualifying as Associate Members.

It has been decided that all members, full, associate and student shall be invited to attend seminars arranged for a trial period of a year. As our numbers increase a Seminar Committee will be necessary to plan the programmes,

MARIANNE JACOBY.

WELL WALK CENTRE FOR PSYCHOTHERAPY

In October 1967, the Well Walk Centre for Psychotherapy moved into new premises at 48 Montagu Mansions, W.1. This move resulted in a number of changes. During the past eighteen months the Centre has grown into a larger organisation with an increasingly professional image. The Centre is now administered by a Management Committee which meets regularly to discuss and determine policy and organisation. The Management Committee entrusted me with the direction of the day to day work of the Centre, which I am carrying out with the help of a part-time secretary. We have been fortunate in securing Dr. Pat de Maré as our Medical Director and Dr. Arnold Linken as our second Medical Psychotherapist.

During 1968/1969 the Centre has had altogether 99 referrals from Hospitals, Institute of Group Analysis, Brook Centres, Psychiatrists, General Practitioners, Probation Officers, etc., as well as self-referrals. Of these, 55 were seen by Dr. de Maré and 44 by other Consultants for initial interviews. Out of the total of 99 referrals, 74 were taken on as patients for treatment either individually or in therapeutic groups. The remaining 25 who had the initial interviews did not wish to avail themselves of the offer of treatment.

Of our members, associate members and students, 43 currently have patients in treatment, most of them on the basis of 2 - 4 sessions a week, The referral of patients to individual psychotherapists is the joint responsibility of four members of the Management Committee i.e., Archie Erskine, Harold Kaye, Pen Balogh and myself who meet once a week for that purpose. Joint decisions taken after discussion ensure that every case has most careful consideration. Some patients are referred to our students, even though we fully realise that so-called 'ideal' training cases for students are rare. An invitation was sent out to all the therapists taking Centre patients to participate in the referral meetings, but unfortunately the response has not so far been encouraging.

The Centre's financial position is now on a fairly sound basis, although the rent of the flat and the rates and all other expenses are high, we have succeeded in maintaining a favourable bank balance. This success is, in part, due to the co-operation of all the Centre therapists who return to the Centre one-fourth of the monthly fees received from patients referred by the Centre. We have also let part of our premises to a colleague from Australia and a room to the Group Analytic Institute.

During the last term the Executive Committee of the Association amended the Constitution of the Association to re-define the relationship between the Association and the Well Walk Centre.

The Well Walk Centre now has representatives on the committee of bodies affiliated to the Association and in the next few months will be evolving its own Constitution.

Therapeutic groups have acquired increasing importance. There are at present seven therapeutic groups being conducted at the Centre. It also co-operates with the Group Analytic Institute and the Association of Psychiatric Social Workers in a training programme for group conductors in which the Centre is represented by myself.

I. M. SEGLOW.

GROUP STUDIES SECTION

The Group Studies Section has continued to run two Intensive Evening Courses in Group Dynamics every twelve months. These are normally held in May and November, although in 1970 there has actually been only one, as the second one for this period has been arranged for January 1971, mainly to avoid the increasing traffic problems that are associated with the West End at Christmas time.

Our last three Courses were held at the Headquarters of the National Marriage Guidance Council, at 58 Queen Anne Street, W.1, and we have been grateful to Mr. Nicholas Tyndall, Chief Officer of the N.M.G.C., for allowing us to hire these premises. In January we shall be holding the Course at yet another venue, this time, Church House, Westminster. Premises for these Courses are usually somewhat of a problem, as a fair number of rooms, preferably on the same floor and as near to each other as possible, is needed, and rents in Central London are high.

A Special Training Group for Advanced Applicants is to be incorporated in this next Intensive Evening Group Course. This is a new step for us. The Special Training Group will consist of people, all of whom have had our Intensive Evening Group Course experience, or who have attended similar Courses elsewhere. They will be holding a position intermediate to that of ordinary Course members and Staff.

An experimental Advanced Workshop in Group Studies was held in the first few months of 1970. This again consisted of 14 members who had been through our Intensive Evening or similar Courses. They met for ten weekly 3-hour sessions. These took the form of Seminars, Study Group Exercises and Theme Centred Exercises which, among other things, offered members the opportunity to experiment with new forms of group learning devised to contribute to their knowledge of group processes, and to serve as models for use in their own work.

In all Courses, attendance has been very well maintained.

A. P. DE BERKER,
Secretary, *Group Studies Section.*

COUNSELLING ASSOCIATION

This new venture was begun by a committee under the chairmanship of Dr. R. Andry. A pilot year's course for training in counselling for 15 students began in May 1970. The students meet one evening a week for three hours, comprising a lecture-discussion, a group studying its own experience and a group studying the application of the learning experience to members' work situations.

Miss Jean Scarlet and Mr. David Fane conduct the group study and the lectures are given by a panel of specialists in fields connected with counselling.

In the light of the experience gained in this pilot course, plans for future courses are being considered.

PSYCHOTHERAPY: DEFINITION AND TRAINING

Report of a Working Party set up by the Executive Committee, with the following terms of reference:

"To produce an operational definition of psychotherapy, and to outline a training scheme for psychotherapy."

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INTRODUCTION

The purpose of this paper is to set out the views of the Association of Psychotherapists in such a way as to provide a basis for discussion with other interested bodies, thus, we hope, contributing to the production of a comprehensive statement which could serve as a charter for professional psychotherapists.

The paper falls into two parts:

A. An attempt to answer the question: "What is psychotherapy?"
B. An outline of the essentials in a training scheme for psychotherapists.

A. WHAT IS PSYCHOTHERAPY?

We have found it necessary, in order to clarify our thinking, to consider this question under the headings: objective, theory, content and process, therapeutic and technical methods.

1—Objective

Psychotherapy is a practice setting out to help a patient/client towards greater personal well-being, by alleviating internal psychological conflict and freeing energy for use in directions which will bring increased psychic and social satisfactions.

It will be seen that in this definition the psychological objective of personality adjustment is linked to goals based on individual and social values. We think that psychotherapists cannot escape involvement in current social value systems, although they do not have to support any particular one of them. We are naturally concerned with the question of what constitutes mental health, but find it unnecessary to attempt a definition here.

Members of the Working Party are divided in their choice of terminology between the words "patient" and "client". This arises partly from the dislike for the derivation of the word "patient", which for some has too passive a connotation to be appropriate for a participant in psychotherapy, and partly from associations linked with the use of the words, "patient" being closely tied to medicine and "client" to social work and to other professions.

Since the manifestations of psychological disturbances are so varied—somatic, psychological and behavioural—it is likely that psychotherapy will always be practised in a variety of settings, both medical and social. Thus, some of those having psychotherapy will be, in the ordinary sense of the word, ill and some will not. There will be psychotherapists who find it appropriate to use whichever of these words is current in the setting in which they work, and there will be others whose choice will be determined by their wish to differentiate psychotherapy from the help offered by other professions. As well as the need for professional demarcation, influencing our discussions have been value judgements and ideas, referred to above, concerning the concept of mental health.

We feel that there is a need for one generic term to describe all those who participate in psychotherapy in whatever setting, but as yet we have not found one. At this stage, therefore, we can only continue to use both "patient" and "client".

Definition by objective is wide enough to enable many forms of psychotherapy to be included, such as behavioural therapy, hypno-therapy and suggestion therapy. The type of psychotherapy with which we are concerned, namely "dynamic psychotherapy", is differentiated by its theory and methods.

2—Theory

Dynamic psychotherapy is based on certain theoretical concepts. Although there are wide variations between the main schools of depth psychology, there is a body of knowledge which is generally accepted. The key elements in this can be briefly summarised as follows:

a. the existence of unconscious as well as conscious levels of the mind;
b. a hypothetical psychic energy (Jung) or libido and aggression (Freud) seeking expression;
c. the importance of personal relationships, both in the early formation and development of personality and in its later functioning;
d. the inevitability of some, and the harmfulness of excessive, internal conflict;
e. the development of ego defence mechanisms against anxiety and guilt, such as repression, splitting and projection, which may achieve their purpose successfully or may become pathological;
f. symptom formation as a sign of underlying psychological disturbance.

We, as an Association, have always stood for a broad theoretical basis for psychotherapy, partly on pragmatic grounds, but partly also because we believe that the interests of psychotherapy are best served through the interaction and cross-fertilisation of a wide range of ideas. Psychological knowledge is far from comprehensive, and further research and development of thought is essential if the practice of psychotherapy is to advance.

3—Content and Process

The material which forms the content of psychotherapeutic transactions includes: thoughts, affects, sensations, memories, dreams, associations and fantasies; all of which can relate to the patient/client's symptomatology, his past or present life and relationships, or to his relationship with the psychotherapist.

The dynamic processes include:

a. the release of affect;
b. regression to earlier states of functioning;
c. projection of unconscious contents and images on to the therapist (transference);
d. acceptance of such unconscious contents;
e. identification with the therapist ;
f. co-operative working with the therapist on the task of mutual understanding (the working alliance).

4—Therapeutic Methods

In general the main therapeutic method lies in the development and utilisation of the relationship between the pt/cl. and the therapist (and, in the case of groups, the other pt/cls. as well), in order that transactions may take place and be jointly examined and understood at various levels.

More specifically, therapeutic methods include:

a. discussions of the pt/cl's personal relationships, life situations, aims and values. This may include, on the part of the therapist, suggestion, manipulation and support;

b. clarification of the pt/cl's emotional reactions and patterns of personal and social behaviour;

c. abreaction of affect;

d. provision of a frame of reference, within which the pt/cl's past and present life makes sense to him;

e. interpretation of unconscious processes, such as symptom formation, ego defence mechanisms, projections, including transference phenomena.

5—Technical Methods

The conditions in which psychotherapy is undertaken should facilitate the dynamic processes and therapeutic methods outlined above. These conditions are either contractual or situational.

i. Contractual

The pt/cl. seeks therapy and enters into a relationship with the therapist to that end, and thus both therapist and pt/cl. are contractually engaged. In this contract the interests of the pt/cl. are the therapist's prime concern. The situation must offer some degree of protection for both therapist and pt/cl.

Psychotherapy can be practised either privately or within an organisation such as the health service or a social work agency. In the first case, the fees charged will be a relevant conditional factor; in the second, the relationship of the pt/cl. to the organisation may be of significance.

Child psychotherapy apart, the pt/cl's involvement in seeking private treatment is, in the first place, one of conscious choice. In other settings, such as the health service and institutions, the element of choice may be more or less limited, and in some circumstances, as with delinquents or psychotics, it may be totally absent. In such cases, the conscious co-operation, which is normally assumed as a prerequisite of psychotherapy, may have to be nurtured by the psychotherapist himself.

ii Situational

Psychotherapy may be conducted in an individual or a group setting. The group may be large or small; it may be of a specific composition, such as family or marital, or it may be within a therapeutic community. We see all these as situational methods appropriate to dynamic psychotherapy.

Among the situational components are:

a. physical conditions; for example the couch or the chair, face to face contact or the unseen therapist, the seating of a group;
b. temporal conditions; for example, the number of sessions per week, the length of session, the rigidity with which time schedules are adhered to;
c. conditions of communication; such as the amount of verbal and non-verbal activity, communication within or outside the session;
d. conditions concerning the participation of the therapist.

6—The Therapeutic Situation as a Whole

Essentially the relationship between psychotherapist and pt/cl. provides a containing framework within which:

a. dynamic processes and transactions can take place;
b. the therapist (and perhaps also the pt/cl.) can become aware of what is happening, both intra- and inter-personally, and in terms of the transference and counter-transference;
c. understanding can be verbalised and insight increased;
d. what may be called either "the working alliance" or "the healing relationship" can become active.

Because dynamic psychotherapy has a broadly defined objective and a wide range of therapeutic and situational methods it can be very flexible. To what extent psychotherapy can be effective with certain types of disturbance is a question that has not yet been fully answered, nor is it for us to attempt an answer here. However, we think that it is part of the essential skill of psychotherapy to attempt an assessment of the degree and pattern of disturbance and of the pt/cl's personality, his limitations, motivation and capacity for effective involvement; and, on the basis of this assessment, to select a setting and methods which will create a therapeutic situation appropriate to the particular pt/cl.

7—Professional Responsibility

In this Association, before undertaking treatment, a non-medical psychotherapist is required to refer the patient to a medical practitioner, medical responsibility for the case being

retained by the latter. The psychotherapist is required to keep in touch with the medical practitioner throughout the treatment period.

Having accepted a patient for treatment, the psychotherapist accepts ethical and professional responsibilities similar to those laid down for the doctor-patient relationship.

8—Boundaries

It may help to make our definition more precise, if we add to the above description of psychotherapy a clarification of the boundaries between it and other practices which are close to it.

i. Experiential situations. These may well be therapeutic, and indeed much of what occurs in psychotherapy may remain at the experiential level. The essential difference is that the therapeutic situation of psychotherapy always contains means whereby behaviour, thought and affect can be examined, understood and verbalised.

ii. Non-dynamic therapies. Earlier we mentioned other therapies which share our aims but not our theory and methods. These we can group together under this term, and can distinguish them from dynamic psychotherapy on the basis of their reliance upon the situational component, the manipulation of conscious processes or upon suggestion, in contrast to the emphasis laid by dynamic psychotherapy on the use of the relationship in order to uncover unconscious processes.

iii. Psychotherapeutic work carried out by doctors, social workers, nurses, teachers, priests and others. Many professional relationships can be psychotherapeutic and many workers in the "helping professions" make appropriate use of theories of depth psychology and methods deriving from them. These are often used in conjunction with the practices belonging to their own discipline. The distinction between these activities and formal psychotherapy lies in the specialised skill of the psychotherapist which determines the depth of work that can be competently undertaken, particularly in the handling of unconscious material and the use of interpretation.

iv. Analysis. Dynamic psychotherapy owes much, indeed its very origin, to psycho-analysis and analytical psychology. Analysis, in its classical form, is work at great depth and intensity, very demanding of time and money, and to be undertaken only with a selected type of pt/cl. by a trained psychoanalyst or analytical psychologist. Psychotherapy, on the other hand, covers work at a variety of levels and intensity, and can therefore be of use to a very much wider range of pt/cl. It requires a different training from that provided by the analytical institutes, less specialised and intensive but broader.

B.—AN OUTLINE OF THE ESSENTIALS IN A TRAINING SCHEME FOR PSYCHOTHERAPISTS

The aim of training is to produce a competent practitioner in the work described above, and the essentials for a training scheme are now outlined. We have tried to steer a course between order and system on the one hand and, on the other, flexibility and allowance for individual differences.

1—Selection of Students

The relevant criteria are:

a. Personality: life experience, integrity and maturity of outlook. We do not think it necessary to fix a minimum age qualification, but some adult life experience is essential.

b. Intelligence and ability to learn. For the present, we consider that a degree is not essential, though desirable. A wide variety of degree subjects are relevant, for instance psychology, anthropology, sociology, medicine, social work, or the humanities.

c. Professional qualification and experience. As a general rule, though there will be exceptions, suitable students will have a professional qualification and experience in one of the "helping professions". We think it desirable that psychotherapists should come from a wide variety of professional backgrounds.

