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Editorial Notice

We would like to take this opportunity of thanking Midge Stumpfl for her successful editorship of this journal since 1989 and for her accomplished liaison work behind-the-scenes in making her mark on both shape and content.

We would also like to thank Ruth Berkowitz for her successful role as Book Review editor which has now been passed to John Clay.

The Editorial Board

MEMORIES IN THE MAKING : THE EXPERIENCE OF MOVING FROM FOSTERING TO ADOPTION FOR A FIVE YEAR OLD BOY

MONICA LANYADO

Psychotherapeutic work with children is concerned with the future. It is an attempt in the present to avert long-term emotional disturbance, mental illness and anti-social behaviour. These preventative efforts, together with the wish to help children who are emotionally vulnerable and behaviourally disturbed, can be viewed as an intensely twentieth century concern. Whilst there were great social reformers in the past who fought against the evils of exploitation and neglect of children - particularly during the Victorian period - the interest in the emotional development of the individual child in society, has only truly started to gather momentum in the second half of this century.

This paper focuses on thoughts about the narrative and memories that a five year old patient, in therapy for nine months, developed as he went through the experience of moving from the long-term foster-home, in which he was settled but couldn't stay, to the adoptive home which offered him long-term security. I found myself wondering how therapy effected the way in which these crucial events in his life were worked through and remembered. How important was it that I worked within the complicated network of carers and social workers which surrounded the child, in an attempt to minimise potentially re-traumatising or negative experiences at this delicate stage in his life, and facilitate positive experiences? Would therapy enhance the coherency of his continually re-written narrative of this painful, exciting and bewildering time of his life, and if so, in what way?

Freud awakened the world to the importance of childhood in the development of personality in health and illness, and Melanie Klein and Anna Freud took this insight further into the direct treatment of children - from the first signs of verbal communication through to adolescence and early adulthood. Over the past twenty or so years, treatment of babies in their families and parent-infant psychotherapy has developed rapidly (Fraiberg (1980), Daws (1989), Hopkins (1992)) as more has been understood about the family dynamics which surround relationship problems, and sleep and feeding difficulties during the first year of life.

These therapeutic interventions in the ongoing development and daily life of children, raise intriguing questions for child psychotherapists, such as 'What will my patient be like as an adult, and as a parent?', 'When can my

patient be considered to be safely on a healthy developmental road?', 'Has therapy affected his or her life in a way which will lead to greater happiness?', and often, when saying goodbye to a child at the end of therapy - 'How will the experience of therapy and the life events surrounding it be remembered and integrated into the emerging story of the child's life?' Whilst adult therapists look backwards in time into the childhood and adolescence of their patient in their attempts to understand the present, child therapists often find themselves projecting themselves into the future and trying to imagine what will remain of the present.

What immediately becomes apparent, when thinking about these 'memories in the making' for young children, is the many different narratives that exist for the *same external event.* Each of the adults caring for the child will have their own particular narrative, and these narratives may well differ significantly from that of the child. Which narrative is the 'true' memory? To what extent is the child's memory vulnerable to being overwritten by the adult narrative? When is history being re-written in a sinister revisionist way (such as with Holocaust denial literature) and when is history being re-written on the basis of increased maturity leading to greater understanding and coherency of life experience? This question of personal narrative, the way in which each of us tells our life story to ourselves, has been highlighted by researchers as being a key issue in determining the quality of internal and external relationships made as an adult, as influenced by early childhood relationships.

In recent years there has been a rapid growth of research and theory developed from Bowlby's original ideas about attachment, separation and loss. One of the most interesting research and therapeutic tools to emerge from this has been the Adult Attachment Interview as developed by Main, Kaplan and Cassidy (1985). This searching, semi-structured interview, thoroughly explores the quality of the adult's earliest relationships, inviting memories of events to illustrate the adult's narrative of childhood relationships. One of the most interesting outcomes of this sophisticated, quantitative and qualitative research, has related to the degree of coherency with which the adult tells his or her story. This has thrown some light on the everyday observation that unhappy childhood experience and relationships, particularly experiences of loss of, or separation from, loved ones does not automatically lead to adult difficulty in forming and maintaining relationships. Main, Kaplan and Cassidy found that those adults who had been able to keep thinking about and working through their difficult childhood, who struggled to remain reasonably in touch with their ambivalent and painful feelings and tried to make some sense of them were emotionally healthier, in the broadest sense, than those who had been unable to undergo these painful processes. This could be seen in the coherency of the way they spoke about their lives. In

contrast, those adults who had been unable to process their painful childhood experiences of loss and separation told very contradictory stories of their lives, often idealising their relationships with their parents whilst giving matter-of-fact memories of terrible childhood experience, the meaning of which they tended to minimise or deny, particularly regarding feelings of rejection or lack of love.

The ability to process painful experience in childhood is dependent to a considerable extent on the presence of an adult who can bear to be in touch with the full range of the child's experience - happy and sad. In Bion's terms, this adult provides the containing function that is so necessary in facilitating the modulation of psychic pain and excitement. Possibly the well-adjusted adults with poor childhood experience in Main, Kaplan and Cassidy's research, had had the good fortune to meet someone else as their life moved on who could provide this containing function. Maybe others were better able through their constitutional resilience to bear the psychic pain engendered by their ruminations and thoughts with only a small amount of external support and containment.

The process of calling up memories, *re*-membering, holds the possibility of putting together the constituent parts of the memory in a different way. There is also the possibility of new understanding in the light of experience and maturity, leading to the re-writing of the personal narrative of emotionally significant experiences and relationships in a more coherent way throughout life.

The work that I am about to describe with 'Sammy', has been carefully disguised to protect his and his carers' confidentiality. Because of this, very few details that might help to identify him or his carers, have been given. I am grateful to the local authority whose care 'Sammy' was in for their permission to describe this phase of his therapy.

The patient, Sammy, was neglected by his fourteen year old mother to the extent that he had to be taken into Care following many attempts by Social Services to support the mother and her extended family. Sammy's natural mother was not physically abusive to her child, but she was totally unreliable and unable to provide the constancy of care that a baby and young child need. In another time and place, this young mother and baby could have received parent-infant psychotherapy which may have helped them. The mother's story no doubt was also painful to tell (Fraiberg 1980). However, in the absence of treatment to help her as a mother, Sammy was taken into Care and fostered with a family. This provided consistent, caring relationships and attention for him in an effort to avoid further damage to his emotional health whilst his mother received social work support. Eventually it became clear that his mother was unable to change sufficiently to have Sammy back, despite several attempts at

reconciliation and Sammy was placed with another foster family who could have him 'long-term', with a possible view to arranging for him to be adopted by a further family if the situation in his family of origin did not improve. He was eighteen months old when he was first taken into Care, three years old when he went to long term fostering, and was five years old when he moved to his adoptive family.

This paper is an attempt to chronicle and understand the emotional tasks that this process from fostering to adoption entailed, with a particular emphasis on trying to hypothesise about how these extraordinary events in this little boy's life may have been remembered by Sammy.

The treatment plan and first phase of treatment

Sammy's referral to me by Social Services was quite explicit about the wish to provide therapy for him to facilitate the move from fostering to adoption. He was felt to be very attached to his first-time foster parents, as they were to him, and his social worker was aware that 'moving on' to the adoptive family that they were looking for, would be a very delicate and important process in his and his foster-parents' lives. Social Services wanted to get this right and to provide as much help as they could during this time, to ensure that the adoption had the best possible chance of succeeding.

Following discussion, it was decided that each therapy session would include some time when I saw the foster-mother and Sammy together, to keep in touch with all the ups and downs of their relationship, and to help them with their feelings about each other as the time for adoption approached. The foster-father and Sammy were also very attached to each other. The fostering social worker saw the foster-parents regularly and this provided the opportunity to include him in the work. This treatment plan worked well in practice and a flexible approach was maintained, in which the foster-mother came into all the sessions at first, and stayed for as long as was felt appropriate each time, depending on current issues. She would then wait for Sammy whilst he had the rest of the session on his own. Interestingly, there was rarely a sense of rivalry or tension between Sammy's needs and his foster-mother's needs, in sharing the session time in this way and the session provided a valuable space in which to help them understand and work through the intense feelings that they had for each other. This became particularly poignant following the introduction of Sammy to his adoptive family - but this is jumping ahead. First I shall briefly describe the main themes of the therapy before the adoptive family were introduced to Sammy.

During the first few months of therapy, Sammy spent a lot of time expressing his longing for his natural mother, whom he no longer had contact with. This

contact had been ended by Social Services when he had been in Care for two years and it was clear, after a number of failed attempts, that Sammy's mother could not provide the parenting that he needed. The contact was ended with an official 'goodbye' meeting. I have learnt through this case to appreciate just how terribly difficult this whole process is of having to make the decisions and then trying to implement them wisely in a young child's life.

At first Sammy clearly felt that he was not allowed to see his mother because the Social Services were horrible and stopped him seeing her. He often asked why he was not allowed to see her, and not surprisingly could not accept that it was because she was not able to look after him. With hindsight, his underlying fantasy may well have been that he had been kidnapped from his natural mother by the Social Services and he constantly anticipated that she would rescue him from their clutches. His play in the early stages of therapy, often centred around offering lots of choices of pretend food to his foster-mother and myself, letting us chose what we wanted, and then telling us that we could not have it. I spoke to him about how this reflected his feeling that he could not have what he most wanted - even though he felt in some measure that his wishes and needs were being taken into account. He could not have his natural mother, plus he knew that he could not stay forever with his foster-parents although he clearly expressed this wish at times, and would be 'moving on' to an adoptive family in due course.

During this phase of the therapy, it was fascinating to see how Sammy became able to express through imaginative play, the feelings and thoughts that filled him. He became very involved in playing 'Peter Pan and Captain Hook' games in which he would frequently play both parts. When he was Captain Hook, he would swashbuckle his way around the room, challenging all comers. At these times, he seemed to be acting out an omnipotent fantasy that he was not a defenceless little boy at the mercy of adult decisions, but was a powerful man who could scare others and put up a real fight. This type of play is very normal for little boys of his age, but was given additional significance because of his extremely vulnerable position, where powerful adults who were not his parents were nevertheless making such vital decisions about his life.

When he was playing the role of Peter Pan he acted out a different aspect of these anxieties and a different solution, in which the little boy part of himself stood up against the powerful adults with courage, and eventually defeated them. I checked out what his personal version of the Peter Pan story was as there was another vital aspect to this well known tale of goodies and baddies that I was not sure if he was aware of - the fact that Peter Pan never wanted to grow up and wanted to remain in the Never-Never land for ever - without a mother. At the end of the story, when Peter Pan could have

left Never-Never land and lived with Wendy and her family, he chose not to. Sammy did know about this side of the story - that Peter Pan and the 'lost boys' boys in his gang were motherless (and fatherless). This story expressed his identification with other 'lost boys' who both longed for a mother and father's love and feared the emotional dependency on, and trust of adults that this required.

This fantasy of Peter Pan followed an obsession with the film *Oliver* which he had watched again and again on video. When I checked out Sammy's version of this film, he spoke about Oliver not having a mummy or daddy and how he was found and adopted by a family in the happy ending of the film.

Sammy's relationship with his foster mother throughout this time was turbulent but playful, and I was impressed by the way in which she was able to be emotionally open with him. She would express her sympathy and tenderness for him as well as her anger and frustration with him. They would often arrive for a session with the foster mother feeling very angry because Sammy had deliberately broken valued possessions of his own and others at home. He would also at times urinate on his bed and on the carpet and conceal his faeces under the bed. This was in addition to becoming argumentative and at times hard to control physically. Usually we were able to make some sense of his difficult behaviour and I would see her 'melt' as she became able to regain her tolerance and sympathy for the unhappy and confused five-year-old boy that she cared for, as opposed to the little monster that he turned into when he was at his worst. Fortunately, Sammy invariably responded positively to this experience of being understood and forgiven by his foster mum and the next session would confirm that they had passed through this latest rough patch, rather than getting stuck in it.

Underlying Sammy's disturbed behaviour were usually intense feelings of being unwanted and unlovable, leading to his feeling angry and retaliatory towards his foster-family, who were the only people available to express all these feelings to in his every day life. In addition, not surprisingly, he was enormously confused in his intense feelings of longing for, and rejection by, his natural mother, foster parents and the fantasised adoptive parents and their families. At times it felt as if he would burst with the intensity of all these powerful conflicting feelings which surged inside him and indeed this was what seemed to happen whenever his behaviour became very disturbed at home. The foster mother had to live with, and survive, Sammy's displaced feelings of rejection and anger from his natural mother, as well as his relevant current feelings of rejection by his foster parents, whom he knew were unable to become his 'forever' parents, however much they cared for him. In addition, whilst he knew that adoptive parents were being sought, waiting for them to be found became increasingly intolerable and unbearable. This was expressed

through repeated 'lost and found' games in his therapy in which Sammy would hide and I had to keep looking for him but to have great difficulty finding him despite the copious clues he gave me about where he was hiding. Thankfully, we were able to increase his sessions to twice a week at this point, six months into his therapy. This helped to contain his feelings and behaviour in fair measure during the introductions to the adoptive family and the transition to living with them which followed.

Throughout this very stressful period for all involved, Sammy was impressively able to express what he was feeling through his play in therapy and with his foster mother. Amazingly, although he had had a far from ideal start at primary school soon after he had started therapy, he managed after a term to settle well in class, attach himself to his teacher and finally start to work. He proved to be a bright little boy, who once he got the hang of it, rapidly started to read and write and produce drawings which expressed a growing core of emotional and educational development, despite the turmoil he was going through. He was rightly proud of his achievements in this area.