2—Personal Training Experience

i Analysis/Psychotherapy

It is essential that the student have first-hand experience of the role of analysand or pt/cl, with a skilled analyst or psychotherapist, so that he can explore his own thoughts, emotions and life relationships within this therapeutic framework. Thus the processes of psychotherapy can be felt, identified and understood by the student at first hand, and evaluated by him. How long it should last and how frequent should be the sessions is a matter to be considered for each individual student, but we consider that a period of three years, at three times a week, should be the norm.

This personal therapeutic experience should benefit the student in three ways: firstly, since everyone has some limitations of personality, the therapeutic process will help him to modify his own tendencies towards pathogenic relationships, and to reduce his blind-spots and prejudices; secondly, it will give him a greater capacity to understand emotional manifestations in his pt/cls.; and thirdly, it will help to make him aware of where

his own personality is likely to intrude and influence the conduct of his therapeutic relationships.

There is no doubt at all that personal analysis or psychotherapy is expensive and demanding of time and effort, and also that it is often difficult and disturbing for the student. The evidence shows clearly that identification with the analyst's theoretical position is one of the usual outcomes, although it must be remembered that the student will have initially chosen an analyst or psychotherapist with whose viewpoint he is in sympathy. Finally, it has to be admitted that not all analysis or psychotherapy is equally successful. While aware of these possible hardships and risks, we are convinced that they are greatly outweighed by the gains to the student.

We consider that personal analysis or psychotherapy should be an integral part of any training scheme.

ii Group Psychotherapy

The small group, conducted on non-directive interpretative lines, offers to the student, amongst other things, a testing-ground of personal effectiveness and an opportunity to study his relationships with others as they occur and as interpreted back to him by the conductor and by other members of the group.

We think that experience in a small group setting can add much to the student's self-awareness and to the breadth of his psychological understanding, and that it is a desirable part of the training experience.

iii Other Group Experience

Therapeutic communities and groups operating in a social setting, as opposed to the closed type of small group described above, may also be seen as offering further opportunities for broadening the student's experience and enabling him to see himself, and hence his pt/cl., as an individual in a social setting, interacting with others. Experience in non-psychotherapeutic group settings, T-group and generic group learning situations, as developed in industry and elsewhere, also have a valuable contribution to make.

3—Theoretical Studies

i Syllabus

It is essential that the student should have a thorough grounding in one of the major theoretical systems of depth psychology, and at least some acquaintance with the others. In the present state of psychological knowledge some eclecticism is likely to be inevitable. However, it should not be the outcome of a superficial acquaintance with a number of theories but of a

broadening in outlook, arising from the integration of additional facts and concepts into a firmly based theoretical framework.

The syllabus should cover the following subjects:

a. the detailed study of the theories of either Freud or Jung, covering both normal and pathological structure and development of the personality, together with the subsequent major theoretical developments; based on original works and accepted sources of reference;
b. a comprehensive survey, covering the theories of other depth psychologies; group psychology; and relevant developments from academic psychology, such as those stemming from learning theory;
c. the various methods and techniques of dynamic psychotherapy;
d. psychiatric diagnoses and treatments, including physical methods;
e. professional practice and ethics, including forensic matters, professional responsibility and relationship with the medical and other professions.

ii Methods of Study

Theoretical learning will include lectures, reading, discussion groups, seminars, presentation of essays or papers, and by case conferences.

The application of theory to practice is of prime importance, and a valuable medium for teaching this is the case conference. It not only links theory and practice but it also increases the student's experience through the study of a wide range of case material.

4—Practical Training

i Cases under Supervision

The most well-tried training method is that of practice under supervision, carried out through a regular and prolonged dialogue between supervisor and student.

The supervisor's function is a dual one: for the benefit of the pt/cl,, to protect him from any gross mismanagement on the part of the student: for the benefit of the student, to help his individual development as a therapist. The supervisor extends the student's understanding of the pt/cl's psychological situation, by reference to theoretical concepts and to the supervisor's own experience. He helps the student to develop his therapeutic skill, through making a close study with him of the process of the treatment sessions, in order to show the student where his involvement or counter-transference may be effecting therapy, and to instruct him in the use of the various therapeutic methods which are appropriate.

At least two cases should be carried on this basis, for at least eighteen months each.

There is much to be said for a student having a different supervisor for each of the two cases, in order to give him the benefit of additional experience. There are advantages in the supervisors being of different sex, and the pt/cls. also. There are advocates in favour of the student's personal psychotherapist supervising one case, in order to work on the problems and counter-transference reactions brought out in the student by his realtionship with the pt/cl. Others think that this requirement can be better met by the personal psychotherapy continuing independently throughout the period of supervision. Yet others argue that, in order to avoid confusion, the personal psychotherapy should be completed before the student takes any cases under supervision.

We think that with the proviso that each student must be considered individually, it is beneficial for the student to have two supervisors other than his own personal analyst or psychotherapist, and for the personal analysis or psychotherapy to continue for most, if not all, of the time during which a student is taking cases under supervision.

ii Group Therapy

Group therapy is becoming increasingly important as a method of psychotherapy. Not all those who wish to train as psychotherapists may wish, or be able, to become group therapists, however, it is likely that an increasing number will do so. As described under the section on personal training experience, all psychotherapists should be encouraged to have the experience of participation in group therapy and, for those who want it, specialist training in group therapy should be provided as an additional option.

iii Clinical Work

The student must become familiar with the manifestations of psychological disturbance, including the symptoms of gross disorder and the variations of patterns of behaviour which are related to different social groupings and environments. He should have a working knowledge of the community's resources for dealing with its more disturbed members, and with the methods of treatment available as alternatives, or in addition, to psychotherapy. He must develop the facility to work closely with members of other professions who, whilst using a variety of methods appropriate to their own discipline, are pursuing much the same ends as himself. Experience of this kind will enable the student to learn how to make the most suitable treatment

plan for any pt/cl. of his, either initially or later, should the pt/cl. manifest acute disturbance in the course of psychotherapy.

We consider, that to serve these ends, experience in a clinic, hospital or broadly-based social agency is essential. Most students will either be working in such a setting or have done so in the past, but where this is not so, some work of this kind must be undertaken.

5—An Integrated Course

Because of the varied qualifications and previous experience that students bring to training, any scheme must be flexible enough to meet individual requirements whilst, at the same time, retaining sufficient structure to provide a systematic course and to maintain a high standard.

We consider that acceptance for training should be on the basis of a six months' probationary period, during which the student should be in personal analysis or psychotherapy, and at the end of which the analyst or psychotherapist should make a recommendation as to his suitability for training. Students are often already in analysis or psychotherapy before applying for training, in which case the probationary period may be shortened.

Students will start their theoretical training at the end of the probationary period, but the time may vary, for the reasons mentioned above and also because courses only start in the autumn. Their clinical work will normally be the work on which the student is remuneratively employed but, if this is not so, individual arrangements must be made for this area of practical training to be covered.

The length of any theoretical course depends on whether it is full or part time. Our experience, so far, is in training psychotherapists who are usually engaged in full-time work and can only train in the evenings. On this basis, theoretical studies are conducted over a period of three years.

As a general rule, the student should complete one year of theory before taking his first case under supervision, and should start his second case a few months later. This would mean that by the end of his theoretical studies the student will have carried one case for two years and one for approximately eighteen months.

If a student had started his personal analysis or psychotherapy six months before the theoretical course and carried it on for three years, he would finish it about six months before the ending of the course. However, we must repeat that there will inevitably be many individual variations of this schematic time-table.

We do not consider that an examination, written or oral, is the most suitable way of assessing a student. During training, progress should be assessed by his course tutors, supervisors and

personal analyst or psychotherapist. If, at the end of the theoretical course, these reports are satisfactory and when two cases have been adequately treated satisfactorily for a reasonable length of time, the student will present a paper on one of the cases. This paper must include a description of the pt/cl. and his problems and a summary of the development of treatment, giving details of some of the transactions which have occurred between the student and pt/cl. It must also show how the student formulates his ideas about the case, in concepts deriving from a recognised theoretical frame of reference. This is not to demand that the student must rigorously interpret his work according to a Freudian, Jungian or other theoretical formulation, but that he must be fully conversant with the conceptual framework and, if he has departed from it, show good reason for so doing. If this paper is judged satisfactory, the student's formal training is finished.

The Association grants associate membership at this stage. Full membership can be applied for after a further period of not less than a year. During this time, the associate will be able to increase his practical experience and prove his professional skill. He may then be required to write a further paper or, in some other way, to demonstrate his professional competence before being made a full member.

CONCLUSION

The need amongst the population for the kind of help offered by dynamic psychotherapy is vast, and every effort must be made to meet it. To find ways of doing so requires research and experiment into methods which, whilst being effective, are economical of time and money, and it also requires an adequate supply of people capable of practising psychotherapy.

Such is the background against which our report has been written. It means that we have to strike a balance between conflicting demands. On the one hand, since flexibility and scope for development are essential, it would be a mistake to define psychotherapy too precisely or to outline a training scheme that is too rigid or constricting. On the other hand, sound professional standards have to be established, and for this purpose there must be a clear formulation of the work we set out to do, and the training that is necessary in order to do it competently.

We recognise that people in many other professions will utilise some of the theory and methods of dynamic psychotherapy, and indeed we welcome and encourage this. However, we differentiate categorically between such use of psychotherapeutic skills and the practice of psychotherapy by specialists qualified according to the standards and training which we have here set out.

THE PROBLEM OF RESISTANCE AS EXPRESSED IN CHARACTERISTIC TRANSFERENCE ATTITUDES

H. J. Home

Throughout the Papers on Technique, Freud returns to the problem of transference acting as a resistance in treatment. In "The Dynamics of Transference" (1912) he writes "This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference". Earlier in the same paper he says "Where the capacity for transference has become essentially limited to a negative one, as in the case with paranoics, there ceases to be any possibility of influence or cure". In his paper "On the Beginning of Treatment, Etc." (1913) where he is indicating how the fundamental rule of free association should be put to the patient, he makes clear its importance for enabling the analyst to discern and interpret transference resistance—"So long as the patient's communications and ideas run on without any obstruction, the theme of transference should be left untouched". In "Recollection, Repetition, Etc." he elucidates the relationship between transference resistance and acting out: "But if, as the analysis proceeds, the transference becomes hostile or unduly intense and therefore in need of repression, remembering at once gives way to acting out. From then onwards the resistances determine the sequence of the material which is to be repeated."

The Papers on Technique are concerned with the analysis of psycho-neurotic patients and with psycho-neurotic transference and, although Freud discusses phases of intense transference resistance, he is still concerned with resistance that yields perceptibly to interpretation. For example, speaking of the strength of transference resistance in "The Dynamics of the Transference", Freud writes "For our experience has shown us—and the fact can be confirmed as often as we please—that if a patient's free associations fail, the stoppage can invariably be removed by an assurance that he is being dominated at the moment by an association which is concerned with the doctor himself or with something connected with him. As soon as this explanation is given, the stoppage is removed, or the situation is changed from one in which the associations fail into one in which they are being kept back."

My paper is concerned with the problem of transference resistance which does not yield perceptibly to interpretation, where there is from the beginning of treatment an inability to

co-operate in the therapeutic alliance by observing the fundamental rule. This inability to co-operate can take many forms. But in every case the patient's failure to co-operate produces an ambiguity in the material which makes it difficult to interpret confidently and eventually makes the characteristic behaviour the focal point of treatment. This characteristic behaviour cannot be understood as "acting out" in the sense of behaviour outside the sessions which is related to a phase of transference in the treatment or as "acting out" in the session that occurs when a recollection comes under repression and is expressed as repetition in the way amply described by Freud in "Recollection, Repetition, etc." I have chosen the term *characteristic* to indicate that the transference attitude with which I am concerned is characteristic of the patient and not of a particular phase of treatment and comes into treament with him openly from the beginning. In so far as it is a response to the analyst and the analysis, it is so because the analysis is experienced as a familiar type of situation to which this characteristic response applies. Whereas the psychoneurotic patient is capable of recognising the analytic situation as strange and unique and therefore explores it (so creating a developing transference relationship), the "character case" sees only a familiar situation which he proceeds to handle in preconceived terms so that even the analyst's interpretations are transmogrified and denatured.

Traditionally the term "character" in psycho-analysis has been used to describe behaviour organised round fixations in libidinal development, e.g., oral character, obsessional character, etc. In this paper I am using it to describe rigidities of behaviour which are derived from the cumulative pressure of experience and which are maintained particularly by splitting identity into an observing part and a behaving part. My approach derives generally from the work of Winnicott, Rycroft and Little. I think about these cases in terms of false and true self, in terms of a phobic relation to the object, in terms of delusional transference. When considering aetiology I think with Masud Khan and others in terms of cumulative trauma; when considering defence I think in terms of Melanie Klein's work on denial and idealisation,

It is always difficult to give the flavour of a patient's communication in which characteristic transference is conveyed but it is easiest to show in detail in the less copious material of some schizoid patients. Mr. R was a young man of twenty-eight from a well-to-do family of considerable culture, He had done well academically at school and university, though not quite so well as expected, and was apprenticed to a firm of lawyers. Wiry, lightly built and stepping lightly he had a swordsman's carriage. His voice was rather high and he often tended to communicate

in flurries of rapid speech. He was referred by a general practitioner whom he had consulted about premature ejaculation. From an ordinary point of view his history was uneventful in the British middle-class pattern of prep-school, public school and university. However, it early emerged that his father had been absent on military service from the time he was five until he was ten or eleven; also that he had, as a young child, been sent to the same girls' school as his sister during an emergency when his mother had to be in hospital. In infancy and early childhood he had been mainly tended by nannies, his mother distrusting her own ability with small children.

Mr. R's manner in the preliminary interview did not seem particularly inappropriate. He described his situation and his symptoms in the intelligent and objective style which any well-educated person might use to present his problem to a specialist. From the first treatment session onwards, however, it became increasingly clear that he could not talk in any other way. Although I put the "fundamental rule" to patients almost verbatim from Freud, he understood it as a request to talk about himself. When opportunity offered I pointed the matter out to him but he simply did not understand what I meant, could not see the difference between free association and talking about himself. This inability to comprehend and consequently to change his behaviour consciously was an index of Mr. R's resistance. I have called such resistance "characteristic" because it is habitual and covers the whole range of communication invariably. At the same time it must necessarily be a transference phenomenon although one so undiscriminating that it probably covered the whole range of Mr. R's relationships.

Mr. R's manner of speaking had the effect of severing the connection between what he was talking about and what he was immediately feeling. This argued that I represented an early object in whose presence it was dangerous to behave in terms of his feelings. The baby Mr. R, like a chimpanzee under test, must have learned to avoid the obvious response if he wanted to achieve his wishes. If he wanted mother it was no use looking sad or kicking up a fuss, he had on the contrary to put on a clean and cheerful front so that he was fit to be taken to her. Eventually the prohibition on feeling came to apply with special force to his phallic and genital wishes and therefore to his penis, which unconsciously he scotomised.

The transference in this case represented an anti-relationship. In a relationship we speak our thoughts in order that another person may know our feelings by identifying with the picture we present in words. We seek to understand and be understood. In the anti-relationship thought is related to fact, to events in the space-time world of sense-perception, and serves to co-

ordinate behaviour in a functional way. Factual thought enables us to co-operate in tasks and implies a task to be performed. Where a patient is capable of relationship we shall observe a state of positive or negative transference but this will be interpretable. The patient expresses the feelings and the analyst supplies the unconscious context which explains them. Where the patient is in a state of anti-relationship interpretation of content is virtually impossible and interpretation of resistance almost equally so because the resistance is so total that the analyst lacks the necessary basis of comparison.

Mr. R. behaved as if the analysis were a learning situation in which he would learn about himself. He would provide facts and I would show him how they fitted together. He would be objective to himself as the subject under study. The study was our common task.

Such a transference was evidence that Mr. R. was potentially in a very dangerous situation because his behaviour was organised to prevent any true emotional expression. He lived in a pattern which lacked personal quality. His job, his friends and his interests were all conventionally appropriate. They could also have been personally appropriate but were not in fact so. Similarly the range of his behaviour was strictly limited; such behaviour as a public situation required he could manage easily but the behaviour required for an intimate private situation was beyond him. The whole structure of his life, as expressed in his behaviour, was like an articulated shell inside which his sensitive personal feelings were incarcerated. Early in the analysis he told me that some months previously a man had entered the large buildings in which his firm had offices, had walked up to the very roof top and had thrown himself into the street. He had looked quite normal, a respectably dressed business man with a despatch-case, a bowler hat and an umbrella. I interpreted that he told the story because he wanted me to know that he felt like the business man. If he could not get out of his conventional shell what would there be for him to do except climb up to a high place, throw himself down and smash the quick and the dead together?

Although Mr. R's material was all in the objective mode, it gradually became possible to distinguish a line of liveliness running through it. This appeared in the form of unexpected events, it might be a glimpse of the dome of St. Paul's at the end of a road, or an encounter in the early morning with the Queen's Troop of the Royal Horse Artillery, their accoutrements aglitter in the sun, their horses fretting. Once it was a rag-and-bone man crying as he went down the street and Mr. R remembered he had heard such a street cry even in the city among the tall buildings—a voice from another world. Then there was

Primrose Hill a green outlier among the pavements and country walks at the week-end when he could surreptitiously make erotic contact with a symbolical mother through his feet. It was amazing to see how he extracted and had extracted the drops of living water which kept him psychically alive although cut off from those sources we normally find in one another.

Theoretically it would have been possible either to have kept silent in the face of Mr. R's resistant behaviour in the hope that he would eventually abandon it, or to have forced the material into the mould of ordinary transference interpretation assuming the personal relationship which the resistance denied. I found neither course possible although I did remain silent for long periods when it seemed appropriate and also interpreted the personal transference on the rare occasions when it showed. At other times I felt it necessary to accept Mr. R's communication as the most expressive he could manage. Because there was no material and no memories which would make "mutative" transference interpretations possible I found myself trying to link his situation with proto-typical situations from history. For example I likened his behaviour in coming for analysis to that of a prince whose throne had been usurped in earliest infancy but who had come into possession of information proving his true identity. He knew who he was but felt obliged to behave as if he did not know for safety's sake. This was a true picture, for his castration fear was unconsciously experienced at a paranoid level of intensity. He had secretly to treat everyone as a potential enemy. I used the material from C. S. Lewis's children's books extensively and referred to them by name. Stories such as Prince Caspian, The Silver Chair and The Lion, The Witch and The Wardrobe are wholly relevant. Such interpretations are, I believe, mutative for they link the present with the proto-typical past (cf., Jung's Collective Unconscious) in such a way as to give the present situation new meaning and to provide a basis for criticising the appropriateness of current behaviour.

The separation anxiety aroused by holiday breaks often allows us to see the transference relationship particularly clearly. Mr. R's denial of individual personal relationship for a long time made the interpretation of this anxiety mainly a one-sided and formal exercise which I carried through on principle. Towards the end of the third year of analysis, however, Mr. R began to express his anxiety at these times by doubting the usefulness of further treatment and considering termination. On the third occasion that this happened it was possible to point out in a way that convinced the patient that this behaviour was typical and expressed anxiety over the holiday. Four sessions in the fortnight before the next holiday can perhaps illustrate

the movement from characteristic to personal transference.

On the Monday a fortnight before the holiday Mr. R came late. It was raining he said and he had caught the bus. Although he knew it would take longer he never allowed extra time for this. He was then silent. After several minutes he said that as usual he had been thinking of many things and could not decide what to tell me about. He recapitulated the whole matter of his difficulty in speaking spontaneously and also wondered whether he would not be sensible just to accept the fact and quit analysis.

I said that he was disturbed to find how completely his behaviour was determined by his unconscious fear. He was feeling particularly upset because of the approaching holiday. That part of him which felt upset looked for a way of expressing itself but could find none except to voice again his despair of ever changing and his thought of leaving treatment.

On the Tuesday the patient arrived on time but said at once that he considered this accidental. To think otherwise seemed to him ridiculous. He had got just as much behind today as yesterday but things had somehow gone right and he had arrived in time. It was chance. Yesterday he said, had been a very bad day, not only for the analysis but at work. He had made lots of mistakes, some quite important ones. He thought of the fact that he was reading a book called " The Spire "—about the ambition of a mediaeval cleric to put an enormous spire on a church, whose structure could not bear it. In the book various aspects of the priest were represented by various voices, e.g., the priest-angel, the priest-devil, etc. He felt it was like himself talking to himself. There was a short pause and Mr. R remembered being with his parents the previous evening and being even more struck by the difficulty of getting on with them. They seemed to be out of touch with anything that really mattered either to them or to him.

Calling on a good deal of previous material I pointed out how desperate he felt about getting into touch with his parents and had felt especially with his mother as a child. It was not that she was nasty; it was simply that she did not understand anything that he wished to communicate and then that part of him seemed not to exist. These " not understanding " parents filled the centre of his life like a vast desert and he could only live on the edges. This made it so particularly painful at times like those of separation when he wished to speak to them as he now wished to speak to me. Fearing not to be understood he conducted an endless debate within himself. The debate prevented him from being aware of his feelings which, however, were the only things able to provide an adequate basis for relations of personal love and friendship (The Spire).

On the last Thursday Mr. R arrived punctually but said that it was really a fluke. He had taken no special steps but a bus had just turned up on time. He said that he noticed he spoke lightly about this, which stood in obvious contradiction to the fact that he came almost every day and had done so for years and that he paid a lot of money for it. It was a pity he was rich and did not have to pay out of his salary. He behaved in the same way with girls and really with anything of importance. Yet he was not a calm person and often spoke excitedly.

I said that he was telling me he would miss me in the holiday but that he had to do it indirectly by implication. His voice did not reflect his feelings so that he was able to speak excitedly about things which were not important and be calm about things that were.

Mr. R said it was like photos of Mars. They came as sounds and then the sounds were transformed into pictures. He then said that he saw Hermione in the office yesterday and had noticed that she was a melancholy sort of person. I said that he saw his own melancholy in Hermione. This was how he saw bits of himself which he could not directly acknowledge in others.

On the last day before the holiday—Friday, Mr. R arrived punctually. He spoke of running to catch the bus. He had run very hard as people seldom do and had just caught it. After a pause he asked me if I had seen the morning paper. It carried the announcement of Sir Alec Douglas Home's resignation from leadership of the Tory Party. He felt this to be a loss. Home had been reasonable and decent, perhaps too decent for the rough and tumble of politics. Yet this was a commentary on our politics. I said that he was also concerned with my loss at the holiday. He had run for the bus to show his real appreciation. Now he also spoke of Home for me, whom he felt he had often treated badly, mainly by disowning me as he had his father. Mr. R said that I had often before interpreted his feelings at holiday time and he had accepted the interpretation without really feeling it. This time he did feel the emptiness of the holiday—everyone was on holiday, Bill, Jill, Phil, etc.

After a silence Mr. R said that he was thinking of a television programme he had seen showing the last span being put on the new Severn Suspension Bridge. At first the span had looked like some vast malevolent bird—then it had become the suspension bridge.

I said that he was making a reconciliation with his father who had let him down by being away at the war during his early childhood. They were separated by this span of years, by the malevolent hate it had engendered in him and later the awkwardness. Running this morning he had been running

into his father's arms—making it up—just at the last minute —before it was too late.

Mr. R agreed. He recalled that his analysis would have lasted four years by Christmas. At the beginning I had told him it might take four or more years. Four years would be up at Christmas; that was like the fourth span of the bridge going into place.

In these four sessions it is, I think, possible to see the gradual though temporary cracking of the characteristic transference under the pressure of separation anxiety. At first the patient misses the bus and it is inexplicable; then he catches it but it is a fluke; then he catches it again by luck but can notice something funny in his own attitude; then he can run hard to catch it and afterwards produce verbal material close to his feelings in the analysis. He can also accept a transference interpretation and develop it. His feelings do not yet, however, modify appreciably his voice or style of speaking and this fact will continue to affect his personal relationships adversely because they will project his state of feeling inaccurately. Nevertheless he is already someone of whom people could say "he is quite different when you know him better".

The means that Mr. R employed to maintain his characteristic transference attitude was that of splitting his identity so that one part of himself could keep watch on the other. Safety, especially safety from separation anxiety, was achieved by keeping behaviour as close as possible to a model. He disassociated himself from his own behaviour so that he could avoid feeling directly responsible for it, while striving continually to bring it into the established line. Where he was required to read a human situation directly and to organise an appropriate response he was at a complete loss. He then fell back on to his repertoire of shock responses, one of which would be approximately adequate. Mr. R was naturally an active man and this solution allowed him to act. Restraint on his action would have been intolerable,

This attitude of splitting and watching is characteristic of these cases.

With even more vicious intensity was it characteristic of Mr. J who was referred for treatment after his discharge from hospital. He had entered voluntarily when he found himself unable to go on working owing to acute anxiety and depression. Unlike Mr. R, Mr. J looked extremely ill. In early middle age he was strikingly gaunt with a sallow complexion which could take on an ashen pallor. His eyes were sunk and seemed red-rimmed. He walked deliberately and with a slight stoop. On the couch he lay on his back quite still and might have been a corpse.

Mr. J found talking very difficult but I discovered that he found silence very painful. During the first year, sessions typically began with a silence and then, after prompting, Mr. J would make one statement such as "I am feeling in a complete fog", "I am feeling terribly anxious", "I am feeling absolutely blank", "I feel as if I were drowning". If asked for associations he would say that nothing came to mind. The metaphors used were often of water, fog or desert.

Finding that I had to make something of this initial statement or leave my patient in mounting anxiety I began to explore the metaphors logically and systematically. For example I would say that if he were in a fog he would not be able to see anything and so would not be able to associate; as there was not actually any fog in the room he must have made the fog. It seemed to me that he made the fog so that someone, and someone whom he unconsciously identified with me, would not be able to see him. Or I might say that fog was to do with water, the water was the tears of his sadness but he felt too hot and angry to cry them openly so the fog arose as a sort of confused compromise.

Mr. J was the only son in a family of four. His father was a master craftsman of withdrawn disposition and habits, who judged everything his son did against a standard of perfection. He was much away from home and for a time lived apart from his wife. At the age of ten Mr. J's father and mother decided to live together again. It was a terrible two years for Mr. J, who was close to his mother, and culminated in her death from cancer. Thereafter Mr. J lived with his father until he grew up. His father almost never spoke to him and a long-drawn war of silence developed.

The essential structure of Mr. J's characteristic transference was that he was in the presence of his father. He wished to speak but feared the killing rebuff. He turned the anger felt against his father against his wish to speak to him, which occasioned the pain. The remorseless eye of anger* now watched his every response, prohibiting any that expressed friendly human feelings or the awareness of such feelings in other people. The prohibition had the effect of turning feelings into facts, for feelings naturally imply other people who occasion them and are unlike facts which exist of themselves. Mr. J could say he was anxious or confused but could never offer any reason for his feeling which was thus treated like a simple fact. Similarly he could sometimes say things like "I feel as if I were standing in a desert surrounded by high barren mountains". But equally in this case no associations came. He was a prisoner to the angry

* cf. J. R. R. Tolkien's "The Lord of the Rings", from which I myself gained invaluable insight concerning Mr. J's condition.

eye which would allow him to call for help but which would not allow him to say where he was. The ban on feeling inevitably cut across his erotic life where feeling and action are most specifically united. It was as if he were pinned face downwards on his mother's coffin unable to complete his mourning. Her he could love without sexual consummation (and any other her); others he could have sexual dealings with, but without love.

It was over a conscious problem in his sexual life that Mr. J opened his analysis. He had for nine years known and loved a girl who refused him both sexual consummation and marriage. He had pressed for both and was now particularly pressing for marriage. She, however, could not make up her mind between Mr. J. and another man, although she said she loved Mr. J. Without free associations it was impossible to take up this conflict in the transference and I analysed it literally in a common sense way. I showed Mr. J the obvious fact that it made no sense for Janet to say that she wanted children if she did nothing about it. It made no sense to say that she loved him if she kept him hanging about for years. It made no sense to say she was a good person if she could endlessly waste his time. Under pressure the girl eventually married the other man saying to the last that she only loved Mr. J.

This triumph of sanity over insanity cost Mr. J very dear. He gradually became more and more depressed and unable to work and eventually went into hospital for a second time. In hospital, however, he found he was deteriorating and after a few days begged to be discharged. Fortunately this was quickly managed and the episode marked a turning point. Although no detailed material emerged to confirm the idea, I felt that Mr. J had repeated in treatment the events of his mother's death. In the end he had decided to live without her.

No dramatic improvement followed but very gradually some colour came back to Mr. J's cheeks. He changed his job for the better and began to speak a little more freely in sessions. This last change was associated with the interpretation of his deathly posture. I began to point out to him that he lay on the couch like a corpse. It seemed to me that his lack of associations stemmed from this fact. Instead of behaving as the reality of the analytic situation demanded he behaved as if he were almost dead. He responded not to the current situation but to his own posture. I pointed out that posture naturally reflects our response to current reality but it can be used in reverse to create a psychic reality, e.g., we can speak in a calm voice to restore ourselves or others to calm. The interpretation seemed to make ready sense to Mr. J. Some sessions later he said that he had always felt lying down a difficult and inhibiting posture and that he felt he would be able to speak more freely sitting up.

Some sessions later he did so and has continued to sit. A change in behaviour of this kind requires further analysis eventually but in the short run it can be worth accepting for its own sake when it in fact makes communication easier.

After sitting up Mr. J talked much more freely although his communication was still very far from free association. This meant that all his improvement was still within the transference but improvement there was—in analysis, at work and in friendship. In analysis he was able to follow up his first communication in the session. He began a session at this time by saying he was feeling hopeless, tired and fatigued. I said he sounded like a person who was physically tired. He said it was as if he were carrying a great weight on his shoulders. I looked my query and quite uncharacteristically he said "As a matter of fact I have the picture that I am kneeling in Euston Square. There is a bed of bright red geraniums there. People are passing by and taking no notice of my suffering". I said "They pass by because they do not see the weight you carry. You play this trick because it allows you to hate them." Mr. J said he now thought of an eccentric tramp he had seen cooking a meal in Regent's Park oblivious of passers by. I noted the antithesis between eccentricity which inflicts itself on people so that they suffer guilt or embarrassment while the eccentric seems quite happy and the sufferer who hides his suffering while secretly imputing guilt to those who do not see it and help him. During the rest of the session Mr. J recalled memories of school which bore on the theme that he suffered at school because he could not reveal how eccentric his father was. He could not take friends home because "one can't entertain in a mortuary".