In the midst of this painful process, when I also felt unsure of which way to interpret and work with all concerned for the best, I was often reminded of Winnicott's wise words about play:

> *"Put a lot of store on a child's ability to play. If a child is playing there is room for a symptom or two, and if a child is able to enjoy playing, both alone and with other children, there is no very serious trouble afoot'. (Winnicott 1964)*

This became particularly well illustrated by his play and communication in the period leading up to his introduction to his adoptive family, and the difficult transitional period that followed before he moved to his new home.

The transition - meeting the adoptive family and parting from the foster-family

Whilst Sammy was struggling to contain his growing desperation that a new mummy and daddy would never be found for him, the adoption and fostering team had in fact found a suitable family who were passed by the adoption panel. Sammy's foster parents and I knew about this process, but Sammy could not be told as the whole process of how he was to be introduced to his new family needed to be very carefully thought about and managed by all involved. Part of this process involved the foster-parents meeting the adoptive parents and the adoptive parents coming to meet me to talk about the therapeutic process that Sammy was involved with - all of this before Sammy knew that his

new family had been found. Whilst he did not consciously know that this had happened, it is very likely that he detected the excitement and tension that surrounded particularly the meeting between his foster-parents and his adoptive parents. There was a period of several weeks in which Sammy continued to yearn for a new mummy and daddy, whilst all the significant adults in his life knew that they had actually been found, but could not say anything to him about this.

During this time, Sammy would plaintively say to me that he wanted his new mummy and daddy 'now', and that he had been waiting a very long time for them. However, it also became clear that he was frightened of meeting his new mummy and daddy, whoever they were, in case he didn't like them. He harboured fantasies that he would be handed over to complete strangers who would abduct him from the safety and care of his foster home. It became important to acknowledge these fears and talk to him repeatedly about the way in which he would move to his new family when the time was right - that it would be gradual and that he would have time to get used to the idea and to say goodbye to his foster family. It is hard to know how well he could really understand these rational accounts of what were such momentous life events for such a young and understandably confused child.

Sammy used his sessions to work on his feelings in response to what he was being told. He became preoccupied with transitions and started to develop what I came to think of as newly created transitional phenomena and experiences (Winnicott 1971). Initially, he simply took little bits of paper that he had cut out of drawings he had done in the session home with him. Although he knew that I preferred him not to do this, I did not let this develop into a confrontation. I felt that in view of the impending separation from his foster parents that he was so upset and confused about, taking a little 'keepsake' home with him from therapy was possibly helpful to him in dealing with his separations from me. The keepsakes felt like a spontaneous solution that he had found to coping with separation. They were a tangible way of keeping our relationship in his memory during the gaps between sessions.

These 'keepsakes', which he did not need to have every session, may have helped him to develop the idea that possibly there could be something else more alive and amenable to being imbued with a fantasy life that could travel between us - literally between sessions, as well as metaphorically between us as individuals. At the end of a particularly upsetting session, Sammy was desperate to take a green ball from his box of toys home with him. This was very much against my better judgement, but there was such an imperative expressed in his wish to take the ball that I let him do this, as long as he brought it back to the next session - which he agreed to do. It was the imperative nature of his wish to take the ball that changed my mind about letting him do this - and

this was after only a brief disagreement. I then said to him that although I did not normally allow therapy toys to go home, on this occasion I would as I could see it was so important to him, and we would see together what came of this. In other words, I was giving his acquisition of the ball my blessing, rather than letting it feel to him like a theft or a triumph over me. This may have helped the ball to become significant for us. However, immediately after the session I was convinced I had made a mistake in allowing this, and that I would now have to battle with him as he gradually removed more and more toys from his therapy box to his home - a familiar problem for many child therapists. However, throughout the weeks that followed, during which time he was introduced to his adoptive family and left his foster family, the ball came and went from the sessions with Sammy. It was played with and carefully looked after when he had it at his foster-home. Even when he forgot to bring it to the session he always referred to it. It was very clearly neither his nor mine - and this was a paradox that I deliberately maintained when I realised that for Sammy, the ball had acquired the properties of a transitional phenomena. With hindsight it is fascinating to hypothesise about how the green ball may have helped him to cope with the paradoxes of moving from foster to adoptive home, in what has hopefully been a manageable transition, as opposed to a traumatic discontinuity and loss in his life. This will be discussed later in the paper.

In the midst of this, his fifth birthday aroused great confusion and very difficult behaviour in Sammy. His foster mother, knowing that this would be his last birthday with her, went to great lengths to give him a special birthday - but of course could not give him what he wanted most - the return of his idealised natural mother herself and her family as a permanent home, or as the perfect new mummy and daddy. Sammy was very destructive of all the foster mother did and she was very upset and felt deeply rejected by his behaviour. When we talked about this together in therapy, I was able to point out to the foster mother how important it was for Sammy to know that what he did deeply affected the way she felt, as this showed him how real her feelings for him were and how much he did matter to her. He was also able for the first time to express his anger towards his natural mother, whom he said had lied to him that she would come and get him out of Care. This was again expressed through some Peter Pan play in which he said that Peter Pan and his mummy didn't want to live "with each other" any more. The distress that the foster mother showed to Sammy when she felt rejected by him (a projection of his feelings of rejection by her and her family, as well as her genuine response to his behaviour) was important to Sammy, and it was possibly from this point on that he started to be interested in the way that she would feel when he left her.

The fact that he could genuinely upset her, not only make her angry, made a

deep impression on him and he often asked her over the weeks that followed his introduction to the adoptive family "Will you cry when I go?" These very poignant feelings were interspersed with more defensive antagonism between them in which both felt unvalued by the other. Again these feelings were expressed through Sammy's play which involved themes about rainbows and the mixing of felt tip colours, which I could interpret as the mixing of happy and sad feelings, producing a new and sensually surprising experience (colourful rainbows from the sunlight and rain, orange from yellow and red).

Throughout this time, Sammy managed to be settled and productive in school, which was very encouraging when everything else felt so fraught. There were significant periods of time when be could play in a free and ordinary way which was clearly absorbing and satisfying for him. This play was also highly informative for me whenever I was unsure of how best to help him contain his feelings. For example, this was vividly expressed in a session two days before the day that I knew that he was to be told by his social worker that his adoptive family had been found. There was definitely an excitement in the air and when Sammy was in the session on his own, I was intensely aware of the enormity of what was about to happen in his life and I felt rather overwhelmed by the thought of it all. By this point he had tentatively been told that he might hear about his new mummy and daddy quite soon. I couldn't imagine what it might feel like to be Sammy at this point in time, and eventually, not knowing how else to express what seemed so important, simply said this to him. He was playing with the sand, making cakes. After a little while, he moved from the sandpit to a chair which he placed beside my chair so that he could sit with me. We sat quietly for a few moments and then, as if he was teaching me, he said "We've got to wait a bit". At first I didn't understand what he meant, but then I realised that he was pretending that the cakes that he had made in the sand were now baking in the oven, and a whole metaphor for his current experience of waiting seemed to tumble out of this little bit of play. I was able to say that he was saying that it was no good taking the cake out of the oven until it was cooked. It was hard to think of a better way of expressing (in a way that he could understand) how important it was to wait until the time was right for him to know that the new mummy and daddy cake was ready to be 'taken out of the oven' . We could almost smell the mummy and daddy cake baking in the session at this point and I was relieved to see that he was able to cope with all the waiting he had had to do in this more philosophical and trusting manner.

Events moved very fast as soon as Sammy was told about his new mummy and daddy by his social worker. He was told a bit about the family and shown pictures which they had prepared for him to introduce themselves and their home to him. The following day they came to visit him for a few hours at his foster home.

When I went to fetch Sammy and his foster mother from the waiting room for his next therapy session, his head was down in a very doleful and ashamed way, he avoided my gaze, and was wordless and reluctant to come to the therapy room. His foster mother was exasperated with him, saying he had been 'as high as a kite' since he'd known about his family and very dismissive of her and her family, to the extent that she had felt really rejected by him again. Sammy continued to stand with his head down in a desolate and lonely way when he came into the room and his foster mother repeated that she didn't know what had come over him, just as he'd come to the clinic. I asked him if he could say anything about what he seemed so upset about, but he just stood rooted to the spot and started to cry. His foster mother was astonished and still feeling fed up with him, so it was easier for me to offer him my lap (for the only time so far in his therapy). He sat on my lap briefly and I wondered if he needed some time on his own with me, so I suggested that his foster mother go back to the waiting room for a little while. No sooner had she done this, than Sammy wanted her back in the room but when we went to fetch her she had gone to the toilet.

The stairs between the waiting room and the therapy room had been important as an 'in-between' (transitional) space for several weeks whilst Sammy hovered physically between his foster mother and myself and, in his imagination, between his fantasised adoptive mother and his foster mother. We had spent a lot of time on the stairs, so I took the opportunity to say to Sammy that I knew that he had had some very important days since I'd last seen him and I wondered if that was what was the matter. He immediately and urgently blurted out 'I don't like my new mummy and daddy'. I had to ask him to repeat what he'd said, as I wasn't sure that I had heard him correctly. But he then said something quite different 'I'm going to miss Sarah and Jim' (the foster parents). There was no time to say anything else as his foster mother returned from the toilet and he flung himself into her arms and she carried him back to the room, rather overcome by his show of emotion. He continued to cling to her and cry for a few minutes and then I said that I felt he was showing her how upset he was about leaving her. She was taken aback as none of this had been expressed before the session. This was one of the many occasions in which she melted for Sammy, and was able to comfort him and talk about how they would all miss him, and how they also felt very sad that he was leaving them. All that I felt that I could do was to talk about what an intensely emotional time the next few weeks were likely to be for all of them and that it was very good that Sammy could share all these feelings and not bottle them up.

The next few weeks were indeed a time of great turbulence. Sammy's initial response to meeting his adoptive family was very clearly that he wanted to

stay with his foster family. It was not a case of them all living 'happily ever after'. He did his best to be as naughty as possible with his adoptive family in the ambivalent hope (and fear) that they would reject him and he could then stay with the foster family. However gradually, over a few visits from and outings with the adoptive family, he began to feel a bit more friendly towards them, as well a bit more confident that they would not reject him when he was being as awful as he could be. He began to see that they were determined to overcome whatever difficulties they needed to, in order to have him as their son. When he finally visited his new home for the first time, two weeks after first meeting his family, he began to genuinely feel hopeful and excited. He told me that when he first went to his new home, he 'couldn't believe his eyes' and felt 'upside down' with excitement and emotion. In many respects, this honest and open expression of the many conflicting feelings he was struggling with, was encouraging and realistic, and greatly preferable to a 'honeymoon period' during the first contacts with the adoptive family.

From this point on, there was relief all round as it felt as if Sammy, having expressed his most negative feelings, was ready to start becoming attached to his new family. The foster mother in her last few sessions with Sammy was able to talk a lot about how she would miss him, and how at times, when he was being very difficult with her, she wondered whether she had really achieved anything over the years he'd been with her. She also often wondered how he would remember her and her family, and all that they had been through together. In their last session together there was a sense of completion, that enough had been felt and talked about in this sad parting, but also an exciting new beginning. The foster mother could feel that she really had helped Sammy significantly through his years with her, and Sammy could feel that his foster parents had really cared for him and would miss him. He was able to express this through an increased sensitivity to his foster mother's feelings of rejection at this time as he gradually accepted his adoptive parents.

Discussion

I have learnt, and continue to learn, a tremendous amount from close contact with the process of adoption. Whilst some of the questions raised at the start of this paper will remain unanswered for a long while, if at all, some indications of the processes that were helpful to Sammy as he attempted to make sense of these enormous life events did emerge. One theme relates to transitions in Sammy's life, which, although painful, could be contained and worked through because their traumatic content had been reduced through his therapy and by the social work case management. It could be argued that the efforts to prevent traumatic *impingement* (in Winnicott's sense) on these delicate transitions in

Sammy's life made it more feasible for Sammy to remember the transition and stay with the experience of its paradoxical nature, because it did not become traumatising. If the process had tipped over into trauma, and had become overwhelming, indigestible and uncontained, Sammy might have had to 'forget' (repress and deny) his experience. Alternatively the experience may have haunted him, in either case interfering with his ability to form new relationships. The story (narrative) about his move from fostering to adoption, and the quality of the memories he retained and could bear to remember as time went on, were hopefully enriched and made more coherent as a result of his ability to keep in touch with, and express, his ambivalent feelings about his foster parents and adoptive parents.

These memories, together with the mementoes that Sammy had from his foster family, provided some continuity to his life. Hopefully this will eventually become condensed into a sense of having been given something very precious by the foster family - in terms of real, open relationships, tolerance, containment and day-to-day safety and security, as well as a generous measure of selfless love. In other words, he may have been able to remember a good-enough experience that he had with his foster carers, that he was sad to leave them, and that this was a planned ending, and not a traumatic one in which feelings of rejection and anger would have dominated.

In a previous paper (given to the BAP in May 1996 - *'Leaving the past behind - the value of 'forgetting' in the treatment of trauma'*) I argued that letting go of the past was vital in enabling traumatised patients to connect with the present and make new relationships. In therapy, this requires a form of selective attunement by the therapist, which holds the patient in the 'here and now' of the transference relationship, as well as the new attachment relationship with the therapist which exists in its own right. The trauma of the past is then dealt with as it emerges spontaneously in the material, rather than being sought out, or focused on, by the therapist. Often, the trauma is expressed non-verbally in the transference, and needs to be held in the therapist's mind for a long while, as opposed to being verbalised - particularly when the patient is in a fragile state of mind and is barely coping with everyday life.