Mr. J began the next session with the unprecedented remark: "I feel excited. I don't know why but I feel excited." He was in fact going to meet an eccentric woman friend whom he liked. It was the first really personal contact he had made since Janet left. In this encounter eccentricity and suffering met like two characters in an allegory, Eccentricity showed her worth by saying to a man who tried to horn in on their conversation in a pub "I wasn't talking to you" and this in spite of the fact that she had been speaking in a voice that easily carried the length of the bar.

The mood of excitement lasted two sessions which were contemporaneous with the friend's visit. At the next session on a Monday the patient looked more alive. However, he said "I have been feeling exhilarated but now I feel deflated. I don't know why." I said perhaps he was deflated by the loss of analysis at the weekend. Mr. J replied that he had been exhilarated at the weekend. He had become deflated this morning. He said that it was all right when he was exhilarated but

that soon passed and then he was deflated. It was not enough. I drew Mr. J's attention to his words exhilarate and deflate. They were words of breathing. Changes in breathing were impermanent. The mood passed because he did not allow it to inform his whole body and so release action which would affect his circumstances. His body remained inert, only his breathing changed. I said his friend could be said to have cheered him up but he had let her. Mr. J said he was thinking of Euston Square again. It was a terrible, devastated place. At one end there were gates leading to Euston Station. They were locked and blocked with rubbish and everyone had to go a long way round. Why did someone do such a deliberately stupid thing. He thought of Soho Square where his last job had been. That was quite different. He paused. I said perhaps he felt Soho Square to be more intimate, residential, homelike. Mr. J. said No, he thought it was large, gay and full of people. I said that Soho Square seemed to have the quality of an erect exhilarated penis, Euston Square of a deflated one. Mr. J. said there was always someone or something preventing one from doing the reasonable logical thing, e.g. gates. He did not know this. He assumed it as a fact and then reasoned logically from that premise. He did the same thing in sessions. He stated something as a fact and then behaved as if it were, e.g. 'my mind is a complete blank.' I reminded him of Janet; how he had defined her in a certain way and then had gone on from there. It had taken months to make him look at the facts. Facts were dense and solid. When he could realise that a feeling was only a feeling and not a fact, he had started to breathe. When he breathed, he came alive. When he did not breathe, he was drowning. He felt his moods were changed from outside but in fact they were changed by his breathing.

Mr. J. now spoke about Janet. He had felt active and stimulated when he was trying to get her to a psychiatrist and to marry him. I said he felt it less dangerous to help someone else than to help himself. Mr. J. now reverted to the gates. They were the straightest road to the station. I said that he felt that the gates were his father's prohibition about going straight to mother. Father's tyrannical behaviour made it difficult to accept his prohibition even when it was necessary. The rubbish at the gate was his rubbish, all the muck he had heaped on father's prohibition. When he had cleaned it up he would see the truth. Then he would feel able to go another way to his own girl. At present he felt locked in silent battle with his father. He would recognise a just father, when his father would recognise a beloved son.

In these sessions Mr. J. is in a phase of recovery. It has probably occurred relatively early in treatment (after 2 years)

because his actual breakdowns have already deeply cracked his defensive wall. His depression is experienced concretely like a sack of wet coal on his back. As insight breaks through, almost like the sun through fog, the coal dries out and catches fire in the bed of blazing geraniums which symbolise his blazing anger. Insensate rage now becomes sensate and people (as passers-by) can walk in his world to be hated. Now the eccentric tramp appears, a single person ushering in personal memories of eccentricity. Blazing anger turns to glowing excitement in the advent of the woman friend who, albeit eccentric, is acceptable in society and can defend herself aggressively with words unlike the alienated tramp. The meeting rouses him to personal life and he comes alive in the next session from his deathlike state. He has a continuous identity against which he can discriminate different moods and different places. He can also discriminate fact from feeling. Finally he can state his anger over the incest tabu although in archaic and symbolical terms. Here at least are gates shut by someone and not a barrier of impenetrable mountains.

* * * *

With the aid of two cases I have sought to use the concept of characteristic transference to focus attention on an aspect of resistance. The type of patient and the type of material will, I hope, be recognisable to every experienced analyst. Such material could be and has been discussed in terms of many other psychoanalytical concepts such as acting out, symbolisation and defence. I have chosen a transference concept because I am concerned with the problem as one of therapeutic change in a diadic relationship.

In each of these cases, and I could have cited many more from ten years of practice, the transference was characterised by a scotoma with respect to the analyst as a person. Instead of a personal transference changing as repression yielded to interpretation, there was a characteristic tranference attitude which implicity defined the analyst in an unvarying and unreal role. This attitude might lift temporarily from time to time but it then returned unmodified. Progress in the treatment was marked by an improvement in the ability to associate freely and went hand in hand with an increasing ability to see and treat the analyst as a person in a functional role.

Inability to recognise a "person" has certain specific effects: —

1. Behaviour towards persons has to be generalised and formalised.

2. All the effect and all the energy that would normally be absorbed in personal relationships is transferred to and bound

in relationships to "things" and in non-personal acts which thereby acquire an unconscious symbolic quality.

3. All acts that would perfectly be performed in the personal relationship have to be performed symbolically either with other people, for example homosexual acts, or with the whole environment—suicidal acts, or within the body—psychosomatic acts. Symbols act as condensers for energy but are themselves maintained only by an expenditure of energy. When a symbolic and general act can become personal and particular, energy is released in a multiplicity of movements expressing personal relationship. Energy is then transformed and liberated in precisely the same way as it is by a new concept such as the wheel. Energy that was static becomes dynamic. Logically and historically, however, new awareness of the person precedes the formulation of new ideas about the external world, which we recognise in analysis when we discourage patients from making major changes in their way of life until the lifting of repression has gone a long way. The extremes of resistance to awareness can be seen as psychosis and "character". Each is a flight from the awareness of personal responsibility at which paranoid fear strikes. The psychotic defence offers us any life we choose provided it is not real; the characteristic defence offers us any life we choose provided it is not our own.

THE SCHIZOID PROBLEM

Comments on the work of D. W. Winnicott, H. Guntrip and R. D. Laing. By C. Edward Barker and David Schmidt.

INTRODUCTION

The advance in our understanding of the schizoid problem during the last three decades owes much to the work of three men; Winnicott, Guntrip and Laing. Each has approached the problem from a singularly diverse background; each has worked independently, but their paths have converged in such a way that at times they appear to be speaking with one voice.

Winnicott came into psychoanalysis via paediatrics and, after receiving instruction in case supervision from Melanie Klein, has conducted both child and adult analyses[8]. Guntrip on the other hand, proceeded to research in psychotherapy from theological and social studies and became the principle exponent of W. R. D. Fairbairn's revisions of Freudian theory[2]. He has extended Fairbairn's work. Laing, the most independent spirit of the three has been deeply motivated by Existentialist philosophy, the springboard of his work on the schizoid state and the psychoses. Laing questioned the principles of psychotherapy by showing sceptism concerning psychopathology. He says "By the nature of its basic approach it precludes the possibility of understanding a patient's disorganization... The very existence of psychopathology perpetuates the very dualism that most psychopathologists wish to avoid[5]. Yet he quotes Freud appreciatively and his insights are far reaching and have much in common with Winnicott and Guntrip. It is the aim of this brief study to examine how these very individual contributions converge, where they differ, and what their work indicates for the future of psychotherapy.

A study of the problems of depression and the theory of object relations in the 1930's led, a decade later to the still earlier problems of schizoid reactions. Fairbairn's paper (1940) on schizoid factors in the personality triggered off fresh interest in the schizoid dilemma, fostered as it was by the movement away from *the psychology of impulse* toward a true *ego psychology*. "It is clear that psychodynamic research has been pushing us back inexorably to the absolute beginnings, the very start of human personality... We have seen how, even since the 1920's, when Freud began to formulate the emerging concepts of his most important theoretical advance, an ever-widening research into ego-psychology, into the deepest depths of the unconscious and the earliest stages of infantile growth has been becoming the outstanding feature of psychoanalysis."[4]

The *depressive* reaction represents *love made angry,* the problem of hate, involving fear that it will destroy the person one needs for survival, turns to guilt and hence to depression. The *schizoid* reaction on the other hand comes from the earlier pre-ambivalent state of the infant where needy and frustrated love becomes so all-devouring that the fear is not that *hate* will destroy, but that love is destructive. This is a much more serious dilemma and the baby's increasing hunger is felt to be so dangerous that he withdraws into indifference and futlity. When love-hunger to devour and incorporate is to intense as to threaten destruction of the love object, it turns backward into indifference. This is the schizoid reaction. "The chronic dilemma in which the schizoid individual is placed, namely that he can neither be in a relationship with another person nor out of it, without in various ways risking the loss of both his object and himself, is due to the fact that he has not yet outgrown the particular kind of dependence on love-objects that is characteristic of infancy. This has two different but clearly related aspects: identification and a wish to incorporate. Identification is passive, incorporation is active. Identification can feel like being swallowed up in another person, incorporation is the wish to swallow the object into oneself. Identification suggests regression to a womb state, and incorporative urges belong to the post-natal oral infant at the breast[4]."

The True and False Self

It is surprising that the concept of a true and false self found no significant place in psychoanalytical literature until the emergence of ego-psychology and it has been coincidental with recent researches into the schizoid problem. This aspect has filled a hiatus in analytic theory and has become of great importance in dealing with severely disturbed patients.

Winnicott approaches the phenomenon of the true and false self by his study of the effects of impingement on the nascent ego of a young infant. He conceives of the false self as the result of "a failure in the primary narcissistic state to evolve an individual . . . who develops an extension of the shell rather than the core, and as an extension of the impinging environment. What there is felt of a core is hidden away and is difficult to find even in the most far-reaching analysis. The individual *exists by not being found.* The true self is hidden and what we have to deal with clinically is the complex false self whose function is to keep this true self hidden[8]." In 1958 Winnicott showed that an infant's capacity to be alone can only develop while someone else is present. This benign state he calls ego-relatedness as distinct from *id-relationship.* When there is a *good-enough-*

mother by the identification of the mother with her infant through maternal pre-occupation, the baby is able to build up a belief in a benign environment. "When the ego-immaturity is naturally balanced by ego support from the mother, in course of time the individual introjects the ego supportive mother[9]." In such circumstances "the true self quickly develops complexity and relates to external reality, but if interrupted, suffers trauma and rigorous compliance[9]." "When mother's adaptation is not good enough at the start, the infant might be expected to die physically because cathexis of external objects is not initiated. The infant remains isolated, he lives, but lives falsely... the infant gets seduced into a compliance, and a compliant false self reacts to environmental demands... Through the false self the infant builds up a false set of relationships[9]." Winnicott refers to a patient who was always looking for her true self but who refers to her false self as the *caretaker-self*[9]. He emphasises that only as we can get through the false self does an analysis begin to be real. "When I said (to a patient) that I recognised his non-existence *he felt he had been communicated with for the first time*[9]."

The false self is defensive to hide and protect the true self. As a defensive function, the false self in extreme cases sets up as real. In less extreme situations the false self defends the potential and secret true self. More towards health the false self searches for condictions which will make it possible for the true self to come into its own. In health the false self signifies "the whole organization of the polite and mannered social attitude[9]."

In intellectuals there is often a disociation between intellectual activity and psychosomatic existence "—the false self being a defensive cover of a weak ego in great distress[9]."

Guntrip's approach is, of course an extension of Fairbairn's treatise on "Endo-psychic structure considered in terms of object relationships[2]." He believes that Fairbairn's basing of the whole of psychopathology on the schizoid position involves one further extension of his endo-psychic structural scheme, namely, the splitting of the libidinal ego under internal persecution into an *oral sado-masochistic* libidinal ego which remains tied to the internal bad-object world and a *regressed libidinal ego* which retires deep into the innermost recesses of the psyche and which can remain out of reach for a lifetime. This says Guntrip "is Winnicott's 'true self', not, however, 'frozen' or 'put in cold storage' till is can obtain a second chance to be reborn. It is in very warm storage and, though itself hidden, it exercises a powerful backward pull on all the rest of the personality in proportion as pressure fear and anxiety are experienced in real life. It is the true source of all passive and regressive phenomena, exhaustion and fatigue, compulsive sleep, agoraphobic anxieties and the

claustrophobias which are a reaction from the fantasies of a return to the womb and retirement and escapist fantasies and longings in real life. The unremitting struggle to keep going and keep in touch with the object-world is carried on in the rest of the personality. This usually leads to an intense drive to over-activity in real life, and/or all forms of sexual compulsion, genital, perverse and aggressive trends for these are all object-relations activities[3]."

Later, Guntrip reminds us "There are two sides of the schizoid phenomenon: the visible side—the devitalised conscious self tending towards depersonalisation—and the invisible side—a retreat of the vital heart of the psyche to a secret 'safe inside' position which is felt and fantasied as a return to the womb. The cause of psychopathological developments would thus seem to be, not sexual or aggressive instincts, but 'fear and flight' from a bad-object world that the infant is too undeveloped to cope with."

Laing, on the other hand, appears to by-pass psychopathology, as such, and sees the creation of the true and false self simply as the result of profound ontological insecurity. In face of ungovernable conflicts the unstable person experiences himself as "primarily split into a mind and a body". "The self then seeks by being unembodied, to transcend the world and hence to be saved, but a self is liable to develop which feels it is outside of experience and activity. It becomes a vacuum. Everything is there, outside: nothing is here, inside. Moreover, the constant dread of all that is there, of being overwhelmed, is potentiated rather than mitigated by the need to keep the world at bay[5]." "The individual experiences his self as being more or less divorced or detached from his body. The body is felt more as one object among other objects in the world than as the core of the individual's own being. Instead of being the core of his true self, the body is felt as the core of a false self, which a detached, disembodied, 'inner', true self looks on at with tenderness, amusement, or hatred as the case may be[6]." "This detachment of the self means that the self is never revealed directly in the individual's expressions and actions, nor does it experience anything spontaneously or immediately. The self's relationship to the other is always at one remove."[5]

Laing points out that the false self system "exists as the complement of an 'inner' self which is occupied in maintaining its identity and freedom by being transcendent, unembodied, and thus never to be grasped, pin-pointed, trapped, possessed."[5] The false self arises in compliance with the intentions or expectations of the other, or with what are imagined to be the other's intentions or expectations.[5] "The 'inner' secret self hates the characteristics of the false self. It also fears it, because the

assumption of an alien identity is always experienced as a threat to one's own. The self fears being engulfed by the spread of the identification."[5]

It will be noticed that each of the contributors mentioned faces this facet of the schizoid problem from his own individual angle and background. Whether it is that of the paediatrician or that of the exponent of Fairbairn's revised psychopathology, or that of the existentialist philosopher they are never nearer together in their conclusions than when they are discussing the true and false self, though they sometimes employ different terminology. We suspect that in the therapeutic programme that proceeds from this point, they tend to diverge again, but here, they are together.

Therapeutic Regression

Guntrip considers that regression still remains the cinderella of analytic theory, still awkward, still neglected. He comments that Winnicott stands out for the courage with which he has commended regression and has done so much to understand it and give it its proper place in psychotherapy.[3]

Regression conceived as an organised return to early dependence is regarded by both Winnicottt and Guntrip as a necessity of therapy for the suitable schizoid patient. Winnicott's view is that it provides a starting-place, what he calls a *place* from which to operate in order to reach the self. To make this possible, the analyst has to be infinitely adaptable so that the patient may involve himself in what Winnicott calls " this highly painful exposure of his regressed self, waiting as it is, for the hope of new birth ".

Guntrip ascribes the clever resistance of the patient to regression to the fear and hate the patient experiences of his own weakness (a) in face of the necessities of living, and (b) in comparison with other people. The biggest barrier is the fear of exposure which the dependency situation in regression involves.

Early in life the child recognises " it is too frightening to be weak in an unfriendly, menacing world "[4] and he becomes identified with his bad objects which seem strong in comparison with his own weakness and his utter inability to stand up to his external (and subsequently internalised) objects. " The hostility of an anti-libidinal ego to direct dependence on anyone for help, and its hating to admit one's needs, is the most stubborn source of resistance to psychotherapy and of resistance to the psychotherapist. It hates the needy child inside and hates the therapist to whom he desires to turn for help."[4]

The resistance the patient manifests constitutes a further isolation of his true self and the maintenance of his inner world,

involving his identifications with internal objects as a "closed system."[4] This *closed circuit* inner world can only be breached in time as a *good enough* therapeutic relationship develops, allowing the patient to test the analyst's understanding of his problem. Winnicott says the risk run by the patient is that the analyst may "suddenly be unable to believe in the reality and the intensity of the patient's primitive anxiety, a fear of disintegration or of annihilation, or of falling for ever and ever."[9]

Laing for his part, expresses the deepest fears of the ontologically insecure person as being those of engulfment, implosion, petrification and depersonalisation.[5] Guntrip says similarly there are four ultimate psychic dangers: (a) claustrophobic suffocation, (b) schizophrenic disintegration, (c) depressive paralysis, (d) schizoid depersonalisation.

In the schizoid patient "the menaced ego is like a hare hunted by hounds; whichever way it turns it runs into a different danger. If the total self, weakened by a basic regressed ego, takes refuge in good objects it feels claustrophobically suffocated; if it chooses bad objects, it risks schizophrenic disintegration; if it compromises by an ambivalent relationship with an object which is seen as both good and bad, it heads for guilt and depressive paralysis, and if in despair it takes flight from all object-relationships it runs into loss of itself by depersonalisation, by feeling emptied and reduced to nothing by having nothing with which to maintain any living experience. In fact, the only hope lies in seeing through and overcoming the fears of loss of independence in good-object relations and the chance of this is what the psychotherapist offers."[3]

These involvements are such that both therapist and patient should be carefully selected. It is interesting, however, that whereas Winnicott and Guntrip lay such store on therapeutic regression, Laing observes a singular silence. This is of importance as Laing's understanding of the needs of the most deeply disturbed patients is beyond question, and his facility for making communication with the schizophrenic amounts to genius. This may account, to some extent, for Laing's silence on the necessity for regression. We think it is bound up with his own peculiar personality, his philosophy and the fact that for the most part he is dealing not so much with schizoid (borderline) patients as with schizophrenics in whom defences have collapsed.

"Except in the case of chronic schizophrenics" Laing says "I have difficulty in actually discovering the signs and symptoms of psychosis in persons I am myself interviewing."[5] He used to ascribe this to some deficiency whereby he was not clever enough to discern hallucinations and delusions. He found the standard text books did not at all describe the way such patients behaved with him. What is the explanation? Laing's difficulty

in recognising hallucinations and delusions comes from the fact that the inner world is as much a reality to him as the outer world. He has such a sense of empathy and identification with the plight of the schizoid and schizophrenic person that when he begins to speak to them, they sense that he is completely at home in their world.

Regression of the schizoid patient involves the therapist in far-reaching adjustments of technique and emphasis. These adjustments may be grouped under the headings of (i) Relatedness, and (ii) Management. With regard to *relatedness* Laing insists that " It is the relation between persons that is central in theory and in practice " ... psychotherapy must remain an obstinate attempt of two people to recover the wholeness of being human through the relationship between them."[7]

We have to keep in mind that Laing is a living protest against the falsities and artificialities of Western society where people are treated as objects. Laing even quarrels with the term "internal objects" reminding us that we are in communication, not with an internal or external ' object ', but with a living person.[7] He views this kind of relatedness in therapy as the highest quality that Martin Buber speaks of in his book *I and Thou*[1]. Only such communication can validate itself as therapy.

Fairbairn believed too that in the case of schizoid patients a rigid technique was inappropriate. But what is this relatedness trying to do? In Winnicott's words—" What we do in therapy is to attempt to imitate the natural process that characterizes the behaviour of any mother with her own infant."

As Guntrip says " He must see the patient through regression to be mentally nursed to a re-birth of the real self."[4] " Psychotherapy is a progress out of phantasy into reality, a process of transcending the transference."[4] It is clear that at this depth we go beyond the classical analysis in its interpretation of the transference. Indeed, Winnicott emphasises that interpretation during this therapeutic phase can hold up healing and advises therapists not to give more than one interpretation per session.[8]

Winnicott has enunciated two valuable safeguards in this delicate matter of therapeutic relationship and management. (a) Where the analyst has been permitted to reach to the deepest layers of the analysand's personality it is most necessary to avoid interpretations, but rather wait for the patient creatively to discover. " If we wait we become objectively perceived in the patient's own time, but if we fail to behave in a way that is facilitating the patient's analytical process, we suddenly become *not-me* for the patient, and then we know too much, and we are dangerous because we are too nearly in communication with the central still and silent spot of the patient's ego-

organisation." In this connection Winnicott stresses that in these deep analyses it is an important function of the interpretation to establish the *limits* of the analyst's understanding.[9]

(b) Winnicott makes it clear that we make more headway by recognising the patient's *non-existence* than by a long continued working with the patient on the basis of ego-defence mechanisms. It is part of the patient's resistance to collaborate with the analyst in the analysis of defences, " being, so to speak, on the analyst's side in the game ". Recognitions of the patient's *non-existence,* made clear at the right moments, pave the way for communication with the true self. " A patient who had had much futile analysis on the basis of a false self, cooperating vigorously with an analyst who thought this was his whole self, said to me: 'The only time I felt hope was when you told me you could see no hope, and you continued with the analysis' ".[9]

Winnicott would limit this peculiar kind of relatedness to regressed cases requiring management rather than psychoanalysis. But Guntrip feels that " management " and analysis merge into one total process of personal liberation and re-growth.[4] This kind of relatedness involves the therapist in an empathy with the patient that is similar to the identity of a mother with her young infant which makes possible the infant's ego relatedness, thus facilitating the patient's relationship with himself, leading to growth of ego.

In this connection Winnicott's observations on the male and female constituents in a relationship appear to us very important indeed. In a mother/child relationship there is a kind of *bi-sexuality* about the mother's attitude to the infant that Winnicott describes variously in terms of *being* and *doing, passivity* and *action,* the female breast and the male breast. He emphasises that a baby must learn to be in a passive feminine relatedness with the tranquil mother before he can appreciate the more active constituents of his dependent state in which his mother *does* for him. It is in the quiet passive *being* of the mother with her child that the foundations of ego identity are laid. It is to a hitherto unpublished paper by Winnicott that we owe this very important insight concerning the earliest ego regression to this point that relatedness with the therapist can encourage a new growth in ego strength.[4]

Hate plays an important part in the patient's relatedness with the therapist. Winnicott makes clear that in a deprived child (e.g. a child with a broken home or without parents), it is notoriously inadequate to take such a child into one's home and love him. " What happens is that after a while the child so adopted gains hope, and then he starts to test out the environment he has found and to seek proof of his guardian's ability to hate objec-

tively. It seems he can believe in being loved only after reaching being hated".[8] So it occurs in therapeutic regression. One patient said to Guntrip "I had rather hate you than love you. It's safer."[3]

Laing makes a similar point. "To be hated may be feared for other reasons, but to be hated as such is often less disturbing than to be destroyed, as it is felt, through being engulfed by love."[5] Indeed, Laing makes the point that the doctor has to care enough to keep after the patient until he does hate. "If you hate you don't get hurt so much as if you love, but still you can be alive again, not just cold and dead. People mean something to you again."[5] Laing says the patient must never be made to feel guilty for hating and it is clear that the hate and agression is, as it were, a halfIway house towards a love relationship that keeps clear of the dangers of engulfment by love.

Therapeutic regression entails the therapist in breaking the bounds of the techniques employed in classical analysis and where schizoid and other border-line schizophrenic patients are concerned, technique is described in terms of management rather than analysis. The accent is on good enough adaptation by the therapist, Such adaptation is very costly in terms of the therapist's patience and understanding, for the patient must get what he needs without impingement. Winnicott mentions one patient in a severe state of breakdown who developed rheumatoid arthritis, an unconsious aim of getting her family to comply with her. He says "Hope of getting what she needed from analysis brought with it the absolute need for me to be ready for her. At one time I had to be at the front door myself, actually opening the door as the bell rang. It can well be imagined that there was an infinity of play round this detail of management. Sometimes she would telephone me on the way, otherwise not believing I existed at all. The reason why I had to take the trouble to do all this, which was very trying, was that otherwise it was no use seeing her at all; she would come, and talk and go, but would get no feeling of our having met."[8]

In 1963 Winnicott spoke in America of modifications of technique required in helping these deeply disturbed patients. He speaks of the analyst as *holding* the patient, "and this often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced or that is waiting to be experienced."[9] "In treatment of *schizoid* persons, the analyst needs to know all about the interpretations that might be made on the material presented, but he must be able to refrain from being side-tracked into doing this work that is inappropriate

because the main need is for an unclever ego-support or holding. This 'holding', like the task of the mother in infant care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall for ever."[9] "This means giving ego-support in a big way. The analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient. The patient must become highly dependent, even absolutely dependent, and these words are true even when there is a healthy part of the personality that acts all along as an ally of the analyst and in fact tells the analyst how to behave."[9]

Laing's terminology is somewhat different where management is concerned, but all his writings emphasise the need for this close personal communication and relatedness. Laing quotes a formerly catatonic schizophrenic patient as saying "I couldn't be sure that I could feel as though I were your child, and I wasn't sure of myself. The only thing I was sure of was being a catatonic, paranoid and schizophrenic. I had seen that written on my chart. That at least had substance and gave me an identity and personality. (What led you to change?) When I was sure that you would let me feel like your child and that you would care for me lovingly. If you could like the real me, then I could too. I could allow myself just to be me and didn't need a title."[5]

Laing insists that one basic function of therapy is to provide a setting in which as little as possible impedes the patient's capacity to discover his own self. He emphasises that the therapist must not only be adaptable, but must be scrupulously honest in his intention by remaining free from any sort of impingement or prejudicing the patient in favour of the therapist's solution of his difficulty.[6]

Conclusions

1. In the last three decades there has emerged a shift of emphasis from "the psychology of impulse" to ego-psychology, and from the centrality of oedipal conflicts to the overwhelming importance of the more primitive oral situation when the very foundations of ego structure are formed. It seems to us that this is a major break-through and has immense ramifications for psychotherapy. Probably one of the reasons for the doubtful outcome of analyses of patients suffering from psychoneurosis has been the fact that the symptoms presented were defences covering up problems of a schizoid nature, This was indeed Fairbairn's contention and he himself was firmly convinced that the genesis of personality problems was in the first year, not in the fifth.

2. As there is a schizoid element in almost every psycho-

neurosis and particularly in the problems of sexual deviation and anti-social tendencies, it would appear that the near future will see a major acceptance of new terminologies and new techniques.

3. Particularly is this so in the sphere of technique concerning relationship and management. In the matter of management it would appear that the analyst must "play it by ear" and it is only with experience that the therapist is able to cultivate a reliable intuition. Moreover, this kind of therapy makes an altogether greater demand on the therapist, much greater than that experienced in classical analysis at the oedipal level. The schizoid level with its problems of management and relatedness involves the analyst in a greater degree of counter-transference. So much is this the case that Winnicott believes that at the end of the analysis the analysand should be given some understanding of the hate he has evoked at times in the analyst.[8] Involvement at the level of oral hunger is indeed necessary, otherwise the analyst cannot help the patient to grow an ego. The schizoid and psychotic patient requires a *merging* with the analyst which is of a direct and primitive kind.[9] He, "in fact, tells the analyst how to behave".[9] At the same time, unless the analyst can keep objectivity throughout, relationship might turn into confusion. Not all analysts—even the best—are suited for work at this level and further research is needed on the counter-transference where schizoid patients are concerned.

4. *Collusion*—to use Laing's term—is, it would appear to us, one of the biggest dangers. At the oral level there is temptation for the analyst to impinge with inferences of guidance and counsel when such impingement has aetiologically been the very factor that has made infant development of ego impossible. If the patient is to re-discover his ego he must be free from any *a priori* suggestions concerning later stages or the shape his development will take. The greatest need for the schizoid patient is to discover and be his true self, even though that true self is a baby-self. There must be no anticipation, for it is only as the re-discovered ego can emerge in all its immaturity without collusion that any further stage becomes possible.

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PERSPECTIVE

The Concepts of Bion and Klein

When confronted with a mass of experience man has the need to organise this into some sort of conceptual units. He can then go on to manipulate his concepts and use them to make further experiences.

In our study of groups we are attempting to organise our experiences in them. Indeed as a first step to this we attempt to cast away our pre-conceived conceptual systems and return to a naive awareness of the emotions that participation in a group offers to its members. Personal perception is the only method used by both Bion and Melanie Klein in constructing the concepts which they offer. Throughout his book, Bion urges the reader to compare his own experiences with those which Bion has had and to draw his own conclusions from them.

The formation of a conceptual system has several steps to it. The first is the experience of chaos. This is accompanied by emotional pain. The second, the formulation of hypotheses about the experience. The third, the organization of the chaotic system in terms of our hypotheses. As step four, a language to describe the experiences then emerges, Heightened awareness of various facets of the experience in terms of language and hypotheses then become possible. As a further step, our system may now begin to develop ramifications and links to other systems. Finally, our now mature system may cloud our experience of further experiential reality and so the system ossifies and falls into error. It is these processes in which we are presently involved.

Jerome D. Frank says " In order to be able to function at all, everyone must impose an order and regularity on the welter of experiences impinging upon him. To do this, he develops out of his personal experiences a set of more or less implicit assumptions about the nature of the world in which he lives, which enables him to predict the behaviour of others and the outcome of his own actions. The totality of each person's assumptions may be conveniently termed his 'assumptive world' ".

At a later point Frank says " Anything that casts doubt on an established assumption arouses an emotional reaction ". He adds " People select material from the world best suited to meet their assumptive world picture requirement ". And still later on, he says " Assumptive systems are anchored to internalised reference points, for example, an established religion, the sort of group to which the person belongs, his series of theoretical beliefs, and so on ".

He says "Assumptive systems are used as an individual control process. For instance, a psychiatric patient open to emotions which he has not previously experienced feels that he is in fact going mad, i.e., losing control".

Our methods of study, and to a lesser extent the concepts which emerge from them are always a part of the culture of our time. We can therefore, look to another movement which offers a similar philosophical approach, namely to the Existentialist movement.

Macnab says "In the modern Existentialist movement... there has been the continued attempt to find the intelligent balance between objective and subjective processes". Later he adds "The Existentialists emphasise the sympathetic appreciation of human experience". And later still "Man is always man in the world as opposed to man in isolation,.. there is a dialectic relationship between man and the world, not a subject-object one".