Writing this paper about memory has helped me to think about the links between states of continuity-of-being, the avoidance of trauma, and transitional phenomena, and how these factors influence and are influenced by what is remembered. It may be that where it is possible to stay with the 'here and now' experience of massive change, in this instance moving from fostering to adoption, with all its paradoxes, it is more possible to process the memories which contribute so importantly to a sense of continuity in life. The narrative of these events is likely to be more coherent as a result.

A second inter-related theme is the question of which memories of his foster family it was useful for Sammy to hold on to, whilst he was in the process of forming new relationships with his adoptive family. If Sammy was too preoccupied with the past, he couldn't live in the present. It is known that it is extremely difficult to form new relationships whilst grieving over a past relationship (Klaus and Kennell 1976, Holmes 1993). In terms of priorities, if these processes cannot take place simultaneously, then Sammy's new relationship with his adoptive family clearly had to come first. (This would be in keeping with the ideas expressed in the paper just referred to - but this in turn raises fresh issues about paradox. For instance, is it possible to have a paradoxical experience but impossible to contain coexisting paradoxical processes - such as simultaneous attachment and loss?) Pragmatically, how could Sammy best become attached to his adoptive parents, without diminishing the importance of his relationship with his foster family, and his sadness at losing them - all this whilst his actual memories would be fading, becoming less and less available to him over time, due to lack of use?

The relationship between the foster family and the adoptive family was an extremely complex one. The foster family had to let go of Sammy, and he and they managed to mourn in an anticipatory way some of this loss whilst they were still together. It was much more difficult for the adoptive parents to cope with their rivalrous feelings towards the foster-parents and there was a clearly expressed wish to 'forget about the past' and discourage appropriate contact between Sammy and the foster-carers (such as an occasional 'auntie and uncle' type visit by the foster parents to the adoptive home). There was a tendency for the adoptive parents to see all of Sammy's past relationships as neglectful and uncaring, extending the natural mother's inability to care for her child to the foster carers. This needed to be understood in terms of the urgency of the adoptive parents' wish to claim Sammy as their own and create their new family history. I suspect that this is very common at the start of adoptive placements, and indeed, as the adoptive parents gain in confidence, they are becoming more able to recognise the importance of the foster family in Sammy's past and present emotional life and not to filter it out in their responses to him - a form of selective attunement (Stern 1985) to their new 'baby' which would ultimately not be helpful for him.

Combined with these themes, I would also like to think about the transference relationship and what could be described as the changes in its function at different stages of this therapy. As I have already indicated, the many twists and turns of this complicated treatment provided many surprises for me, which, with hindsight, were not really that surprising at all. In particular I came to realise that in terms of this aspect of Sammy's emotional life, *I was his memory* for a very significant period in his life - albeit an auxiliary memory - but

nevertheless the only person who knew in such intimate detail, what he had been through emotionally. In addition, whenever he came for his session after moving to his adoptive home, his memories of the sessions with the foster mother were stirred and he could share these with me in a way that did not feel too threatening for the adoptive parents. In this respect, I felt somewhat like an old-fashioned midwife, who had known the baby during pregnancy, through the dangers of childbirth and for a short while post-partum.

This metaphor illustrates my experience - that I have rarely interpreted to Sammy in terms of the maternal transference, although his response to breaks in sessions in particular could well have provided this opportunity. To talk of myself as being *like* a mummy to him, in the midst of his confusion between his natural mummy, foster mummy and adoptive mummy, would in my opinion have created even greater confusion for him. However, I did feel I could talk about how unwanted and rejected he felt by me particularly during breaks in the sessions - but this stayed closer to the realms of our perceived external relationship than to the realms of his unconscious and conscious fantasies about me as an internalised maternal object. I only interpreted along the lines of maternal transference when I felt that not to do so would create a greater confusion - such as when he clearly had fantasies that I was his new mummy.

In effect, I did not want to 'gather in the transference' with Sammy, because it felt more important to work with him within the context of his external and changing family relationships, rather than drawing his emotionality towards me. This was the rationale for the work with the foster mother and the adoptive parents. In this respect I felt that I tried, in conjunction with the social workers, to provide a facilitating environment in which these relationships could be thought about and developed, rather than becoming a transference object for Sammy. It is really a question of priorities - and I realise that what I felt to be my priorities in this case - may be different to the way in which other therapists would have approached this case.

Therapy may also have facilitated the creation of a new and pertinent set of transitional phenomena which helped Sammy to bear to exist in the *paradoxical* emotional space between his foster and adoptive family. This was indeed a very difficult place to be and took a great deal of courage to enter. The green ball that travelled between sessions with him, and the amount of session time spent on the stairs between the waiting room and the therapy room, were ways which he found to express and contain the anxiety he felt, as he stepped into the frightening space which existed when he had to let go of his loved foster family and was trying to accept the unknown and initially frightening (in his perception) adoptive family. In addition, there were times when his adoptive parents visited the foster home and when he told me that he had 'two mummys

in the kitchen and two daddys in the garden'. He didn't know where he was - this would be a mind-blowing experience if he could not accept a certain degree of paradox - which fortunately I think he could.

What I have presented here are thoughts, speculations and hypotheses about how this little boy's therapy, and the case management around it, may or may not have helped him to develop a coherent narrative of these close to overwhelming experiences. Just as I have found myself thinking about these experiences as being 'memories in the making', the ideas expressed in this paper are 'ideas in the making' which I hope will stimulate further thought about the complexity of what we mean by 'childhood memories' and their significance for the emotional development of the individual.

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HYSTERIA BEYOND ANNA O. AND DORA - THE SEARCH FOR A CONTAINING MOTHER

JUDY COOPER

Introduction

In a sense it could be said we all want a containing mother and a father who provides structure but in this paper I am dealing with the specificity of these needs in three hysterical women. I have traced the changing focus of female hysteria from two seminal examples; Anna O., the first psychoanalytic case recorded, and Dora, some twenty years later, to my own experience with a patient.

It may seem strange that this paper is about hysteria, for hysteria today is not a fashionable term - "The word 'hysteria' has now been banned from medicine" (Shorter, T.L.S. June 17 1994 p.26) - nevertheless, it holds a very special place in the history of psychoanalysis. Indeed, it was through hearing about Dr Joseph Breuer's treatment of Bertha Pappenheim (Anna O.) that Freud first became aware of the power of the unconscious. Hysteria was the diagnosis that psychoanalysis started with. It was the bastion of neurosis. (Breuer & Freud, 18930-1895; Veith, 1965).

In classical psychoanalytic theory hysterical symptoms were explained as a result of repressed memories. It was held that because it was taught from childhood onwards that sexual feelings were unacceptable, any sexual stimulation or arousal would need to be repressed and these unacceptable desires could emerge in a dissociated symptom, as hysteria.

However, there is no doubt that hysteria still exists. The inextricable link between body and mind presents itself in familiar and less familiar ways: anorexia, bulimia, cosmetic surgery, self injury, gender changes, perversion. And, of course, psychoanalysts and psychotherapists are familiar with "psychosomatic illness" where there is no evidence of an organic problem behind a troublesome symptom. Moreover, the unhappiness and depression which always underlies hysteria now manifests itself as chronic pain or chronic fatigue rather than hysterical paralysis or phantom pregnancies.

Hysterical features can also be detected in other severe pathology: phobias, manic-depression, multiple personality disorder, narcissism and borderline difficulties.

Freud emphasised that hysterics have difficulty with three-person relationships and early psychoanalysts stressed the sexual rivalries and the

fear of punishment for infantile masturbatory phantasies and adolescent daydreams associated with the oedipus complex.

Although early analysts were aware of preoedipal conflicts in hysterical patients, they viewed these conflicts as regressions from oedipal turmoil and not as fixations at earlier developmental levels. In stressing the hysterics's search for the containing mother I am not saying anything particularly new. I am merely endorsing the more recent trend of analysts who have pointed out the deficiencies of adequate early holding in those people who develop hysteria (Horowitz, 1991; Khan, 1975; Welldon, 1995). The psychoanalysts who stress preoedipal issues emphasise that aggressive as well as sexual urges can produce hysterical symptoms.

Although my three illustrations in this essay all happen to be women, hysteria is definitely not confined to women. One can see numerous instances of male hysterics, certainly in the entertainment world.

Anna O.

Bertha Pappenheim, better known in psychoanalytic circles as Anna O. was the patient who inadvertently stumbled upon the free associative "talking cure" (she jokingly called it "chimney-sweeping") which became the basic tool of the psychoanalytic method. Although the case actually belonged to the highly respected physician Josef Breuer (1842-1925), Anna O. is renowned as Freud's first reported case-history using the concept of the unconscious systematically to treat an emotional disturbance.

Anna O. was an intelligent, attractive woman from a cultured, wealthy, orthodox Jewish family. She was the third and only surviving daughter out of three (Henriette 1849-1866; Flora 1853-1855; Bertha 1859-1936) and was overshadowed by a brother Wilhelm (1860-1937) who was eighteen months younger than she.

In 1880, at the age of twenty-one she displayed a florid array of severe symptoms which included various paralysed limbs, a persistent cough, visual and speech difficulties, hallucinations, a marked weakness and a refusal to eat. Various specialists had been consulted before Breuer and they could find no physical basis for Anna's difficulties. Dr Breuer was called in to treat her and he immediately recognised that she was *not* suffering from tuberculosis but rather from hysteria. Most nineteenth century physicians thought of hysteria as a disease of malingerers but Breuer did not. He took Anna O.'s predicament very seriously, at times visiting her once or twice a day.

She was described as having a "passionate love for her father who pampered her". Although she was intensely Jewish and observant in her later life, Breuer notes that at the time he was treating her she was "thoroughly unreligious"

and only followed the ritual practices to please her father. During the course of her treatment, which lasted about 8 months (end of November 1880-June 1881), her symptoms were traced back to the pulmonary illness of her father whom, together with her mother, she nursed with complete devotion even though a paid nurse would have been easily affordable. Sigmund Pappenheim (1824-1881) died in April 1881, during Anna's treatment with Breuer.

It would seem that the treatment did not end as successfully as Breuer would have had us believe, concluding his account with, "Since then she has enjoyed complete health". Suffice it to say that the oedipal explanations given to Anna O.'s predicament are undoubtedly confirmed by her phantom pregnancy where hysterically she imagined she was giving birth to Breuer's child. However, I feel that the preoedipal facets and particularly the maternal relationship is important too.

Although Recha Pappenheim (1830-1905), Anna O.'s mother, is hardly mentioned by Breuer in *Studies on Hysteria* and little is known about her, we can try to build a picture of her relationship with her daughter. One snippet of information we have is that Anna O. was said to have had difficulties with her "very serious" mother whom Ernest Jones (1953) described as "somewhat of a dragon". Consider, Anna was born sandwiched between the deaths of her two sisters, Flora, who died of cholera at two years of age, four years before Anna's birth, and Anna's eldest sister, Henriette, who died of consumption at the age of seventeen when Anna was seven years old. With two daughters dead, Recha Pappenheim may well have been depressed, anxious and fiercely over-protective of her surviving family and unable to provide the holding a small child needs. We can imagine that Anna's mother called Breuer in panic when her daughter was so strangely unwell, probably profoundly anxious as to her own destructive urges, wondering whether her third daughter was being harmed by her, as she unconsciously must have felt the other two had been. It is also quite possible that Anna unconsciously saw her mother as a murderess.

It has been observed that the third same-sex child in a family is frequently prone to difficulties. Such was the position of Anna O. It seems likely that her mother was unable to meet her primary needs, being disappointed that she had borne another daughter, and perhaps seeing her as a replacement for her dead daughter Flora rather than in her own right. Anna's conflictual relationship with her brother Wilhelm must have also been, in part, due to the mother's inability to hold both children equally inside herself. Anna O. fought constantly with Wilhelm because

> *he was provided with an education and a profession. In childhood he seemed constantly more favored than she. He got the mother's attention and care and, since he was the first and only boy, possibly the father's as well. (Stewart, 1984, p.49).*

Although Anna acknowledged that she was irritated with her family, it is likely that there was little opportunity to express her criticism and rage as a well brought up, submissive daughter of the time, and most of it remained suppressed and hidden. Mother must have encouraged Anna's closeness to her father and sharing the nursing of Sigmund Pappenheim with her daughter was one way of keeping her close to home. The sexual suppression that this involved was apparent in the nervous cough that Anna developed when she was sitting at her father's bedside, listening to the sound of dance music next door, longing to be there.

It is tempting to conjecture that the expression of anger was not only culturally unacceptable but also personally so: Recha was ill-equipped to contain Anna's rage which would have been necessary to help her separate and grow. Clearly rage was associated with many of her hysterical symptoms. It also erupted as "childish opposition" to her physicians when she was in the sanatorium but most dramatically with her attempted suicide. It should be mentioned that when Anna O. finally managed to recover from her illness she expressed her rebellion against her wealthy family in a more creative way, as a social protest.

It seems likely that Recha Pappenheim, because of her own pathological needs, put a premium on submission and dependence, rewarding Anna with special attention when she was unwell. So, although hysterical conversion symptoms can be triggered by oedipal conflicts and adult sexual desires, there is always a pregenital two-person basis to this (Sperling, 1973). A good example is that although Anna O. had been a devoted nurse to her father, she had not been allowed to see him during the last two months of his life. Recha lied in response to her daughter's enquiry about the true condition of her dying father's health, ostensibly to protect her, but when Anna O. learnt of his death, her symptoms intensified and she became agitated and had visual disturbances: the symptoms being her way of hitting out at her mother for "robbing" her of her right to say goodbye to her beloved father (Ellenberger, 1972).

Another pregenital indicator in Anna O.'s story is her quite severe eating problem. She refused food which, at one level, represents survival and one's earliest helpless dependence on mother. At one point in her treatment she agreed to eat if Breuer fed her. He did. In fact, Breuer's case report mentions several forms of physical contact between them.

He frequently touched her hand. He gave her massages. He restrained her forcibly at times. He fed her. He took her riding in his *carriage* (Spotnitz, 1984).

All this must have intensified Anna O.'s problems with boundaries and separation, and undoubtedly excited her phantasies of an hysterical pregnancy. What we know today is that if there is any real danger of psychotic acting out by a patient with the therapist as victim, all physical contact should be avoided.

Seeing the analyst merely as a "victim", is to ignore the analyst's part in the interaction and his counter-transference. What fired Breuer's intense devotion to this particular patient? At its simplest level it could be said that Anna O.'s real name, Bertha, was also the name of both Breuer's dead mother and his eldest daughter. His mother had died as a beautiful, young woman of 26 when Breuer was two or three (Decker, 1991). It has been suggested that Anna O.'s youth and attractiveness may have aroused Breuer's unconscious longings for his lost young mother. Moreover, the illness and death of Anna O.'s father may have sparked off Breuer's own unresolved feelings of his early loss of mother as well as of a younger brother who, like Sigmund Pappenheim, had also died of tuberculosis seven years earlier. In a way it could be said that Breuer was using his young charge as a containing mother for the lost bewildered child in himself, and that both he and Anna O. were yearning for the same thing.

Somehow, Anna O. was able to resolve her conflicts in an impressive way. She found an admirable ancestral female role model in Gluckel von Hameln (1645-1724), who was related to her from her mother's side. Gluckel had thirteen children, twelve of whom survived. She was a devoted mother, very religious, successful in business as well as being actively concerned with her community responsibilities. She wrote her memoirs for her children, describing what it was like to be a woman, a mother, a widow and Jewish and the problems of survival in that time. Anna O. translated these memoirs from medieval German Yiddish into German and, in 1900, she and her brother Wilhelm had them published privately.

From the late 1800s Anna O. became a philanthropist and pioneer of social work. Some may argue that her activities were neurotic adaptations rather than successful sublimations. None the less she achieved a role of social motherhood: for twelve years she became the director of the Jewish Orphanage for Girls in Frankfurt, which was for those children who had lost their parents in the pogroms of Eastern Europe, and later she became a vigorous and tireless pioneer of the Jewish feminist movement in Germany, which was primarily involved in trying to curtail the white slave traffic in Eastern Europe which exploited poor, young, Jewish girls.

By devoting herself to caring for these helpless, needy girls, Anna O. was unconsciously providing the holding maternal presence for which she herself had longed.

Dora

Some twenty years after Breuer's fascinating treatment of Anna O., in October 1900, Dora's father took his young daughter of eighteen to consult Freud. She

had already had a series of unsuccessful treatments including electrotherapy, hydrotherapy and various drugs. Although she only stayed in treatment with him for eleven weeks and left abruptly, Dora became one of Freud's principal cases. He was keen to use her material to flesh out his understanding of hysteria.

Dora's real name was Ida Bauer (1882-1945). She was the younger sister by fourteen months of the distinguished leader of the Austrian Social Democrats, Otto Bauer (1881-1938). She came from an assimilated Jewish family, Dora's mother has been described as 'cold and withdrawn' and her father as 'self-made' and 'hard-driving' (Decker, 1991, p.1). However, due to the fact that her parents were estranged and, like many a nineteenth-century daughter (just as Anna O. did), she nursed her ailing father until twelve or thirteen. She became unusually close to him, although in her later adolescence and at the time of her referral to Freud, she was said to be 'unfriendly toward her father' (Decker, 1991, p.5). In fact, Philipp Bauer (1853-1913) was an extremely attractive and successful textile entrepreneur, a member of the new rising Jewish upper-middle class.

It is said that Dora was on 'very bad terms' with her mother (Decker, 1991, p.5), and one imagines that Käthe Bauer (1862-1912) had very little in the way of nurturing to give her children (Decker, 1991). She neatly fits Khan's observation that, 'hysterics live in a perpetual psychic state of grudge' (Khan, 1975, p.52). They are full of resentment because no loving attachment seems to sustain them and their relationships are doomed for they seem condemned to remember through repetition (Cooper, 1993). To quote Breuer and Freud (1893-1895, p.7) 'hysterics suffer mainly from reminiscences'. Sadly, Dora was to become a replica of her mother. Käthe displayed a host of hysterical symptoms and suffered from 'housewife's psychosis'. In response to feeling sullied and enraged by the gonorrhoea passed on to her by her husband and his infidelities, she was obsessed with cleaning. She tried to retain a feeling of mastery and power by locking certain rooms and not allowing her family freedom of access and she made the house unliveable in, in an attempt to keep certain sections pure. She was not fun or warm in any way and was preoccupied by her constipation.

Before and after marriage, Philipp Bauer led a sexually carefree life and contracted syphilis, which was common in the large cities at the time. The marriage between Philipp and Käthe was unhappy, and Philipp looked elsewhere for consolation, falling in love with Mrs. K., the wife of a family friend. As a result Mr. K made inappropriate sexual advances to Dora. Both the affair and these sexual overtures were denied within the family: it did not suit Philipp Bauer to believe his daughter when, at fifteen, Dora confided her distress to him (Cooper and Cooper, 1993). Philipp's affair with Mrs K. became obvious for all to see the summer just before Dora was thirteen. Dora related to Freud that,

while previously Frau K. had been an invalid and had spent some months in a sanatorium for nervous disorders because she had been unable to walk, on receiving Philipp Bauer's attentions, she became a healthy and lively woman. The Ks and the Bauers had always been close but the affair threw Mrs K. and Dora into even closer proximity, with the young woman spending many hours with the adolescent girl:

> *When Dora stayed at the Ks', she and Mrs. K. shared the main bedroom and Mr. K. had to sleep elsewhere. They talked to each other about everything, including Mr. K. Mrs. K. confided in Dora the details and concerns of her married life and asked her advice. When Dora admired some of Mrs. K.'s jewellery, Mrs. K. saw to it that Philipp bought his daughter the same piece. Dora clearly had an adolescent crush on Mrs. K (Decker, 1991, p.67).*

Apart from her own mother and Mrs K., Dora chose a third ill role model on whom to pattern her behaviour; another psychologically disturbed woman from whom, nonetheless, she was hoping for some containment. She was very close to her father's younger sister Malvine (1855-1899) who, like her mother and Mrs K., had children but was very unhappily married. Freud knew Malvine and stated that although she had no characteristic hysterical symptoms, she suffered from a severe form of psychoneurosis. In her early forties she began to lose weight and died fairly quickly without any clear cause (Decker, 1991, p.50). The loss of her 'treasured Aunt Malvine' (p.195) undoubtedly added to Dora's sense of isolation and abandonment in the months before she was taken for treatment to Freud by her father.

It must be mentioned that Dora's affection for both Mrs K. and her Aunt Malvine must have also held the split off part of the love that she had for her own mother. In many ways they were very like Käthe but different enough for Dora to confide in them. Although Dora had various symptoms from the age of eight she produced a more serious set of symptoms when she was twelve: migraines, loss of voice and a chronic cough; these developed seemingly when she stopped nursing her sick father and when Philipps' affair with Mrs K. blossomed. Later she could not walk properly and had a phantasised childbirth. Just before Philipp took her to see Freud, she became irritable and self-critical. Her lifelong affection for her father disappeared and her relationship with her mother got worse. She withdrew and felt tired and unable to concentrate. She ate badly and lost interest in her looks. She felt suicidal but did not act on it although she wrote a suicide note. Finally, after an argument with her father, she became delirious, had convulsions, lost consciousness and could remember nothing of what happened.

Although Freud was the first person to believe Dora's story of Mr K.'s uninvited sexual overtures, he trivialised the episode and interpreted the story in oedipal terms - as her unconscious wish for her father's affection and her

painful disappointment at having lost his attention to Mrs K. Freud apparently said nothing about Dora's mother's lack of warmth and maternal nurturing. It does not seem that he fully appreciated the fact that, at some stage, Dora was very involved with Mrs K. Dora was obviously hurt and felt misunderstood by Freud, who was shocked and quite unprepared when Dora left the treatment abruptly after 11 weeks, giving one day's warning. Just like Breuer in the case of Anna O., Freud, in the case of Dora, miscalculated the importance of the intense primitive feelings aroused in both patient and therapist (Cooper and Cooper, 1993). Freud had bombarded his young patient with interpretations, confronting her quite openly with her unconscious sexual phantasies and desires as soon as he discovered them. He told Dora that her symptomatic cough expressed her unconscious phantasy that Mrs K. was gratifying her father sexually through fellatio. His basic interpretations centred on his belief that Dora loved Mr K. deeply, and unconsciously wished to have sex with him. Freud's solution was a wholly oedipal one, that Mr and Mrs K. should divorce and Mr K. should marry Dora.

Perhaps Freud did not fully appreciate Dora's helplessness on all fronts: in her family constellation, as a woman and as a Jewess. She had no opportunities for education or a career and no satisfying maternal model with which to identify. Anna O. suffered from exactly the same predicament and was consumed with envy of her younger brother's prospects. But Anna O. somehow managed to fare better than poor Dora; she found a creative role model in her ancestor, Gluckel von Hameln, she apparently succeeded in having a better relationship with her mother after her father died, when they moved to Frankfurt together, and she managed to overcome her rivalry with her brother, at least to the extent that they collaborated in having Gluckel's memoirs translated and published.

Although Dora never fully understood what her analysis with Freud was really about, she recognised some of her repressed emotions concerning her father and Mr. K. and thereby gained some temporary relief from her debilitating symptoms. She was able to marry at the age of twenty-one (in 1903) and subsequently had a son who became a famous conductor. However, one feels that nothing basic was ever resolved with Dora and the theme of primary unintegration is evident throughout her life. Marriage and motherhood seemed to offer her little fulfilment. In fact, Dora replicated her mother's miserable situation. She was unhappily married, her husband was unfaithful to her and she developed an obsession with cleaning. Unlike Anna O. she could not sublimate her energies into Jewish cultural activities.

Dora and her husband had tried to gain acceptance and safe holding by converting to Christianity after the birth of their son, but, like Freud, she was compelled to flee Vienna. She left in 1939, and ended her life having to be forced

back into her Jewish status, as a refugee, alone, in an old age home in the United States.

Fiona

Now let us jump over one hundred years and look at my hysterical patient, Fiona. She was referred to me by a colleague several years ago at the age of twenty. I was greeted by a very attractive, refined looking, intelligent and likeable young woman. She had the charm and promise characteristic of hysterics as well as the ability to communicate in such a way as to draw sympathy to her predicament. At her first session she explained that she was confused and unhappy and felt insecure about all her relationships, at University, with friends and with her family.

Her family came from Australia and she had a sister, Helen, just over a year younger than herself. At Helen's birth Fiona lost her primary devoted mother. Fiona used to bite her little sister who was tiny and ill and got a great deal of attention. She still felt that Helen was her parents' favourite, as she was not intense. Fiona told me that she, herself, was a bitch and rebellious.

When my patient was four years old her father, a successful young doctor, died unexpectedly at work, of a brain haemorrhage. She said that she could remember that she was very close to him and they had "a wonderful relationship". Mother left her two daughters with her in-laws and went almost immediately to America and then on to her parents who lived in London. She met a man in London, returned to Australia to collect Fiona and Helen, and went back to London to marry the new man. One can see that here is a family in which there is little place for depression and, repeatedly, one could see by Fiona's anecdotes that mother found it difficult to frustrate the child and work through the depression. The response to sadness was always frenzied activity (e.g. no mourning for her husband's death but immediately travelling and filling the gap with a new man) and consequently there was nothing to help Fiona tolerate absence, disappointment, frustration.

Her step-father was a businessman, and the family had moved around, living in Hong Kong, Japan, America and England. From the age of thirteen she had been sent to boarding school in England and she had not lived properly at home since then, although now she was at University in London, she had the basement flat in her family's home in a very fashionable area of London. She said she was dependent and had a constant need for approval.

Fiona told me in her first session that her relationship with her step-father was good and she had chosen to add his surname to her own at fifteen years of age. He was warm and loving but there was also shouting and screaming between them.

From the age of ten she had some sexual experience with a step-uncle. There was fondling; she never considered this "abuse" but that he was teaching her. From fourteen, she had various sexual relationships and she felt her relationship with men was destructive. In the eighteen months she was in treatment with me, she was promiscuous and always found some man or other with whom to be sexually involved. It is well documented that females with hysterical personality disorder are often promiscuous and use seduction of the male as a manipulating technique to obtain emotional indulgence. This avenue is much more available to women today rather than the women of Freud's social milieu at the turn of the twentieth century.

She constantly wanted the power and gratification of men falling in love with her but all these manoeuvres seemed to be an attempt to avoid depression. For Fiona, to be depressed was to lose power. Indeed, one of Fiona's male friends, whom she was trying to cajole into having a committed relationship with her, told her, when she was petulant about the fact that he had chosen to develop a relationship with a girl she thought of as fat and pimply and far less attractive than herself, that he did, in fact, prefer his girlfriend and would never have a serious relationship with Fiona. He liked her and found her attractive but felt she just was not suitable for him. He could not say exactly why but he knew he could not think of her in that way. It would seem that he had unconsciously picked up that he was not a whole person to whom she could relate but merely a part object, an interchangeable function: a penis or a breast.