R. D. Laing has said that the Existentialist approach is a method of research into human affairs. Macnab goes on to say "The Existentialist approach is psychotherapy... studies in painstaking detail, the subjective states, moods and emotions... in all the Existentialist approach is concerned with a person's mode of being, his being with others, his being in the world".

Later on Macnab says that the unbiased observation of phenomena is our aim and that this also was the aim of Freud. This method he calls phenomenology.

It is worth noting that the Existentialists have been prompted to this method of reviewing experience anew by a feeling of imminent crisis. They feel that mankind is always faced by the possibility of chaos and within this chaos the potentiality of death is always present. Their search for reality in the moment of experience thus takes place against this background of potential disaster and chaos. This postulant of imminent chaos needs to be kept before us in our studies of group life.

PAUL DE BERKER.

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NOTES ON ACTING OUT IN PATIENTS WITH WEAK EGOS

INTRODUCTION

I should like to make some observations arising out of my clinical work about the relationship between a patient's acting out while in therapy and significant disturbances in his ego development. By acting out I have in mind the negative of Freud's definition of acting, namely, motor discharges which bring about an inappropriate alteration of reality (Freud, Coll. Wkrs. XII, p. 221) and take place instead of a communication of transference feelings by words, gestures or facial expressions.

Such an investigation may have been done better elsewhere, but I should like to discuss my personal experience of it in my therapeutic work with patients at a Neurosis Hospital in the South of England.

I found that acting out can occur as an occasional episode with a patient who, by and large, can employ verbal expression of fantasy and symbols to work through his childhood and infancy experiences, i.e. with the neurotic patient. I think it is also likely to occur with patients whose weak ego is defended by a false ego structure which they are able to maintain during supportive psychotherapy; but it will occur most frequently and over a long period of time with people who have a fragmented and hence weak ego. Such a patient, if treated by deep analytical therapy, may be enabled to regress and actually relive the earliest level of his development when he had no word symbols to communicate but only movements and noises. This is, of course, his infancy, the word "infans" implying "not talking". (This reliving of infancy is different from communicating in words, fantasies and dreams, occurrences in, or feelings about, his infancy as it is common in the therapy of neurotic patients.) This reliving will be, to a large extent, an acting out situation for the patient. It can, as far as I can see, arise either after a false ego structure has been analysed and the real fragmented ego has been laid bare (after considerable therapeutic work) or it can be there from the start of therapy and flood the sessions, if the patient's defences have broken down of their own accord and he is overwhelmed by libidinal experiences which his weak ego cannot contain or master.

I will now illustrate with two cases both the short, sporadic occurrence of acting out and the long persistent one which is usually so extremely trying for the patient as well as the therapist. In both cases the patients concerned are still under my treatment.

CASE 1

My first illustration is the case of Mrs. D., who appears to have an insufficiently developed ego, due to severe deprivations in her infancy. Owing to the time limitations in National Health psychotherapy she could, unfortunately, not get nearly enough therapeutic time to have her false ego defences analysed and hence she was not in a position to regress. Consequently, in the course of her therapy, acting out occurred, probably due to insufficient therapeutic holding, always outside sessions, and only sporadically; no fundamental ego repair could take place.

Before describing the acting out as it happened in her case I should like to give briefly a few relevant facts of her early life.

Mrs. D. is a woman of 27 with two illegitimate children and two broken "marriages", only one of them a legitimate one. She herself is the illegitimate child of a mother who had conceived her shortly after having deserted her husband and only son. The mother never got legally married to the patient's father and, when soon after the patient's birth, she was unfaithful to him, he took the baby (patient) away from her and the patient spent her first year of life with various neighbours and relations until she was allowed to settle down with foster parents. She grew fond of them and thought they were her parents when, at 18 months of age, she was brought back to her real parents. This shuttling between parents and foster home went on for several years. It is not surprising that Mrs. D. has not been able to develop a healthy ego, This manifests itself in her inability to make stable relationships as feelings and instinctual needs sweep her into actions, which she often regrets afterwards. Thus, before she came under the care of our Hospital, she had impulsively left the two men whom she had loved and has led a promiscuous life ever since. She also had committed acts of a psychotic nature, like attempting to suffocate her baby boy.

She was in hospital for 14 months and, from the third month onwards, was referred to me for three psychotherapeutic sessions per week. This seemed to have provided sufficient coverage of her weak ego to prevent her from any serious acting out—there was only an occasional getting drunk. This limited therapy was, however, not sufficient for her to let go of her false ego defences and to relive and work through the emotional traumata of her infancy. When Mrs. D. was discharged and thus deprived of the security of the Hospital, her weekly therapeutic sessions, by then reduced to two, were no longer enough to supplement her weak ego and to hold her infantile instinctual urges in check. She did not feel sufficiently held by me to communicate—or indeed to become aware of—the intensity of her longing for a good breast (represented by me), nor had she reached a

position of trusting me enough to risk getting in contact with her destructive rages towards the bad breast (therapist). These feelings were too powerful and too threatening for her weak ego and through projective identification I frequently was felt to be a frightening wrathful person. I think that this is the reason why she was swept into action by her infantile drives outside sessions.

I should like to give two examples of such occurrences.

When I went away on my Christmas holiday, nine months after her discharge from Hospital, she did not express—nor indeed was she aware of—any feelings of abandonment or rage and distress about my absence. But when I returned she told me with an intense feeling of shame that, for the first time in her life, she had offered herself as a prostitute to a man. She excused herself by saying that she had panicked about not having enough money to buy Christmas presents for her children. Although there was some reality in this I took this to mean she had identified with the children, deprived of good things, and the lack of money stood for the absence of the breast. Also during my absence, she was longing for the comfort of physical contact with another body more intensely than while she had felt held by me in sessions. She told me that she had had an irresistible wish to be cuddled and could have gladly done without the actual sexual act. At the same time her destructive rage with me for abandoning her became turned against herself and, inasmuch as I had become a valueless mother-therapist for her, she acted destructively against the mother-woman inside herself by smashing up her values and standards of behaviour. From a chronologically later level of her psyche she also wanted to punish the mother-therapist by destroying her work, namely the sense of personal value that had developed inside the patient as a result of therapy over the past months.

The other acting out experience was even more disastrous and almost fatal for her. It happened some months later, again in connection with a break of therapy due to my holiday, but this time shortly after my return. Again she had not been aware of her hate for me. After two weeks of therapy we had to interrupt once more because her children were then on holiday and she had nobody to leave them with. She had, at that time, a man friend who took a fatherly interest in her and helped her a great deal financially in return for being allowed sexual relations with her. During the children's holidays she had a minor quarrel with him; she could not even remember afterwards what it was about. The next thing she knew, however, was that she woke up out of a deep coma in the Intensive Care Unit of a General Hospital more than 24 hours later. She had swallowed a whole bottle of pills without even knowing what they were. She had not been aware of any suicidal wishes or impulses prior to, or

at the time of this incident, and she was not at all averse to having been brought back to life by medical care. Once more her raging despair of the breast-mother-therapist had not registered and, triggered off by an insignificant quarrel, she was swept into this disastrous action being hardly aware of what she was doing.

Since then there were very occasional isolated incidents of promiscuity, no more suicidal attempts and no more drinking. I take this to mean that Mrs. D. is feeling somewhat more secure in her relationship with me. I should like to quote from the letter she wrote to me during this last summer holiday: "I am managing quite well, I think, because I can see now that any upsets I get are simply because you are away, and therefore make me feel angry and cross because I cannot come to you to help me to cope, but by knowing this the problem is already reduced to half and the one half I can cope with."

After having gone through a very difficult time with her children who had problems of their own (having been separated from mother for quite some time and having experienced the break-up of two marriages) she has now settled down to a reasonably contented life with the children and has recently started a part-time job. Thus it is hoped that, although her ego damage could unfortunately not be repaired fundamentally, she will be less likely to be driven into dramatic acting out.

CASE 2

My second illustration is that of Mrs. P. who, (see Introduction), was already at the onset of therapy, overwhelmed by infantile experiences which were of a psychotic nature as her ego was weak and fragmented. As infantile feelings are always intense and of a total nature (the infant has no shading), and as her pristine infantile ego does not seem to have been covered by her mother's ego, she expressed these experiences in a most dramatic and devastating kind of acting out.

Here are the first few facts about Mrs. P. She is a woman of 37, married with two children. She came to us at a moment in her life when her weak false ego structure began to collapse. This manifested itself in her having uncontrollable rages in which she would scream in public or would throw her little boy on the floor or wildly bang her little girl's head against a door. She was obsessed by a wish to sleep so as to escape the unbearable tensions inside her and she had made several suicide attempts with overdoses and razor blades. A course of ECT, which she had at a Mental Hospital prior to coming to us, had been without results.

Her infancy and childhood could only be reconstructed with the help of the transference as we had no other information than

that her mother stated that she had not wanted a baby and had weaned her from one day to the next when she found herself pregnant with a second child. Mrs. P. herself has practically no memories of her childhood or adolescence.

Mrs. P. has had intensive psychotherapy (5 sessions per week) for 4 years. For the first two years she seemed unable to take in any interpretations and many a session consisted of her lying on the couch in a withdrawn state turned away from me alternating with dramatic and violent acting out, mostly of a destructive kind. Treatment became a tough test of endurance for the patient, the Hospital, and last not least, for me.

Her manner of acting out underwent many changes . I should like to suggest that different phases of her acting out might have been related to the reliving of different levels of her development; but as the psycho-soma is a continuum from birth to adulthood there was, of course, constantly an overlapping of phases and a going forward and backward between them. Her acting out took many forms. It consisted mainly of smashing windows and crockery, of frequent running out of my sessions or out of the hospital, and of innumerable suicidal gestures. The kind of violent acted-out destructivity which she showed in the first year of therapy seemed to express inner events which took place during the earliest pre-ambivalent time of infancy when the baby is not yet aware of the presence of " the other one ", the mother. In this phase Mrs. P.'s destructive despairing rages seemed unrelated to me. In sessions she appeared to be hardly aware of my presence and expressed neither hostile nor friendly feelings towards me; for instance she appeared completely indifferent when I informed her that I was going on holiday. Indeed when I interpreted her smashing windows in terms of wanting to smash me up as representing the bad breast, she vehemently, and I think, quite rightly denied having angry feelings towards me. She turned the full blast of her destructive rage against inanimate objects. This was the time when almost every session ended with a window smashed or the telephone thrown on the floor unless she was forcibly being prevented from doing so by me, or whenever possible, by a nursing member of staff.

This distressed and distressing behaviour made a lot of sense to me when I read in Winnicott's paper (Communicating and not Communicating leading to a Study of certain Opposites; The Maturational Processes and the Facilitating Environment, p. 181): " In the area of development that is prior to the achievement of fusion one must allow for the infant's behaviour that is reactive to failures of the facilitating environment, or of the environment-mother, and this may look like aggression; actually it is distress."

Somewhat later in therapy, when there was more awareness of my presence, these destructive acts seemed to me a manifestation of what Klein calls the paranoid-schizoid position, when persecutory anxiety is at its height. In a person, whose fragmentary ego nucleus was insufficiently supported by the mother's ego in infancy—as must have been the case with this patient—persecutory anxiety becomes so intense and unbearable that the only relief she knows is destructive acting *out*. These observations were born out by communications which she made to me years later. She said that it was an enormous relief to her when she had smashed a window. Although, by then, she was glad to have stopped smashing which had caused her much terror as it had threatened her stay in the Hospital (our Hospital is not equipped for such disturbed patients and she had to go to an Observation Ward for several weeks when her destructive acting out was at its height); yet, in many ways she regretted not having this " relief " any longer. She finds the present state of feeling the full impact of her rages and persecutory anxiety more painful than the expelling of them by acting out (although it had incurred the physical pain of cutting her fist and arm badly on broken window panes). Her repeated shouting " I must smash something " also seemed to express another defensive manoeuvre against persecutory anxiety, namely the omnipotent control of objects. Breaking a window or some Hospital crockery gave her momentarily the delusion of omnipotence.

Another defence against persecutory anxiety became acted out, namely the defence by denial: she frequently packed her suitcase and intended to run out of the Hospital, saying that she was not ill and not in need of treatment. She could only be prevented from doing this by sheer physical rstraint (to which she succumbed after some struggling). Also many times during this phase of treatment she ran out of sessions. I think this occurred when either her destructive feelings had been projceted into me so that I was felt to be dangerous, or her anxiety was so intense that she tried to deal with it by denying her need for me.

Another indication that her acting out frequently meant reliving events belonging to the paranoid-schizoid position seemed to me the fact that they almost invariably ended with her collapsing on the floor (in the early years of treatment outside my room or in the street, later on inside my room during the session). It was only recently that she could tell me what she experienced during these collapses. She said " I felt I was dying "; she was no longer aware of having a body nor of having any emotions. It seemed to her that her body had burst asunder and she was quite unable to get up for some time because she felt as if she had no arms and legs. Having relived the phantasy

of smashing the breast into bits led to the re-introjected breast making *her* feel all in bits: this brought on the horror of disintegration and depersonalization. Another form of acting out (the term taken in its widest sense) occurred much later in treatment, yet possibly relates to an even earlier event in her life. She had a phase of several weeks, which occurred about nine months ago, when in many sessions after much bodily movement of struggling she would wildly throw herself off the couch and experience a prolonged delay of breathing and hence a terror of suffocating. Remembering Winnicott's paper on Birth Memories, Birth Trauma and Anxiety (Coll. Papers, p. 191) I felt inclined to understand this in terms of reliving a drawn out birth experience in which breathing became delayed and in which she had experienced terror. The fact that the patient always brought this frightening acted-out experience to an end by throwing herself onto the floor, seeking to feel the impact of something hard and safe, suggested to me her need to relive the conclusion of her birth terror which was, presumably, feeling herself firmly held in the arms of a midwife. It took me some weeks to understand this act and when I did and gave her this interpretation on two occasions this particular acting out stopped occurring and has not happened since.

Her frequent craving for feeling her stiff arm and fist penetrating a window pane seemed to me also to express an attempt at re-assuring herself that she was not an impotent castrated male. From an interview which the psychiatrist had with Mrs. P.'s parents (at the beginning of the treatment) as well as from transference feelings towards me and the male psychiatrist, there seemed to be evidence that she grew up in a family where the male members (father and one brother, one year younger than her) were dominating, sadistic and devaluating the female members, her mother and herself; also that her mother had felt weak and impotent due to being a woman. Thus smashing a window was giving Mrs. P. the illusion that she possessed a powerful sadistic penis like father.

Concurrently with her smashing external objects went another kind of acting out which caused the greatest anxiety to the psychiatrist, the nursing staff and in particular, to myself: her innumerable suicidal gestures. They consisted of frequent and quite serious slashings of her wrists with razor blades, trying to set her nightgown alight with burning cigarettes and later on, when she was able to go home for part of every day, turning on the gas oven at home followed by ringing me up, panic-stricken.

Psychodynamically speaking, I think these actions presented a complex picture. There are, of course, numerous motivations of suicidal attempts. As it is, in my view, certainly possible that a

person with a well-developed ego can choose suicide, one cannot consider suicidal gestures during psychological treatment as necessarily constituting acting out due to an ego weakness.

In Mrs. P.'s case, however, it seemed to me that these gestures arose out of having a weak ego. In her case I understand them as communications of transference phenomena which she could not verbalize and, indeed, not experience as feeling in connection with me. Hence she dealt with them by acting out.

I perceived these gestures in terms of information about psychological events of her infancy and childhood in different ways at different times.

Usually, and particularly during the first years of treatment, they occurred when she seemed to have regressed into the pre-ambivalent state of earliest infancy prior to the experience of fusion, or to the time when breast and mouth feel to be one and the same thing for the baby. Thus at times, I understood these attacks on herself as pre-fusion distress (see quotation from Dr. D. W. Winnicott) and, at other times as intensely destructive impulses against the breast, turned against herself. Also seen, from the level of the paranoid-schizoid position, she was too terrified of her destructive wishes for the breast (therapist) to risk feeling them for me and thus turned them against herself. Furthermore, we think that at moments when the baby phantasies that, in its rage, it has destroyed the breast, it feels the terror of being alone and of facing annihilation. Fearing this she tried omnipotently to bring about her own death. Only after about two years of treatment was she able to put this into words. She said then: "I want to die because I feel you will soon stop seeing me; rather than being thrown out and perish I want to remove myself by killing myself."

The fact that she sometimes shouted out "I want to draw blood" and experienced a state reminiscent of ecstasy before she cut her wrists with razor blades or pieces of broken glass (at times during a session!) suggested to me the experience of wanting to castrate herself as punishment for possessing father's sadistic penis (her destructive arm). At other times these violent acts seemed to express the wish to punish me which, at that time, she was not able to verbalize. Not infrequently I understood her fierce self-destructive attacks as expressions of her sadistic super-ego with which she persecuted herself relentlessly. This seemed to have risen out of an internalised predominantly hated breast and is only lately becoming somewhat modified as she has become able to experience me also as a benign and feeding breast.

Much later in treatment, when she could verbalize her hate for me and throw cushions at me shouting "I hate you, I want to kill you" her suicidal gestures had practically ceased to occur.

At other times her acting out consisted in attacking me physically, trying to hit me or push me out of the room. At such times I did not symbolize, but *was* the bad breast or mother, whom she tried to destroy. This, I believe, arose out of magical thinking (another schizoid defence), in which the thought is identified with the external object. One is reminded of the Egyptians of the Middle Kingdom who thought they had destroyed the enemy tribes by having smashed pottery bowls inscribed with the names of these tribes.

Sometimes it appeared as if unmanageable envious impulses drove her into destructive acting out. For instance, I might have made an interpretation which she felt to be true or she might have managed a difficult situation outside sessions better than she had done previously. This made her feel that I had the potency to intervene successfully in her inner world and it reactivated " the angry feeling that another person possesses or enjoys something desirable—the envious impulse being to take it away or to spoil it " (M. Klein, Envy and Gratitude, p. 6), a reliving of the original envy of the breast. In this case it was wishing to spoil my capacity to treat her by making herself worse.

As treatment progressed she conceived me more as a whole person than as the part object of earlier days. In this phase her acts of self-destruction seemed to express her wish to alert and alarm me. Whenever she thought that I considered her to have made some progress she panicked and feared that I might cut down the number of her weekly sessions and she tried to alarm me by acting out. As Winnicott puts it so well (Winnicott: The Maturational Processes and the Facilitating Environment, p. 209): " it can be said that acting out is the alternative to despair ". Sometimes she explained her acting out afterwards by saying " actions speak louder than words ". This made me think that she must have felt as a child that her words were not having an impact on her parents and that she had to take recourse to dramatic actions in order to make an impression on them.

Now we have entered the fifth year of treatment and for the last six months there has not been a single instance of acting out. She is still struggling with defences against severe persecutory anxiety and expresses frequently magic thinking, omnipotent denial of feelings, impulses to run out of my room and occasionally a longing to die. However, she is now able to express all these feelings in words to me and she has not been driven into acting them out. For many months now she has managed to go home every afternoon and cook an evening meal for her family for which she also does the shopping.

These facts, I think, confirm my thesis that acting out is related to a very weak ego. As her ego grows stronger, even

very powerful and painful feelings of infancy can be felt, contained and communicated by words and they begin to be handled by the patient instead of being expelled by acting them out.

R. S. LEDERMANN.

OBITUARIES

DR. R. A. MACDONALD

Dr. Ronald A. Macdonald, a long standing and valued friend of our Association, died of a heart attack on February 26th at the age of seventy-one. He was the youngest son of a Free Church of Scotland minister in Perthshire, who became incapacitated by disseminated sclerosis and died when the boy was only three. He grew up with the ideal image of his father as a generally admired preacher; yet, he had only known him in a wheel-chair. This was probably the main motive for his choosing a medical career.

He volunteered for the Army at the age of eighteen, and served with the Artillery in France during the last year of the first world war. After graduating at Edinburgh University in 1924, he studied biochemistry in London and obtained the D.P.H. in 1927. Later on he worked at the Maida Vale Hospital for Nervous Diseases and began his psycho-analytic training with Ella Sharpe; he became an associate member of the Psycho-analytic Society in 1938, a full member in 1942.

During the last war he stayed on in London as Assistant Director of the Clinic; together with Dr. Gillespie, he helped Dr. Edward Glover to carry on with all the essential clinical work.

Since the war, Macdonald had been devoting his considerable clinical skill to his patients in private practice. He was a man of deep human sympathy and understanding. This, together with his unfailing wit, could be clearly seen in his all too rare contributions to discussion at scientific meetings. For several years he was one of the psycho-analysts who took part in the training for our Association.

It was always both a pleasure and a relief to be able to ask his help with regard to new or experienced patients and to hear his views and advice about them. He combined an unique delicacy and sensitivity about people with a completely scientific appraisal of them, which was wonderfully refreshing and inspiring to work with.

ELLICE ROOKER

We were very sad to hear of the death of Ellice Rooker in May 1970. She was a Founder Member of the Association of Psychotherapists, and also a Member of the Association of Child Psychotherapists.

Ellice was with the Association from its inaugural meeting, and by her vigorous work on the small first Executive Committee, she contributed greatly towards its growth. She will be affection-

ately remembered by all who worked with her then. To begin with, the Committee met, as often as not, in her flat in Marylebone, and it was at that time that she introduced us to Dr. R. A. MacDonald, another of the earliest friends of the Association Later she went to live in the country, but though, at this stage, she resigned from the committee, she came as often as she could to Members' Seminars and Annual General Meetings, and an open invitation was always extended to any of her Association friends to visit her.

Ellice was one of the pioneer non-medical psychotherapists in this country, gaining recognition on her own, well before the establishment of the Association of Psychotherapists, by the sheer quality of her work and the integrity of her character. She will be much missed—as a colleague and as a friend.

A. PATRICIA DE BERKER.

E. L. GRANT WATSON

E. L. Grant-Watson, more generally known as 'Peter' Grant Watson, who died on May 21st, 1970, in his 86th year, was a distinguished Honorary Member of the Association. Of recent years, due to increasing frailty, we had not seen him often, but he retained a lively interest in the Association and kept in touch personally with some members.

He was a man of many parts. At Cambridge, he studied biology, but on the encouragement of Joseph Conrad, he began to write novels, and this line he pursued for some years. However, it did not adequately satisfy his very individual bent which was to find expression in activities that combined his absorption in natural history and his involvement with his fellow beings. He became one of the first of a number of naturalists whose subtle observations of aspects of natural life haye led them to question the scope of Darwinian theory, most particularly in the apparently purposive growth processes of living things. He wrote a number of books, where a meticulous record of natural events is accompanied, though never intrusively, with a discreet invitation to the reader to speculate with him on the metaphysical implications of these marvels. There is no jargon nothing obscure, and we are led swiftly into the intricacies of natural processes as if they were the most natural things in the world, as indeed they are, but as they are rarely so presented. Such works as *Enigmas of Natural History* and *Profitable Wonders* will be remembered, as well as, on a level of really perfect and beautiful lucidity his four illustrated "Ladybird" books for children, on *What to look for,* in *Spring, Summer, Autumn* and *Winter.*

In the last year of his life I was privileged to receive from him the offprints of two of his last articles written for *The British Homoeopathic Journal,* on *The Transformation of the Immature.* In these lovingly detailed studies of the birth and death of the caterpillar, the strange catelepsy of the pupa ,and the emergence of the butterfly, his own special vein of creative speculation emerges as challengingly as ever. To see nature through Peter Grant Watson's eyes is to see it in a new perspective.

It is the task of psychotherapists to discover the significant in disguised form, and it was not surprising that one of his temperament should eventually find his way to this profession. He was drawn to the Jungian discipline, and indeed, carried on a correspondence with Jung for some time. Towards the end of Jung's life, Peter accepted an invitation to go to Zurich and meet Jung and the two thinkers enjoyed some talking together. He practised psychotherapy in Devon and in Hampshire.

Peter Grant Watson remained alert and young in spirit to the end. He finished the book he was working on, and, two days later, slipped quietly away. He was not at all afraid of death, seeing in it another stage in that natural order which he had studied and revered all his days.

A. P. DE BERKER.

DR. D. W. WINNICOTT

The death of Dr. D. W. Winnicott has left a gap in our lives which can never be filled: his strength, his compassion and his insights made him unique and irreplaceable. He once said "I am only of use to people who are 'there' already!" He was loved by many such people, and one can only hope that what he found in them, and enriched, will not be lost.

He was a very generous person. What he discovered, he shared with others, even during the process of discovery. He had a deep respect for other human beings: he met them where he found them, always prepared to enter their reality whatever that might be.

We think of him as a paediatrician, a psychoanalyst, an author. He was, I feel now, above all an artist. Because he was so creative he was also destructive: this destructive element in himself was never denied or split off from the rest of him. Because he could face anything within himself, he was able to face anything in others.

I remember his saying "Immortality is to be quoted by somebody a hundred years hence, without the somebody knowing that he is quoting". If immortality means incorporation, then Winnicott's after-life is assured.

BARBARA DOCKAR-DRYSDALE.

DR. D. W. WINNICOTT

He charted
The darkest depths
Below the troubled sea of consciousness
Whereon we wreck ourselves,
We, the fainthearted.

Holding us,
Waiting and watching for our dawn
The light, gay voice
Built itself into our craft.
Wisdom and courage never to be parted.

PENELOPE BALOGH.

REVIEWS

INTERACTION

Nine Studies edited by Paul de Berker

CAESNER. 40/-.

In this book, under its subtitle *Human Group in Community and Institution,* nine authors report on particular group situations in which they have been involved professionally. In addition in an introductory essay the editor suggests some conceptual framework with which to view the behaviour and experiences of individuals in groups. For this purpose he chooses the concept of role and adds to its essentially sociological use, by showing the extent to which individuals may define and experience themselves in terms of roles. He also illustrates, with examples, how people rely on role inspired images for their experience and definition of each other. He lays stress on the dependence on role experiences and attributions which people commonly feel, and the distress which can ensue when role experiences are lost or radically alter. The illustrations are mainly taken from records of small groups of people convened to explore with the help of a "consultant" their experiences of themselves and each other. These people have participated as an aid to their work in their various professions which in most cases involve them in "helping" roles, i.e., as social workers, doctors, industrial personnel workers, priests, etc. They are in fact people similar in professional involvement to most of the nine authors in the book.

Thus the practical examples given by the editor constitute the first in a series of contributions which have as a common main theme, reports on work carried out in a wide variety of practical group settings. The quality of the contributions varies very widely. In fact the on-going experience of reading the book is in itself not unlike hearing out and reacting to a very varied group of people assembled for an assumed common purpose such as the editor has described. One has to wait to the end to realise that it might not have been fair to the whole enterprise to blame it for the very great differences in quality between individual contributions, and for some repetitiveness. Marked differences in the quality of thought and expression are certainly a feature of this book, although they may be unavoidable when such a variety of experiences is presented between the same covers and broadly speaking in the same spirit.

A list of the authors and settings they describe will give an idea of the book's scope.

This comprises:

Analytic psychotherapy in Group, (milieu not specified) by I. Seglow and H. Kaye;

Community therapy in a N.H.S. hospital unit for treatment of severe social and character disturbance (The Henderson) by M. Sunderland;

Community therapy approaches in three penal institutions: Borstal girls in Holloway Prison by J. Scarlett; a new special men's prison at Blundeston, England, by E. A. Towndrow; and a similar but more clinically orientated prison in Holland by J. A. van Belkum;

Teacher training college courses which have attempted "insight training" by J. W. Tibble;

An industrial management training establishment for Tube Investments' employees by Dr. Guereca;

Some means of communication in a chain of department stores, John Lewis, by I. H. Colquhoun;

Reports from a survey on race relations in a part of Birmingham by R. Moore.

With such a large number of contributions it is not possible to comment on each one individually. The styles and approaches of the authors range through, theoretical exposition, descriptive, textbook instruction, persuasion and somewhat romantic impressionism. Most contributions use direct description to a greater or lesser degree as central, and adopt one or more of the other styles as background or introduction. The contributions which seem most evocative of the implicit spirit of the collection are those where straight description of people, situation and action (or interaction, including verbal) takes precedence, and where conceptualisations and evaluations are clearly made but remain supplementary and tentative. This kind of balance occurs in something like half the contributions. One which seemed to me outstanding in this respect was that by Michael Sunderland on the Henderson Hospital, and its very disturbed and disturbing patients. He does justice in a balanced way to the number of forces at work in the situation he describes and keeps a firm grasp of the difference, from the individual's point of view, between the "inner" and "outer" forces. He shows distinctively, for instance, how the "outer" forces bearing on the individual emanate in turn from other individuals, definable groups (including family), institutions and elements of society at large. Perhaps all the authors attempt the same kind of clarification but to my mind none quite so consistently.

An article which is similarly clarifying of the complexities in a very different situation is that by Dennis Guereca on the Tube Investments Management Training Courses. It is particularly illuminating on how transactions between groups involve mutual prejudice connected with projection of group experienced

anxieties, equivalent, say, to those between functional groupings of people in industry, like management and shop floor. A similar appreciation of these things is expressed in a rather more stilted fashion, perhaps because of translation, by J. A. van Belkum on the Dutch prison which was changed from an orthodox prison asylum to a community treatment centre.

Most of the approaches described in this book which involve discussion in a group setting have evolved from the application of psycho-analytic techniques in small psychotherapeutic groups. Thus the article Therapeutic Groups by I. Seglow and H. Kaye occupies a key position in the book. A great deal of information is skilfully assembled in this article and it gives a background to the work both historically and by reference to a wide range of relevant disciplines. When it comes to describing and illustrating the authors' approach, however, their style to my mind tends to convey an impression that group therapy comprises rather standardised happenings and procedures. This does not quite do justice to the cautious and openly tentative way in which, in my experience, most analytic group therapists approach their work, including no doubt the authors themselves. From some things in this article a potential patient participant could get the, mostly mistaken, impression that his experience in a group would proceed along quite predictable lines, at least from the therapist's point of view. So by the same token might a prospective therapist. The manner of presentation to my mind is rather too certain, not sufficiently tentative to convey as well as some of the other articles the strains experienced by all participants, including therapists or "consultants", in relatively unstructured group situations.