This scenario convincingly illustrates Khan's (1975) view that precocious sexual development is the hysteric's way, right from early childhood, of trying to deal with the failure of good-enough mothering and care, and that, continuing into adult life, the hysteric's focus on sexual solutions is essentially the body language he uses for expressing the primitive needs for care and protection that were lacking in his earliest environment. In Fiona I could see how these early environmental failures resulted in a disturbance of her emerging ego, so that there was a constant search and demand for id experiences with a desperate hidden agenda of ego-needs behind this.

Alongside her focus on her sexual life, Fiona at times produced other body symptoms like dizziness, nausea and headaches. She also had a preoccupation with eating, alternating between dieting and exercising, bingeing and apathy. She announced that she "loved eating" but felt good when she was hungry and ever so guilty when she was full. Her first dream in therapy was quite revealing of her relationship with the non-containing maternal environment:

> *In the dream, Fiona was at a huge, huge party. A cousin [female and married] and she exchanged wedding rings. She was in the bathroom, people came in and offered her hash and she took it. She went on to the dance floor stoned and did*

a dance alone. Mother said it was terrible, so she went off and ate lots of Toblerone.

In her therapy she tried to tell me everything. She filled my mind with events and people in a frantic bustle which was not useable. Her accounts prevented me from thinking about or sorting out anything. She was showing me how she felt filled up but with no sense of continuity inside her, showing me an absence of a mother who could contain her core self. As the therapy progressed we could see how fragile her sense of self was, and we began to explore if she could feel that she was actually there behind the activities she related.

Fiona repeatedly presented to me her search for any pair of arms that would hold her. She prevented anyone from meeting her need by the desperate way she presented that need. It became clear that I could not get hold of her as she could not get hold of her early object. We saw how there was no tolerance of depression or constant climate in mother. She was pregnant almost immediately after having Fiona and was preoccupied with her own loss, finding a new partner, moving home and her own restlessness and ambition. Fiona's frantic inter-activeness was to do with her early mother. Hardly surprisingly, her attachment to mother was very insecure, and like a child from an institution, she had adapted to getting what she could from whom she could.

In the transference, her attachment to me was very insecure and, although she stayed in twice weekly therapy for eighteen months, she frequently spoke of leaving. She could not take my ideas in and was constantly pouring everything out because she did not have a place inside herself to receive and digest her feelings. She needed me to be a mother who could contain her and bear her depression, then she may not feel so empty but rather richer, even if the feelings were painful. She began to write some really moving poetry.

Although Fiona talked about leaving therapy after getting her degree, part of her knew that our work was not finished and it was inappropriate to end as a lot of difficult feelings had not been explored. There was an element of flight in all this which was her attempt to overcome her anxiety. She was often vague in her talk of going and left her intention obscure because she felt so mixed about. She was trying to get me to say that I agreed to her going so she could avoid the conflict and leave comfortably. As things stood, she left for Europe after her exams, unsure if it would be for an extended or more permanent break. In the same way that she was deeply hurt at the thought that her parents may not keep their basement flat available for her indefinitely, she wanted the option of having her therapy times back should she want to return at any time.

There was part of her that felt she could do anything with her objects. She could not take responsibility for the fact that if she took off, it was aggressive

both to herself and to me. There was a frantic fear in Fiona of being engaged with someone and truly dependent. I felt that she avoided the ending with me: she found it hard to commit herself to a proper relating in the therapy, and although she got to a point where she could value it, she avoided the mourning.

Zetzel (1968) found that the outcome of therapy for hysterics depended on the level of aggression to the primary object. I believe there is every indication that Fiona's prognosis is hopeful. We both knew that at some future date she would return to therapy somewhere.

Fiona wrote me a letter some twenty months after leaving therapy. She had got a good degree, although not the first she had been hoping for. She had been travelling around and was planning to settle down with a man she had met on her travels. However, as his job involved moving around, she acknowledged how insecure her circumstances were. She wrote she wanted to come back into therapy with me but, although she had 'no strong idea about her future plans', London was not on her foreseeable agenda. She wrote, 'I imagine the security and safety of my visits to you and I would very much like to see you again'. I felt she was drifting and had, once more, attached herself to an available object without real choice or discrimination. In her letter, one can see her longing for the containing mother but also her flight from the containment. Her choice was to pursue the familiar, restless unholding object, like her early mother.

Although she wrote a beautiful letter, saying all the right things, I sensed how anxious and troubled she was. I felt she was repeating words she had learned in the therapy but nothing had really changed. I wrote back to her saying I would be happy to see her, even for a few sessions, in early summer when she planned to be in London but I have heard nothing further from her for almost four years.

Conclusion

So let us sum up. We have seen three emotionally deprived girls, all from upper middle class, cultured, wealthy backgrounds. Each had a mother unable to provide the vital containment necessary in infancy, childhood and adolescence, which led each girl to a turbulent expression of her unhappiness in symptoms of bodily disintegration. Also, it does not seem merely by chance that each had a rivalrous relationship with a sibling. I believe that each of these women was searching for a new mother but that did not prevent them from attacking the new mother for those very containing functions which they craved.

We know that hysterics take flight. Anna O. stayed with Breuer around eight months, Dora stayed with Freud under three months, Fiona stayed with me eighteen months but at the end of the day they all attacked the holding provided

by their treatments and took flight.

The hysteric lacks a good internal object, feeling the bad, rejected object inside himself and the good, acceptable object outside (Fairbairn, 1952). Something has gone wrong with the mother-child bond - either too much or too little mother - and the child may feel it safer to pursue the penis than to acknowledge a longing for the hated mother. As Winnicott says, what is needed for the hysteric's treatment is "a new example of infant care, better infant care in the analysis than was provided at the time of the patient's infancy" (Winnicott, 1952, p.100).

So what has changed in our treatment of hysteria? What have we learnt? What has improved? I think we understand far more about primary fragmentation and disintegration. We are better at recognising that there is much more early trauma involved in hysteria: that, in addition to the level of oedipal fixation, there is a profound gap in early maternal holding. Secondly, I think, we realise the importance of a proper therapeutic contract with reliable boundaries and a constant frame. Thirdly, the whole dimension of the therapeutic relationship, and the feelings evoked in the transference and countertransference, has come under closer scrutiny: the timing and handling of sensitive interpretations and the focus on shared experience as a way of strengthening the therapeutic alliance, attempting to maximise secure containment and minimise these patients' tendency to attack the very links they crave (Momigliano and Robutti, 1992).

In forming his explanation of hysteria Freud ignored the mother's role. Gradually, it could be said that psychoanalysis has moved too far the other way, in the direction of the mother-infant bond. Today, no-one would dispute the essential role of the early containing mother. What is important is to remember that we all have two parents and they both hold an essential place in our internal worlds. We relate to each of them separately, as well as to a joint parental imago. It is precisely in the unravelling of all these bewildering and intense feelings that the essential and fascinating work of an intensive psychotherapeutic treatment is done.

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THE 'MARITAL TRIANGLE': TOWARDS 'TRIANGULAR SPACE' IN THE INTIMATE COUPLE RELATIONSHIP

STANLEY RUSZCZYNSKI

The vital process that drives men and women to each other, to love each other and then create life, and thus achieve the continuation of the human race Freud called the Oedipus complex (Henri Rey, 1994).

In this paper I explore the idea that the intimate couple relationship recreates some of the Oedipal conflicts left unresolved from childhood and in so doing offers the possibility of these conflicts being re-worked and possibly resolved. This psychic re-working takes place naturally in the everyday relationship of the couple: it may also take place in the transference-countertransference relationship with the psychotherapist in psychoanalytic couple psychotherapy. In the former, the re-working and resolution take place, mostly unconsciously, in the everyday dynamics of intimate living; in the latter, more conscious awareness of the Oedipal anxieties and object relations enacted in the marital relationship and in the psychotherapeutic situation need to emerge. Of course, for all couples some of the time and for some couples all of the time, the nature of their interaction is such that they become psychically gridlocked in a way which is unconsciously designed to create a psychic structure which defends against possible re-working: the pain and anxieties associated with such emotional work are felt to be unbearable (Morgan, 1995; Steiner, 1993). I will focus on one particular constellation of object relations which are central to the resolution of the Oedipal situation. The focus is that discussed in Britton's seminal paper, 'The Missing Link: Parental Sexuality in the Oedipus Complex' (Britton, 1989). Britton shows that for psychic development to proceed it is necessary for the infant and child to be able to relate not only to individual others (ie. each of the parents) but also to others in a relationship (ie. the parental sexual relationship). Coming to terms with the reality of the triangular nature of the Oedipal situation leads to the developmental move from narcissistic to more mature object relationships and heralds the capacity for true intimacy, which might be defined as the ability to tolerate both one's separateness and one's need to relate to a valued and separate other, a tension at the heart of

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every intimate couple relationship (Ruszczynski and Fisher, 1995).

Introduction

Contemporary psychoanalytic theory emphasises the interactional nature of the therapist-patient relationship, be that as it is applied in work with individuals, couples, families, groups or institutions. This emphasis is most clearly demonstrated by the clinical centrality of the analysis of the transference-countertransference relationship.

This clinical and theoretical focus has come about largely as a result of the development of Klein's descriptions of the unconscious mental mechanisms named projective and introjective identification (Klein, 1946). These concepts, especially as they have become developed by Bion and Rosenfeld, have led to a deeper understanding of the ways in which the patient unconsciously influences the therapist to become involved in and to enact aspects of the patient's internal object relations in the transference-countertransference relationship. Bion writes that we find ourselves,

> *"being manipulated so as to play a part, no matter how difficult to recognise, in somebody else's phantasy" (Bion, 1961).*

For Bion then, projective identification refers not only to a phantasy but also involves the projector unconsciously using subtle verbal and/or non-verbal means to give effect to the phantasy, evoking or provoking aspects of it in the recipient. (Here is the inescapable meeting between the intrapsychic and the interpersonal.) The recipient containing object (initially mother) receives the projection and, via reverie, will metabolise it into something manageable, understandable and knowable. This is then reintrojected by the projector who not only regains that aspect of the self previously split off and projected but also introjects the experience of containment and, crucially, the experience of thinking (Bion, 1962). To fully internalise and integrate this psychic development, the projector has to come to bear the pain of being separate from the previously containing object (Steiner, 1990). (I will discuss this last point below.)

The mothers' capacity to think about her infant is as necessary for the infant as is her love and nurture of him in other ways. This dynamic interaction, the container- contained process, constitutes the source of experiential knowledge about the self, about the other and about the relationship between self and other. The infant's growth and development crucially requires both this 'learning from experience' (Bion, 1962) and internalising the psychic mechanism by which to do so.

There is debate regarding the understanding of the concept and mechanism

of projective identification: is it to be understood *only* as an intrapsychic process; or is it also, or mostly, an interpersonal mechanism; or can it usefully be understood to encompass both meanings? I will not in this paper join this debate (see Spillius 1988, 1994, and Ruszczynski and Fisher, 1995), but will simply say that clinical practice with individuals and, perhaps, particularly with couples demonstrates beyond doubt that we can be, and often are, induced to play parts in others' internal dramas.

This theoretical development emphasises *interaction* as having centre stage in the understanding of psychic development and growth and has accordingly influenced psychoanalytic theory and practice. The experiencing of and then the eventual interpretation to the patient of what may slowly come to be understood from the transference- countertransference experience leads to their gaining or regaining of knowledge about themselves and about their ways of relating. This transference-countertransference based experiential knowledge of the patient is now at the heart of clinical practice.

However, the patient-therapist relationship is not the only relationship in which aspects of an individual's internal world are enacted in a contemporary relationship and so made potentially available for becoming known. The intimate couple relationship may be understood in a comparable way.

Unconscious partner choice, containment and ambivalence

When two people form a relationship they do so substantially for unconscious as well as for conscious reasons. These unconscious reasons are sufficiently shared so as to create what might be called a 'marital fit'. The means by which this takes place is via mutual projective and introjective processes and identifications. By receiving the other's unconscious projections, each partner gives the other an initial feeling of recognition and acceptance and, therefore, attachment: the couple find a sufficient equilibrium in the mutuality of their projective and introjective identifications (Ruszczynski, 1992). In this sense the couple relationship may be described, in part, as a mutual transference relationship.

Following Klein (1952), Betty Joseph (1989) significantly developed the view of transference specifically to that of the transfer of 'total situations'. She writes that,

> *"everything of importance in the patient's psychic organisation based on his early and habitual ways of functioning, his phantasies, impulses, defences and conflicts, will be lived out in some way in the transference" (Joseph, 1985).*

If we can conceive of the couple relationship, to a sufficient degree, as a transference relationship, we may assume that the couple will jointly recreate,

in the nature of their interpersonal interaction, structures and forms of relating based on these unconscious "phantasies, impulses, defences and conflicts". Shared and individually held intrapsychic phantasies – particular those relating to the internal couple – become externalised and re-enacted in the marital relationship (Ruszczynski, 1993).

In this unconscious re-enactment a fresh opportunity is created within which earlier unresolved internal conflicts have a further opportunity to be attended to. In this way, intimate adult relating may be said to offer the holding and containment required for further emotional development and growth, a drive for which exists in most individuals throughout their lives.

Couple relationships will, of course, also be used more defensively: the other will be obliged to carry projected undesired or feared aspect of the self without any drive for this to be worked on and re-introjected. Projective identification will then be being used, as Klein first described it, primarily for defensive evacuative purposes (Klein, 1946). This will be more or less detrimental to the individuals and to their relationship according to the nature and the force of the projective identifications.

All relationships are a complex and fluid mix of both developmental and defensive interactions. The important issue is whether the relationship is flexible enough to allow for appropriate attention to be paid to both partners' individual needs and to the needs of the relationship they aspire to. The tension and conflict that this will provoke is inherent in every intimate relationship and tests the individuals' capacities to manage love and hate, tolerate ambivalence and mourn that which cannot be had. How do we try to understand whether and how an intimate relationship allows for this?