When comparing the different descriptions of settings and transactions I was struck by the possibility that where an attempt was made to face the sheer inescapability of a particular situation an "inner" or an "outer" situation from the individual standpoint, then there seemed to be the most convincing possibility for therapeutic gain. Presumably, that is, it is easier to attend to what is possible when what is not possible ceases to be so preoccupying. The descriptions of prison situations, or near prison situations, in the book seem to highlight this aspect. It also seems that wherever it could in effect be said "we are at this time and in this place unavoidably in it together", then the shared experience seems to have come as near as possible to providing individuals with an alternative to isolation in which to face that which is inescapable in themselves.

I think the evidence cited in the book makes it clear that it is not only the experience itself but the articulation of such experience that is crucial for outcome in any particular setting. It is further apparent that there can be no substitute for individual

understanding and expression as a means of articulation, but that this function of the individual is always the outcome of relatedness in some form.

These are by no means new conclusions but it is one of the chief merits of this book that it offers so much and such varied living material for further thinking about people's experiences in groups.

FRANK ORFORD.

THE BULLRING

A. J. Grainger

PERGAMON PRESS, 1970. CLOTH, £1.75. PAPERBACK, £1.00.

Except in progressive primary schools education has increasingly concerned itself with exams, with subjects, and with an increasingly narrow range of attainments and achievements, It leaves people out. Where it does include human beings and their interaction and co-existence this is often 'taught' and alienated from opportunity for the development of understanding, of self awareness or of other awareness, a potentially powerish and acquisitive "knowing about" is substituted. Another subject.

The quality of learning depends on the quality of the teacher as a person, What the teacher is, his relationship to his colleagues, to his children, to life, are at the heart of moral education. An ancient Chinese adept observed "The right method used by the wrong person works in the wrong way". The main subject a teacher teaches is what he is.

Tony Grainger has sub-titled his book "A classroom Experiment in Moral Education". He has not restricted this to the morals of others, and the account of his work with adolescents reflects the man. His writing has the authority of experience. He has not attempted to change his pupils in an offensive omnipotent way but simply to offer a service, to provide *help* for his own group of children by providing an additional opportunity for learning from experience. 'The declared aim of the Bullring is that the children should study their own behaviour as it occurs it is the teacher's task to *help* them to do this' (my Italics). This is no new cult, no Bible, no instant group takers tool kit. Courageously, since those who can provide this sort of opportunity for others in a helpful way are themselves often the most vulnerable and most exposed, he has done this within a traditional secondary school setting. He observes (page 149) "The responsibility for developing the therapeutic school community must lie, in the first place, with Headmasters, for it is they who must put themselves 'at risk' by creating situations in which their staff will really be free to

speak the truth. It would be surprising if a staff's reaction to their Headmaster in a Study Group did not resemble—and perhaps quite closely—that of the children to the teacher in the Bullring". Usually there is an assumption that the institution is more free to examine the children within it than the children within it to examine the staff and institution. It is assumed that the staff are slightly protected as "beyond reproach". Breaking away from this tradition will always and everywhere create intense anxiety and sometimes cruel lashbacks.

Derek Miller commented in his book 'The Age Between' on the problem of the adolescent and the adult in a teaching institution where there is an attempt to talk about human interaction or introduce communication in the absence of mutually helpful relationships. Adults are regarded with intense suspicion. Only when the overall environment is related to the needs of its charges does authority exist and are staff secure in roles ("As those in authority, not one of the scribes"), Unless the teacher has power to reform the institution the adolescent feels cheated "any faith in authority adults which may have been developed is dissipated!" and he goes on—"If an attempt at reform is made the institution may, with many rationalisations, try to get rid of the person who tries to discredit it!" Either this was an exceptional school, or it got rid of T. Grainger or it integrated this experience and it influenced the whole radically. I wonder what did happen?

Grainger approached this with sensitivity and with deep concern for the feelings and anxieties of his colleagues, but he has not, as so many have done, shirked the isolation and the loneliness that must go with innovation and change.

I myself believed that the temptation to impose the 'cult' of 'group dynamics' on others or to 'use' groups and interpretation of group processes in a powerish and unconscious way, is considerable. Tony Grainger has, I know, prepared himself through considerable training, and training which has not left himself out, as the instrument of change. He writes "Interpreting a group's behaviour is an art supported by a science, based on the objectivity of feeling judgements and refined through experience".

The Bullring is the most clearly written account I know of an "insider" with direct responsibility within the framework of his own setting as a teacher writing about Study Group work. He writes, directly and authoritatively about his own experience without drumming up the latest fashion, without creating a new empire, without pushing a new prestige technocratic expertise—simply attempting to provide increased opportunity to help children to learn about themselves and others. This is, therefore, not a "success" story. It gains authority from that.

The book is mainly a description of a series of free discussion groups. They include therefore what is usually taboo, an open examination of the transference phenomena (and the counter-transference) between teacher and class.

My own experience in trying to create opportunity for open discussion in small groups within an Approved School in process of conversion to a therapeutic community is of the incredible inhibition of *any* communication. A well preserved apartheid is maintained and a tacit and unexamined agreement that there is a huge taboo area where the teacher must not listen and the children must not speak. I was delighted to find how freely these children seemed to communicate in Tony Grainger's school and this must, to a considerable extent, reflect the climate of the place and their own bunchy and lively ego functioning. In this sense it must be different from many schools. We, in working with the educationally rejected, have found we have had to reduce groups to two's and three's just to get any communication going at all.

This accout of this sort of work rings true. It has none of the flavour of the fascination, over-valuation, or "involvement" in group dynamics and group work. It was, I think, a sad Tony Hancock who said he had a terrible nightmare—"There were no people, just groups".

These were groups with egos bursting out all over the place and ego boundaries noticeably in evidence. Nevertheless all adolescents at the moment have such a difficult time in transition to quasi adulthood and in male and female identification. The missing adult "models", sometimes the blurring of the mother's role, and the woman's role in society, all too often the complete blurring and confusion in the father's role across the boundary of the family and into society, are critical. The dearth of models of adults with authority (the opposite of the woolly permissive adult which is the last thing the adolescent needs) and the opportunity to examine authority, are the central problems of young people between 14 and 21. It was a hypothesis of the Newsome Report, and certainly a hypothesis of the "Young Adult Resource Project" sponsored by Christian Teamwork Institute of Education that "In order to understand the nature of authority it is necessary to learn to recognise the structures of society, roles, boundaries and resources. For young people this can best be done in the first place in structures such as those at work or at school rather than in the family". For this to happen the adults have to be sure of their own roles in society and within the structures in which they work and, in an enterprise where needs are being met, it is the teacher who is in one of the best positions, I feel, to communicate this. To do this, however, he must not only himself be prepared to create situations as Tony Grainger has

done, where adolescents can learn from experience of relationship with those in authority but the institution itself must create situations in which the staff do likewise. He has to be brave enough to shut up and listen rather than put in a barrage of words and explanations at the first drop of an obscenity.

Education is all too often the means by which adolescents are " processed " into a society—however shabby that society may be. I suppose up to a point it must be so. It must aim perhaps at reducing the ego functions of all but a few, and goodness knows what would happen if it set about to provide opportunity for the development of ego functioning in the majority. A few manage to retain some integrity to themselves despite some of the worst ravages of this anti-life process and are themselves strengthened by this very experience. Many, however, are badly harmed. Neither the authoritarian nor the woolly permissive teacher provides opportunity for ego functioning. The adolescent must test the adult environment to destruction for validity. Many adults, at the moment, are either partially annihilated or themselves so confused and uncertain that they collapse under the strain of this essential testing. Where the adolescent destroys he achieves a miserable victory which leaves him totally deprived.

I am left wondering how we can even begin to liberalise our schools. Probably it is, as it has always been, and will always be, an individual here and there, a Tony Grainger or whoever, prepared to work if necessary without any " support " whatsoever which could possible begin to effect change and go on working despite set back after bloody set back!

In a recent article in New Society " How School Leavers Rate Teachers " Joan Maizels made some lucid observations. (These were deeply resented by teachers in subsequent correspondence!) She wrote " If schools are to train the child for his ' place ' in society, he must learn to adapt to a school situation already prepared and defined for him. He will then more easily accept a social or economic role which he himself will have played little or no part in creating. The school is the way that pre-formed definitions of situations are imposed on the young. Its usefulness for the social system would be impaired if the young were encouraged to determine for themselves what their future roles should be ".

And we were all trained as teachers under an Education Act the foundation of which is " child centred education "! She ends her article " So long as the selective function is pre-eminent in the educational system and the requirement of the labour market that systems chief concern, neither children nor teachers will be liberated from the inhibitions that the social machinery of school imposes on free and creative inter-change between them ".

Tony Grainger's book is, to say the least, timely and important. It is also very well written. It is no description of "technique" separated from person. Throughout thrusts through the continuous, lively and pro-life interaction between person and person and the relationship between them. At the same time ego and role boundaries are not hopelessly blurred. The professional role and the specific and limited task and objective is kept in the foreground and is not confused.

I hope it will be widely read and the implications understood. Anything that can help teachers to become more available for understanding and their pupils to have the opportunity for developing this consciousness and understanding and to see their lives in some context of meaning, of some inner and personal meaning, even in the rat race, is so vitally important.

I met Tony Grainger many years ago when we both attended two courses arranged by the Tavistock Institute of Human Relations and Leicester University. Many other sources of inspiration and help are acknowledged by him, but that to the Tavistock Institute and its staff is made very clear. The bibliography is useful and comprehensive. It might have helped a little had it been indexed.

Understanding and learning in this particular field can only develop from personal experience, it is "better felt than telt", but this book is told well and clarifies rather than instructs, It was the plea of the small child in the formal primary school "I think I could understand if only they didn't explain so". There is no attempt to prove a theory, it is not produced within an over-valued functionally autonomous theoretical framework, but simply describes what happened by a teacher as he learnt.

I would very much like to know what happened later. His last sentence is "The Bullring is a failure but it ought to continue". Has it, and did it, and what has happened since?

RICHARD BALBERNIE.

THERAPY IN CHILD CARE

Barbara Dockar Drysdale

PAPERS ON RESIDENTIAL WORK, VOL. 3. LONGMAN GREEN & CO.

This book covers Mrs. Dockar Drysdale's work from the beginning of her ventures, which led to the creation of the well known school for Malajusted Children, The Mulberry Bush, to the present time.

The collection of papers can be roughly divided into two: those descriptive of the setting itself, the training and helping of staff and papers on the children themselves. They are not sharply divided and one can see two parallel themes running

through it; the understanding of the children and their problems and the understanding and dealing with staff in order to integrate the treatment. It is possible to envisage the enormous difficulties that had to be surmounted and the organic process of the growth of the work as well as the acceptance and gradual spread of its contribution.

The book is well laid out making it possible to follow chronologically the development of the author's thinking; in some way it is like an autobiography. Each chapter is prefaced by a short explanatory note of when and why that particular paper was written; the author exposes and subsequently reviews her thinking, sometimes in a critical way, stating how she feels at the time of publication. It is thus easy to see the growth of understanding and subsequent conceptualisation, which have made Mrs. Dockar Drysdale's work so valuable to the field of Residential Care.

The papers on Children, such as "Residential Treatment of Frozen Children", "Communication as a technique in treating Disturbed Children" and "The provision of primary experience in a therapeutic school" I found particularly valuable. Although the author emphasizes that these concepts are strictly related to Residential Care, I find them applicable to not only children, but to adults also and very helpful in elucidating the sometimes difficult diagnosis of personality disorders.

As the book progresses, the concepts become clearer and more lucid. One can see that the reason why much of the work is done successfully is because of a total internal accessibility by the author and members of the staff. I mean by this an immediate understanding of symbolic communication at all levels and a capacity to respond to it on the spot, as well as an understanding of transference-counter transference that occurs with an amazing rapidity in situations where the variance of the setting and the role of the people involved is also in continuous shift.

It certainly stimulates thinking about all those patients who do not and can not respond to orthodox treatment, where perhaps some investigation into a possible adaptation of Mrs. Dockar Drysdale's concepts might be extremely valuable.

The frozen child . . . the archipelago child . . . the false self, etc., are clearly described and interpreted in terms of their attitudes, responses and the responses they elicit from those who deal with them. One realises then how effectively imagination and flexibility coupled with knowledge of oneself can be used in situations which seemed utterly hopeless. The contribution of this series of papers reaches beyond the field of child care. I would certainly recommend this book to social workers and therapists of children and adults.

EUGENIA HUNEEUS.

I'M GLAD I WAS ANALYSED

Petronella Fox

PERGAMON PRESS, 1968. £1.5.

We often meet prospective patients who are unsure about embarking on a course of psychotherapy or psychoanalysis; neither popular books and films, at one extreme, nor erudite texts, at the other, can convey to them a true image of *experience*. Here is a book which can be recommended to such people. Lively, readable and extremely personal, it is based both on the author's own training analysis and on her many years of practice in analysing others. Part I, starting with a chapter entitled, " Therapists begin by being patients ", describes with courage and honesty the author's journey through defences, despair and anger to insights and a measure of peace. In Part II a more systematic study applies psychotherapeutic processes to world-wide agression and hatred; in so far as each individual resolves his own problems he serves the whole community. There is an interesting final chapter on religion and phantasy.

The school of thought is Kleinian, but a vocabulary of terms and a chart summarising types of illness with their corresponding ways to health help to clarify otherwise difficult concepts for the layman. This book fills a gap by explaining to the general public in a human and constructive way a process which, owing to ignorance, has too often been ridiculed or else feared as an esoteric mystique.

MARY SWAINSON.

FREUD

A biographical introduction by Penelope Balogh

(Leaders of Modern Thought Series)

STUDIO VISTA. £1.80. PAPERBACK 75p.

This book was published while this bulletin was in printing, and time only allows a notice of it.

A general foreword to the Series of Modern Thought says that it is " primarily designed for senior school and university students, who are studying sociology, history, economics, anthropology and medicine, yet whose work at some time crosses the disciplines of psychology, literature and philosophy."

In his review in the *Observer* of May 16th, Geoffrey Gorer states that Penelope Balogh's book fulfils this purpose very adequately. He writes " Lady Balogh's short book has distilled Ernest Jones' three-volume biography (and some lesser works) very skilfully to present a convincing and sympathetic picture of a lonely genius."

EDITORIAL

This is the last number of our Bulletin that I shall be editing and possibly the last to be published in this form. The time has come to invite new people to participate in publishing for the Association and I hope that anyone, who is interested in this work, will write to me so that a new Editorial Committee can be formed.

Many members find it difficult to write about their ideas and their work, I believe, because we are engaged in a discipline in which we learn a little more with every patient or group we work with. This is very good, but it makes it difficult for busy psychotherapists to write about what they are doing and this may be why we have had to wait a long time for enough material to publish. That some of our members are fully capable of a high standard of exposition is proved by the fact that the four books reviewed are all by members of the Association.

We delayed publication for some months so that the report from the working party on Psychotherapy; its definition and training could be included. This will give those interested a clear idea of what our Association means by psychotherapy.

ROWENA PHILLIPS.

NOTICE

MSS. offered for publication in the Bulletin of the Association of Psychotherapists should be sent to the Editor, 36 Queen Anne Street, W.1. Two copies should be sent, typed in double spacing and with wide margins and one copy retained by the author. All contributions are submitted to the Editorial Committee.

All members receive a free copy of the Bulletin and contributors of articles twelve free copies. Further copies can be obtained from the Editor, price 50p at meetings, or 55p by post.

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