Oedipus revisited

This question invites us to turn to the myth of Oedipus which has become central to psychoanalytic theorising because it represents the earliest human relationships – those between an infant, a mother and a father – which set down patterns substantially influencing all subsequent relationships.

Britton, drawing on Klein's theories of the early Oedipal situation (Klein, 1945) and on Bion's notion of the container-contained (Bion, 1962), has elaborated a particular dimension of the Oedipal situation (Britton, 1989). He highlights that, as well as relating to the parents as individuals - as mother and as father - the young child, driven by natural curiosity, is confronted by the dim recognition of a link between the parents, ultimately their sexual relationship, and of a difference between the relationship of the parents and the relationship between parent and child. The parents may not only exchange physical sexual gratification but their intercourse may also lead to the actual

creation of a new baby. This knowledge has to become tolerable to the child's mind otherwise it will give rise to feelings of exclusion, envy and deprivation.

In this process the child is confronted with the pain of acquiring knowledge of the *true nature of the parental relationship* and of the *true reality of the Oedipal triangle.* If this is to become tolerable and made available for integration the infant has to relinquish omnipotence and narcissism. If this can take place there becomes possible a psychological move from narcissistic to more mature object relating, which includes the capacity for ambivalence, in which the task of mourning is essential.

The toleration of this knowledge of the link between the parents provides the experience of an object relationship of a *third* kind in which the child is *not a participant.* This is unlike the first two relationships which directly link the child to the mother and to the father.

> *"A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage* being *observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves" (Britton, 1989).*

The third factor - intrapsychic and interpersonal

The development of this capacity for self reflection (knowledge of the self) and for having the other in mind (knowledge of the other) - clearly achievements of some substantial psychological maturity - constitutes Bion's third factor of psychic life, that which he called 'K' or knowledge (Bion, 1962). The integration of the capacity for 'K', for experiential knowing, may be said to be a development of the capacity for containment: a capacity to emotionally manage the likely vicissitudes of human relating, *be that the therapist-patient relationship, the parent-child relationship or the intimate adult couple relationship.*

Britton clarifies the means whereby this capacity for reflection and containment may be developed. He writes that,

> *"The closure of the Oedipal triangle by the recognition of the link joining the parents provides a limiting boundary for the internal world. It creates ... a 'triangular space', i.e. a space bounded by the three persons of the Oedipal situation and all their potential relationships" (Britton, 1989).*

Hanna Segal, in a commentary on Britton's paper, stresses a crucial difference between this notion of the triangular space as a product of the closure of the Oedipal triangle, and the original relationship between the container and the contained. She writes that,

> *"in the original situation the child is a participant and a beneficiary of that (container-contained) relationship. Recognising the parental couple confronts*

him with a good contained-container relationship from which he is excluded. *It confronts him with separateness and separation as part of the working through of the depressive position" (Segal, 1989, my emphasis).*

The development of this capacity to tolerate the link between the parents and therefore to tolerate the reality of the Oedipal triangle also offers the opportunity for the child to begin to learn that there are *different types of relationships* - some of which he will always be excluded from, some of which he will be included in, and some of which he may create for himself, in his own right, at some future time. The infant is confronted with the harsh realities of the human community which have to be accommodated throughout life in all the different relationships developed in childhood, adolescence and adulthood.

Segal's comments relating to the child being a participant and beneficiary of the container-contained relationship may, I think, be compared to the situation of a patient in a psychoanalytic relationship. The nature of both of these relationships is necessarily and appropriately asymmetrical, being more for the benefit of the child or the patient. (I am not suggesting, of course, that either as parents or as psychotherapists that we do not benefit substantially from our involvement in such relationships.)

In a healthy couple relationship, however, even though such an asymmetrical division of emotional labour will, from time to time, be appropriate and necessary (at the time of an illness, for example), there needs to be the *possibility of and capacity for symmetry*. Such a possibility and capacity symbolises that there are two separate but 'equal' claimants to the benefits of the containing process.

The nature of the containment offered by a good enough couple relationship may, therefore, be better understood by adding Britton's notion of triangular space to Bion's linear model of container-contained. Within this triangular space each partner is not only and always a beneficiary of the containment but the other's needs and the needs of the relationship also have to be born in mind and at times given priority.

If the psychic work of establishing the triangular link, and all the benefits that accrue from it, was **not** achieved in the Oedipal struggles of infancy and childhood, subsequent relationships will be flawed, intrapsychically and interpersonally, by the individual's inability to bear the inevitable ambivalence inherent in human interaction. As I have already said above, the intimate couple are likely to recreate and, in their interaction, live out aspects of these conflicts. This reenactment in a contemporary relationship (as in a therapeutic relationship) potentially provides a further opportunity for revisiting and reworking some of these unresolved Oedipal remnants.

The 'Marital Triangle'

I would like to suggest that Britton's conceptualisation of the triangular space may be *adapted* so as to be seen to have the potential for a *symbolic* existence within a intimate couple relationship. The triangle in the couple relationship - let's call it the 'marital triangle' - may be thought of as being made up of each of the two individual partners and *their relationship as the third element.* The relationship may be said to have a dynamic identity of its own in addition to the identity of each of the partners. Clearly, because the relationship is made up of the two individuals concerned, I am describing a symbolic triangle rather than that which could be drawn between a child and two parents.

This notion of a relationship as an object in its own right has recently appeared in the writings of Kernberg. He writes that,

> *"The interaction of the partner's superego over time results in the forging of a new system, which I am calling the couple's superego.....*(The) couple (acquires) an identity of its own in addition to the identity of each of the partners." *(Kernberg, 1993, my emphasis).*

Ogden, too, refers to a similar idea when he writes of the intersubjectivity of the patient-therapist relationship which constitutes what Ogden calls "the analytic third" (Ogden, 1994). Elaborating on Winnicott's notion of it not being possible to speak of an infant without also thinking of some form of maternal care, Ogden says that in the analytic context there is no such thing as an analyst or an analysand unless one also speaks of their relationship with the other, which is the third element in the analytic space.

In the intimate couple relationship there is at times inevitable tension between the needs of the partners as individuals and the requirements of the relationship they aspire to. It is in this way that the *relationship* of the couple may be experienced as if having interests or requirements which may be in tension with, or even to some degree at odds with, one or both of the partners' individual needs.

What I am suggesting is that just as an infant and child needs to learn to tolerate that the parental relationship will at times, for its own legitimate purposes, exclude him, so the individual partners in an intimate relationship have to tolerate that for the *purpose of the marital relationship* they may sometimes have to give up some needs or interests or aspects of themselves, and tolerate doing so, however ambivalently.

If each partner in a marriage sometimes refuses to accept a projection from the other, as is likely in all but very disturbed and gridlocked marriages, the projector is obliged to have to take back and accommodate that particular aspect of the self which had previously been disavowed, and, in doing so, to accept a reality other than the one previously constructed. Hence, participation

in a reasonably healthy intimate couple relationship obliges each partner to be re- united with feared aspects of the self, previously split off and projected into the ever-present other. This loss of a previous psychic equilibrium may seem disturbing, traumatic and undesirable; it may cause substantial instability in the relationship. However, if this can be contained, either by the more mature parts of the partners and their relationship, or by the therapeutic process, omnipotent projective identification and narcissistic relating may slowly be given up and lost parts of the self, previously split off and projected, may be regained. This leads to the greater integrity of each of the partners and so to a more mature interaction between them. I am here again referring to the move from narcissism to more mature relating.

The requirement for mourning

This move towards relatively mature relating requires the toleration of loss - at the very least the loss of omnipotence and narcissism - and the work of mourning which this requires. Steiner has written about the painful necessity to experience the mourning process which arises from this reclaiming of parts of the self from the object. This takes place in the transference whenever the analyst is experienced as acting independently and outside the control of the patient (Steiner, 1990). I suggest that exactly the same process takes place in the couple relationship when a partner refuses to accept a projected attribute and acts independently of that projection.

Steiner goes on to say that if this independence of the analyst, and I would add, or of the marital partner, can be tolerated,

> *"the loss of the possessive relationship can be mourned and a degree of separateness results. Disowned parts of the self are regained and this ultimately leads to an enrichment of the ego. In the process, however, guilt and mental pain have to be experienced and these may be difficult to bear. If they are bearable the sequence can proceed and further separateness is achieved by progressive withdrawal of projections. More realistic whole-object relationships result....."* (Steiner, 1990).

In the couple relationship, this unconscious process just described will never be fully realised. Unlike analysis, the intimate adult relationship at least promises to be interminable. Ordinary life transitions, constantly buffeting every relationship, provide lifelong opportunities to rework intrapsychic and interpersonal object relations. In as much as a couple is able to manage this successfully, they will be creating a relationship based on more realistic knowledge and awareness of themselves and each other.

If this can be achieved I suggest that a space is created - a space which I have called the 'marital triangle' - a space within which the couple may better

be able to reflect both on their own individual needs, on the needs of the other and on the requirements of their relationship. At times, these various needs will inevitably be in conflict and will require reflective thought and tolerable, if ambivalent, resolution.

The couple relationship, therefore, through the possibility of creating a 'marital triangle', holds the potential of promoting the psychological development of both partners comparable to that made possible by the successful negotiation of the original Oedipal triangle. It is in the bounded space of this triangle that containment is offered for reflection and thought and for the further reworking of Oedipal conflicts as they emerge. As I have already said, this constitutes a push towards the depressive position which includes the toleration of one's own separateness and that of the other. From here true intimacy becomes possible rather than subjugation and/or domination.

There will, of course, always be other psychic forces within the partners and their interaction which will seek to sabotage such potential development. This sabotage is in the service of the narcissistic part of each of the partners whose omnipotence and envy will not allow for proper acknowledgement of the separateness of the other. Neither the other nor the relationship will be allowed the recognition which could then lead to the creation of the marital triangular space.

The 'marital triangle', the symbolic third and the actual third

Evidence that the 'marital triangle' exists may be most clearly demonstrated by the way in which an *actual* third is incorporated into the couple relationship. I have in mind, perhaps most commonly and concretely, a child or work demands or demands of external family. But I am also thinking of less concrete factors such as an illness, or a preoccupation, or an interest, or even just a thought in the mind of one of the partners. The other possible third is the psychoanalytic psychotherapist in a clinical situation with a couple in treatment.

The existence of the 'marital triangle', within which reflection and thought may take place, suggests a capacity for observation, thought, mourning and the toleration of ambivalence which may all be required in the process of the integration of an *actual* third object, even when the third is desired and welcomed.

If, however, there is no 'marital triangle', it is likely that the actual third will create an intolerable triangle or be experienced as uncontained and uncontainable. As such it would evoke all the unresolved primitive Oedipal conflicts: the third object would be experienced as intrusive and persecutory, the anxieties aroused would be likely to be paranoid and the defences would include splitting, projection, omnipotent projective identification and

idealisation and denigration.

The diagnostic clinical questions, therefore, become something like this: how is the third related to? Is it related to substantially from within the thinking space of the 'marital triangle', with the impact on, and meaning to, the needs of the relationship and of each individual taken account of? Is it related to with the sense of a shared enterprise, however exactly managed on a day to day basis? Or, is the third experienced as disruptive, imposing itself in some persecutory way into the marriage? Or, is the third hijacked by one partner at the expense of the other, or abandoned by one partner to become the sole responsibility of the other? Can the third be tolerated or is it found to be persecutory and threatening either to the individuals or of their relationship?

Clinical illustrations

I will now give two short clinical vignettes to illustrate my theoretical discussion. The material has been very substantially disguised so as to maintain total confidentiality.

I am reminded of Mr and Mrs Jones (as I will call them), an intelligent and attractive couple in their early thirties who came for treatment because of a growing non-specific sense of discomfort and tension between them. They work in the same profession, but not together, and have one three-year old child whom they both care for by both working part-time.

In the clinical situation both Mr and Mrs Jones are very anxious about securely retaining their sense of themselves and of their superiority. I would describe both as narcissistic in their character structures and their marriage as one based on narcissistic object relations. By this I mean that both function significantly by splitting and projective identification, as a result of which each feels that the other threatens them in some way. Both, it seems, are only capable of the most minimal emotional contact and both attempt to control the other and their family interactions in a variety of ways. This emerges in relation to the ways in which they manage their professional lives and their child. Similar dynamics also emerges most vividly in the transference-countertransference relationship with me.

In relation to their work, they both often feel very threatened and diminished by the other's professional interests because they feel envious and out of control of the other. For example, Mrs Jones is beginning to have some of her work published and Mr Jones regularly undermines or attacks this activity. However, he himself is often enviously criticised by his wife because of his greater flexibility at work, a flexibility she does not have but would dearly like. Often, they each attempt to control and exclude the other and perhaps arouse envy by flaunting their preoccupation with their work.

Something similar takes place in relation to their child. Both can argue that the other's parenting is not good - too rigid is usually the main criticism - and that they themselves are the better parent. Alternatively, each desperately tries to hand the child over, feeling controlled and threatened by the needs and demands of the child.

Under the influence of such paranoid-schizoid object relations, with a predominance of projective and introjective identifications, *pairing with an object* is experienced either as greedily desired or as very threatening. Equally, *relating to a pair* for each is found to be unbearable because the other's pairing is felt to be excluding of the self and provoking of feelings of persecutory envy.

In the transference, I am often related to by each of them as if I am a wise sage whose every word is profound. For each I would be the much preferred partner in comparison to the spouse and am often competed for. Behind this idealisation, however, there lies a barely hidden near- denigration of me. This is evident, for example, when the couple leave the consulting room and go down the corridor conspiratorially giggling, whispering and physically holding each other, leaving me, alone, watching this apparently enviable couple.

In the countertransference, at least initially, I would feel suddenly dropped and abandoned by this intimate couple who make their sexual relationship very explicit. Sometimes they would spend a lot of their session time telling me in detail about the sex they had together over the weekend.

This idealised contact or persecutory abandonment of me in the transference indicates that the capacity for ambivalence has not been achieved. This suggests that there would be some difficulty in achieving a more depressive state of mind which might allow for the toleration of some separateness and difference. In the transference they act out either a highly idealised two person contact (each of them separately and me) or an idealised couple (them) with an abandoned third (me).

I would suggests that for both Mr and Mrs Jones, the Oedipal configuration consists of an idealised sexual parental couple with a lost, abandoned or rejected child, *or* an enviously attacked and denigrated parental couple with a narcissistically self-sufficient child. There is no Oedipal triangle and this idealisation/abandonment or denigration/self-sufficiency dynamic is re-enacted in their life as a couple and in the transference-countertransference relationship with me.

In the countertransference I feel myself as either invited to join in their idealisation of me or I am excluded by their provocative conspiratorial coupling. There is no 'marital triangle' and so no mental space between the couple within which to think together about their experiences and concerns. Equally, there is only rarely 'triangular space' in the therapeutic situation -

thinking space between the three of us - within which thought and reflection might take place rather than enactment.

The second couple I want to discuss are Mr and Mrs Brown (as I will call them). They have one child, eight years old, and work in sister professions. They have very similar histories: both had distant and rejecting fathers, and mothers who were narcissistically and dependently attached to them as children. One major difference is that Mrs Brown had a number of brothers and sisters whom she seems to have had good relationships with as a child. These sibling relationships offered a legitimate refuge or escape from the parents.

By contrast, Mr Brown was an only child and his only escape was, as he put it, "into a secret place in his head". In the clinical work, Mr Brown's level of anxiety is often highly paranoid and he relates with a high degree of passive aggression, projecting much of his anger and violence into Mrs Brown or, in the transference, into me, whom he often experiences as highly persecutory or even threatening.

The couple came into marital psychotherapy following severe bullying and abuse of their daughter at school. It appears that when they were required to offer their daughter the emotional support and response she required following the attack on her, they found themselves completely incapable of doing so either as a couple or as individual parents, though Mrs Brown was able to identify to some degree with her child. Such a trauma would, of course, test any parental couple, but for Mr and Mrs Brown it led almost immediately to a near total collapse of their relationship both as parents and as a couple.

What I think emerged in the clinical situation is that Mr and Mrs Brown had unconsciously recreated a marital relationship based on narcissistic pseudo-independence rather than more real ambivalent emotional contact. When their daughter needed a *real* emotional contact from them they were incapable of giving it, either as individuals or as a parental couple. Their relationship as a couple was not mature enough to establish the marital triangle which could take care of the needs of their daughter and the traumatic impact on themselves as parents. As individuals too, they had no personal experiential knowledge of containment and care, though it seemed that Mrs Brown was able to draw to some degree on her relationships with her brothers and sisters. A further problem was the degree to which both of the couple could become identified with the very vulnerable and needy child rather than with an internal caretaking parent or parental couple.

I will briefly describe the transference-countertransference experience which I think indicates the level of the primitive Oedipal themes emerging in the clinical work with this couple.

I find myself struggling to make *any* contact with either of them as individuals and I am left feeling almost totally hopeless in trying to relate to them as a

couple. This is instructive in terms of gaining some experiential understanding of how *they* struggled to relate emotionally to either their mother or their father, or to their parents as a couple. Alternatively, I feel under enormous pressure to relate to Mr Brown. I eventually came to realise that in the countertransference I experienced this as a pressure to strengthen and enliven him and to diminish his very anxious and suspicious view that I might be critical of him and bully him. This countertransference feeling of being a bully is very interesting given that their daughter was badly bullied at school.

I have come to wonder whether this very strong countertransference is a projection from *both* Mr and Mrs Brown of their unconsciously shared desire to reach and enliven the distant father, to bring him to life, and for him to then contain the anxieties of the mother, and so to create a functioning parental couple. This desire, however, produces an anxiety that to make demands of the father would be felt to be bullying and attacking of a weak and vulnerable man.

At the present time, therefore, the possibility of establishing a triangular space in the mind of this couple seems a long way off. The wish to unite the parental couple seems to be very problematic. For both, the search seems to be for a father-man who is neither weak nor a bully; but it is this which feels to be almost impossible. What is of clinical interest is whether the internal relationship they each have with their narcissistic mothers establishes a narcissistic identification which actually works against them securely finding the father (in the transference, me), because to do so would then deprive them of the illusion of their own narcissistic autonomy and independence and of being a primary object for their mothers. The sabotaging of this developmental step might be defensively provoked because if a good father were to be found he would step in and spoil this illusory mother-child Oedipal couple by reclaiming the mother, and constructing a generationally appropriate Oedipal situation. The loss and mourning that this would produce, in this move towards the acknowledgement and toleration of the parental couple relationship, could feel to be unbearable. As a result there is, in the transference, a constant attack on any possibility of making use of me by constantly relating to me only as if I were either a bully and persecuting or as weak and impotent.

Summary

Bion first established the notion of the container-contained relationship as central to the process of psychological development. Britton elaborated the importance of the infant's relationship to the *parental couple* in this containing process, which, by definition, has to involve an intercourse from which the child is excluded. The capacity to mourn the loss of sole possession of the

object and to tolerate observing good intercourse outside of oneself is a necessary step in the psychic move from narcissism towards a more mature capacity for object relating.

Because the intimate couple relationship is likely to recreate some of the Oedipal struggles left unresolved from childhood, it offers the possibility of there being a fresh opportunity of working through and possibly resolving some of these remnant Oedipal conflicts and anxieties.

The infant's realisation and toleration of the link between the sexual parental couple allows for the creation of a triangular space bounded by the three persons of the Oedipal situation and all their different relationships. This space provides the arena within which self-reflection, awareness of the other and thought can begin to take place. A suggestion is made in this paper that *symbolically* a similar process could be seen to take place within the dynamics of the intimate couple relationship. By withdrawing more narcissistic and omnipotent projective identification from each other, the couple not only move towards a greater degree of integration within themselves as individuals, but the relationship of their coupling is allowed to develop in its own right as a *symbolic third object.* This then creates the possibility of what I have called a 'marital triangle' within which there is the space for the consideration of the needs of each of the individuals and of their partnership.

Clinically, the psychotherapist will be drawn into the re- enactments of the Oedipal struggles and will certainly hold the potential for being the third element to be both included and/or excluded. The therapeutic role is that of maintaining the psychoanalytic stance: to maintain a capacity to continue to observe, to think about and comment on the dynamics being created in the relationship between the couple and in the transference-countertransference relationship between the couple and the therapist. The therapist's struggle to be both involved with the individuals and the couple and to be sufficiently separate so as to comment on this transferential involvement enacts the very struggle at the heart of the Oedipal situation.

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BETWEEN FEAR AND BLINDNESS: THE WHITE THERAPIST AND THE BLACK PATIENT

HELEN MORGAN

Introduction

This paper is an attempt by a white psychotherapist to consider issues of racism, and how they might impact on the work in the consulting room. There are two main features of this first statement that I want to emphasise by way of introduction. The first is that I intend to explore questions of difference in colour, and not issues of culture. This is not because I believe that matters of cultural differences in the consulting room are not interesting, or that culture and race are not often conflated, but rather that there is something so visible, so apparent, and yet so empty about colour, that to include a discussion of culture can muddle the debate and take us away from facing some difficult and painful issues. A black patient may come from a culture more similar to my own than a white patient, yet it is the fact of our colours that can provoke primitive internal responses that are hard to acknowledge and face.

Clearly there are many differences such as culture, class, gender, sexuality, etc. that form divides of definition within the wider society and where the power balance is asymmetrical. But those are the subjects of other papers. It is my experience that when the subject of race and psychotherapy arises among white therapists, we often quickly widen the question out to include other issues. It is as if we are trying to swallow up this difficult subject and lose it in a generality of difference. I am always struck by how very hard it is to think about racism for it is essentially such an irrational phenomenon and yet one that is so insidious and pervasive. Colour blindness, ignoring difference of this nature, is more comfortable, but I believe it to be a denial and a defence against a complex array of emotions that includes anxiety, fear, guilt, shame and envy. No wonder we do our best to avoid the subject.

The other point I wish to make is that this paper is written from the perspective of the white therapist. It is the only position I might have any authority from which to speak. There are worryingly few black people entering this profession. It seems that those who have are impelled by their experience in the consulting room with both black and white patients to consider matters of race and racism. Some have written of their subsequent thinking. On the other hand, there is a notable paucity of writing from white therapists on this subject. Paul Gordon conducted a survey of psychoanalytic psychotherapy trainings and equal opportunity policies in 1993 which he refers to in a paper

written in 1996. He concluded:

> *'not only that few organisations had actually done anything meaningful in this respect, but that many simply did not regard it as a problem and some completely misunderstood the issues'* (1996, p.196)

Because we work in an essentially white profession within a society where white holds power, the white therapist can go through life avoiding this matter altogether, assuming it to be a problem for our black colleagues. Pressures to think about it may be dismissed as mere fashion and political correctness. I will suggest in this paper that we as individuals, our work and the profession in general are the poorer for such avoidance .

A paper by Bob Young on how little the issue of racism is addressed within training organisations, is entitled 'A loud silence'. There is a silence generally within our profession concerning racism, but I believe also that a silence can too easily develop in the consulting room. It is a dangerous silence for the therapy because it contains too much background noise for it not to infect all the other work we try to do. A frequent response by the black patient is to stop and leave therapy, often silently. Another response is not to enter in the first place - which is the loudest silence of all.

Psychotherapy - 'What's race got to do with it....?'

In its essence psychotherapy is a process of an individual therapist working with an individual patient. In that work a relationship develops which is specific to those two individuals. Our focus is on the vicissitudes of the internal world of the patient and how it emerges transferentially within that relationship. The terms 'black' and 'white' are definitions of collective categories of so-called race. Racism involves such collective definitions which carry a process of de-personalisation, seeing only the characteristics ascribed to that category and not the individual. What, therefore, has such a topic to do with the business of psychotherapy?

Assuming racism to be a non-issue for psychotherapy is tempting. However, I believe that racism forms a backdrop which exists to any therapeutic encounter. It is a form of pathology and, therefore, should be open to the exploration of therapy. It is so for our white patients and needs, therefore, to be available to analysis where it appears. When a black patient enters therapy, because of the effects racism will have had on him or her, these experiences will be present in the room. Power differences, both real and perceived between a white therapist and a black patient will exist, and we need a way of exploring them especially when they occur as transference resistances.

In *The Good Society and the Inner World* Michael Rustin (1991) describes the concept of 'race' as 'an empty category':

> *'...differences of biological race are largely lacking in substance. Racial differences go no further: in their essence, than superficial variations in bodily appearance and shape - modal tallness of different groups, colour of skin, facial shape, hair, etc. Given the variations that occur within these so-called groups, and give rise to no general categorisations or clusterings.... it is hard to find any significance in these differences except those that are arbitrarily assigned to them (....even physical visibility has been lacking in important cases of racism as a ground of distinction - the Nazis compelled Jews to wear the Star of David because they were not readily identifiable as Jews....) Racial differences depend on the definition given to them by the other....and the most powerful definitions of these kinds are those which are negative - definitions that we can call racist.' (p.58)*

The emptiness of this category 'race' emphasises the irrational foundation of racism. Any analysis of these foundations has to include a political and economic perspective. Colonisation and the riches of power and wealth that were exploited by white Europeans in the past, and the continuation of such exploitation in the process of globalisation, require moral and psychological constructs as a justification for the exploiters. Exploration of the psychology behind and within the process can be helpful if it goes alongside other approaches. In his paper 'Souls in armour' Paul Gordon (1993) argues:

> *'Psychoanalysis cannot provide a theory of racism, although it can - and should - be part of one. Racism is in the material world as well as the psyche and our attempt to understand it - like our attempts to understand all other phenomena - must be in two places at once.' (p.73)*

Those who have considered the subject of racism from a psychoanalytic perspective focus on different possible aspects. Rustin sees racism as akin to a psychotic state of mind. The mechanism includes a paranoid splitting of objects into the loved, and the hated and the racial other becomes the container for the split-off, hated aspect which is then feared and attacked. Rustin argues that it is the very meaningless of the racial distinction in real terms that makes it such an ideal container, for no other complications of reality can intrude. Splitting mechanisms include idealization as well as denigration. The latter is mobilised and expressed in political speeches which refer to excrement and the terror of floods of immigrants taking over the country. The former is evident in the idealization of Afro-Caribbean youth culture and the attribution of the abilities in sport, music and dance. This process of idealization carries with it the dynamics of envy.

Stephen Frosh argues that racism is a response to modernity and the fragmentation that is experienced. The move to a more pluralistic society together with the dismantling of much of the external forms of superego control carried by the established institutions, such as church and state, may mean greater freedom but places a considerable strain on the individual ego to manage that freedom and hold the depressive position. The fragile ego, fearful of fragmentation must find ways of defending itself. The need is to establish a boundary between self and other and to then define the other as inferior and thus the self as superior. Hated feelings can be projected into the other and feared, envied and attacked. Frosh predicts that the retreat to fundamentalism and the growth of racism will be the key problem for modern society.

From a Jungian perspective James Hillman (1986) in his paper 'Notes on white supremacy' explores the meaning of the colours white and black:

> *'Our culture, by which I mean the imagination, beliefs, enactments and values collectively and unconsciously shared by Northern Europeans and Americans, is white supremacist. Inescapably white supremacist, in that superiority of whiteness is affirmed by our major texts and is fundamental to our linguistic roots, and thus our perceptual structures. We tend to see white as first, as best, as most embracing, and define it in superior terms'. (p.29)*

In his paper 'The soul of underdevelopment' to the International Congress for Analytical Psychology in Zurich in 1995, Roberto Gambini quotes a statement of the Pope at the time of the conquest of South America; 'There is no sin below the Equator'. Gambini notes that:

> *'In sixteenth Century catholic Europe, the shadow was kept under relative control by ethical institutions and civil law....The shadow stayed in the corner, pressed for a way out to be lived and projected. Thus, when a vast geographical area was opened under the rubic, "Here it is allowed," the shadow disembarks on the shore and runs free, proclaiming gladly: "I made it! This is home!".' (1997, p.142)*

Hillman talks of the projection of the shadow onto the black population. The very nature of white and its equation with light, bright and innocent means it cannot include the dark within it. He suggests that *'whiteness does not admit shadow, that its supremacy rejects distinctions and perceives any tincture as dullness, stain, dirt or obscurity' (1986)*. White, therefore, casts its own white shadow and casts it into the black.

The concept of projection of the shadow into the other who is then feared, hated, envied, etc. allows a generality that leaves open the question of what that shadow aspect might consist of. So-called racial groups - the Jew, the African, the African Caribbean, the Asian, the Middle Eastern and others - all carry separate collective projections and evoke various primitive responses. The threat each category is perceived to contain, from a white racist

perspective, is seen to be different in each case, as is what is perceived to be enviable. Each is seen to be available to carry an aspect of the white shadow. The effect of the process, in each case, is one of depersonalisation and dehumanisation.

As a side point I am not saying that the process of shadow projection is the perogative of white people only. To do so would be to engage in a reverse form of splitting, assuming pathology to belong to white people and health to black people. This would be to deny the facts and to idealize the other. However, I do want to keep focused on white racism for two reasons. One is that the power balance between white and black in this society is not symmetrical and that needs to be owned as a reality. The second is that my concern in this paper is the white therapist and the implications of white racism for him or her.

The White Liberal

The racist self is an ugly creature and one we wish to give no house room. This ugliness has expression in such groups as the BNP, the Klu Klux Klan, apartheid, etc. It does untold harm to the black 'Other' who is the recipient of the evacuation of the hated parts of the racist self and who then is hated and attacked. Their existence is also a problem for the white liberal in that, in themselves, they provide a container into which we can project the racist self.

When we consider racism as a splitting or projective mechanism it is easiest to focus on the extreme forms of overt racist attack, genocide, slavery and exploitation. Of course this is important but, the danger can be that those of us who do not engage in such acts of hatred and who abhor such groups, can retreat to a fairly comfortable position of disassociating ourselves from the whole process. Racism is a pervasive business, and it gets into everything and everyone. I doubt whether there is any black person living in this country who has not been subject to it in some form or another in their life. But nor am I, as a white person, free of it. Like everyone else I grew up in a racist society, and it would be a supreme statement of omnipotence to say it hasn't got into me too. When we attempt to disassociate ourselves from the phenomena, I believe that this is denial and another sort of defence. A defence against something ugly we fear in ourselves.

Julian Lousada describes two traumatic aspects of racism in his paper 'The hidden history of an idea. The difficulties of adopting anti-racism' (1997):

> *'There are, it seems to me, two primary traumas associated with racism. The first is the appalling inhumanity that is perpetrated in its name. The second is the recognition of the failure of the 'natural' caring/humanitarian instincts and of thinking to be victorious over this evil. We should not underestimate the anxiety that attends the recognition of these traumas. In its extreme form this anxiety can*

produce an obsequious guilt which undertakes reparation (towards the oppressed object) regardless of the price. What this recognition of a profoundly negative force fundamentally challenges is the comfort of optimism, the back to basics idea that we are all inherently decent and that evil and hatred belong to others. Being able to tolerate the renunciation of this idea, and the capacity to live in the presence of our own positive and destructive thoughts and instincts is the only basis on which the commitment to change can survive without recourse to fundamentalism.'

This trauma of racism, then is not in Julian Lousada's view just the horror of the racist act but the problem for us all that it exists. The problem for the white liberal is not only the negative racist feelings we may have towards the black 'other', but our need for denial of them out of guilt and shame.

On being white

When I first began to think about these issues, largely via my contact with black friends, colleagues and clients, I found that the previous basic assumptions about my own identity were challenged. Growing up as a white person in a white society, I had no cause to question either my culture or my colour. If asked to describe who I was, I wouldn't have even considered defining myself as white.

Doubtless such primary assumptions exist for all human beings. However, I cannot imagine a black child growing up in this country who does not have to face, fairly early on, that he or she is black. The luxury of it never crossing my mind that I was white is not allowed the black person. I call it a 'luxury' because of the sense of ease that being permitted to take an aspect of my identity for granted brings. But I wonder. Taking something for granted is a near relative of it being unconscious.

In his book *Partisans in an Uncertain World* Paul Hoggett (1992) says:

'....uncritical thought will not simply be passive but will actively cling to a belief in the appearance of certain things. It actively refuses, rejects as perverse or crazy, any view that may contradict it. To think critically one must therefore be able to use aggression to break through the limitations of one's own assumptions or to challenge the 'squatting rights' of the colonizer within one's own internal world' (p.29)

He goes on to suggest that if the movement of thought is to be sustained, the act of aggression must be followed up by the act of play and he quotes Winnicott (1974):

'The creativity that we are studying belongs to the approach of the individual to external reality...Contrasted with this is a relationship with external reality which is one of compliance, the world and its details being recognised but only as something to be fitted in with or demanding adaptation...' (p.76)

Given the fact of global colonisation by white western Christian culture, for us who are defined as belonging to such a culture, we can, if we choose, avoid external pressure to make that act of aggression that challenges the 'squatting rights' of the internal coloniser. But not noticing this figure who inhabits at least a corner of our minds demanding compliance does not mean he does not exist. I suggest that we are the poorer if we do not attempt the act of aggression to break through our assumptions for they then remain an area of internal life that is unexamined. The tenacity of the uncritical thought that actively clings to a belief in the appearance of certain things in Hoggett's quote may give us a clue to the tenacity of the fact of racism despite legislation and attempts at training. For me to think differently about my place in the world and the privileges it has brought me requires an undoing of a well-laid system of assumptions about myself. The fact that those assumptions existed and continue to exist does not make me an inherently bad person, but to break through their limitations is hard work. For Hoggett to then suggest I am required to take it further into the area of play is asking a lot. This is a not an easy subject to 'play' with. It raises feelings of guilt, shame, envy, denial and defiance, all of which are hard enough to face in the privacy of one's own life. To explore it publicly can bring up in me a fear of getting it wrong, of saying the unforgivable and of exposing a badness in me.

I wish now to consider work with two patients, one white and one black, to illustrate the issues as I perceive them in therapeutic work.

A White Therapist and a White Patient

J was a white woman in her late forties who at the time of the incident described below had been in therapy with me for several years. She arrived at one session disturbed and shocked. J was a social worker in an inner city area. She had been working with a client for some time and she had become emotionally close to this young woman of eighteen who she saw as vulnerable and abused. That day the client had told J that she had started going out with a black man she had met in Brixton. J's immediate reaction to this news had been one of fear and loathing, this was followed by real distress at her own 'unthinking' reaction. J considered herself to be a rational liberal person who was used to having black colleagues and friends and thought she had 'worked through' issues of racism.

J reported the news and her reaction at the start of the session but hastened to assure me that she had had a chance to think it through and things were OK now. She realised her reaction had been from a stereotype of a black man and she was ashamed of her initial response which she considered primitive and racist. Soon she was on to another subject and apparently the matter was over and done with. I was struggling to work out what might be going on here. The

telling me of this event had the feel of the confessional where J was telling her secret 'sin' to me. It seemed that the telling of the secret was enough and, with a sigh of relief, we could both move on.

In this she seemed to be appealing to my 'understanding' as another white woman on two levels. One was a recognition of the stereotypes conjured up by the words 'black man' and 'Brixton'. The other was a liberalism that had no truck with such silly notions. Both expectations were accurate. The questions in my mind, then were: What was her immediate response about in terms of her internal world? What was she defending against in the shame and the wish to move on? What was being re-enacted in the transference?

Despite an uncomfortable feeling in the room I returned to the subject of the client's boyfriend and tried to explore her associations more explicitly. Brixton, it emerged, was like London's 'Heart of Darkness'. It was for J a vibrant, but fearful, place which both repelled and fascinated her. Locating this black man in Brixton embued him with both excitement and fear. J imagined this man to be sexually active and attractive, and she feared what he might do to her client. She was able to acknowledge both her fear of him as threat, and her envy of the client having this exciting sexual object. She feared he might have AIDS, and had already imagined the man making the young woman pregnant then abandoning her. The fear of the aggressive, contaminating and feckless man was evident.

Clearly there are some complex processes occurring here that were specific to the internal world of my patient. For the purpose of this paper I want to emphasise a few main themes. Put simplistically, one theme was how she had projected a primitive animal male sexuality onto the man, and an innocent pure femininity onto the client who had to be protected. But there was also the issue of her sense of 'badness' and shame at having these feelings. After all the work she had done on herself in developing her awareness of her racism, she still was capable of such 'bad' thoughts. These thoughts had intruded into her mind like an aggressive attack. In themselves they were shadow aspects which penetrated, left her with a shitty baby, and then abandoned her. The client, perceived as the victim of the black man, was also 'innocent' and 'pure' of such nasty thoughts.

In seeing the black man through her initial lens which she defined as 'racist', she employed a mechanism of projecting the aggressive, physical and sexual masculinity onto him and the innocent feminine victim onto the white female client. As such it is a projective defence. However, the more difficult issue to explore was how her denial of her racist feelings was also a defence against her own aggressive and penetrating thoughts. By telling me of the initial reaction and the subsequent process back to a more comfortable position she was inviting me to collude both with her initial disgust and with her

subsequent shame. We were to be 'in this together'. Her 'confession' followed by the response 'it's all right now' seemed to be an appeal for me to ally myself with the aggressive intruding thought, with the innocent female victim and the rescuer who protected my client/patient from this attack by denial.

What I am wanting here to point to for the purposes of this paper is the following:

1. 'Bad' intolerable aspects of aggression and sexuality were projected onto the black man and onto Brixton. As with all projections, their acknowledgement allows the possibility of their withdrawal and these 'bad' aspects integrated into the self.
2. The projection itself was experienced as a thought that was invasive and intolerable as it evoked shame, guilt and anxiety.
3. The patient tried to resolve a dilemma by 'confessing' the initial reaction to me, and then making a speedy retreat from the subject. Shame and anxiety led her to avoid exploring the projective processes and their potential access into internal structures.
4. Because both the racist 'bad' thought and the shame this produced echoed in me, the patient's invitation to collude with her avoidance was tempting. I was required to face and accept my own responses in order that there was permission for the patient to explore some important material. Whilst these responses may have been used unconsciously by my patient to support her avoidance, they were not of themselves counter-transference responses. They were more general processes familiar to me as a white individual, living in a white racist society.

A White Therapist and a Black Patient

D is a woman of African descent who was brought up in France. In her mid fifties when she first came to see me, she was the eldest of four having come from a religious family where a strict, sometimes harsh, discipline was imposed on all the children. This discipline was often experienced as arbitrary and D responded by retreating into a fantasy world inside herself. It was only in her late teens that she discovered that she had been adopted when she was six months old. Her 'mother' was, in fact her aunt who had just married at the time of D's birth. They had then had three children of their own. The birth mother left the area and all contact with her was lost since the adoption. The identity of the father was not known by the adoptive parents.

At our initial interview I raised the fact of the black/white differences between us. She assured me that this wasn't an issue, that she was used to living in a predominantly white culture and knew that she was unlikely to find a black therapist anyway. It made no difference to her. In my experience this

is a common response. I know there is an argument that the therapist should wait for things to come up in the material and not refer to these matters unless the patient does. On the issue of difference in colour I disagree. I believe that, given power issues and possible anxiety the patient may be feeling about my response as a white person, it is a lot to expect that a black patient will risk raising the issue themselves. Stating that the difference is noticed and acknowledged by the therapist and that it can be talked about gives permission for the matter to emerge at a later date.

D was very polite and well-behaved in her sessions for some time and, whilst the work went on, there was a sense of a lack of engagement. It was only after the first long break came that any negativity surfaced when she began to miss occasional sessions. We both understood this to be an expression of anger and a re-enactment of her 'disappearance' from the family as a child, but it remained a theoretical understanding and wasn't felt in the room by either of us. Gradually I became aware of a feeling in me in her sessions of wanting her to leave. As I looked at her on the couch, the phrase that came into my mind was 'cuckoo in the nest'. More to the point she was a 'cuckoo in *my* nest' and I didn't want her there.

Usually, of course, when I have negative thoughts about patients I am reasonably able to accept them, welcome them even, as a *counter-transference* feeling and therefore of an indication of what is going on. This time I was also aware of an urge to push this feeling away. I felt I 'shouldn't' feel this way towards her, and an effort was required to stay with the thought. Eventually I said something about the wish for us not to be together. She seemed relieved and said she had been feeling she didn't belong, that being in therapy was a betrayal of herself and maybe not right for her. There followed a period where she verbally attacked therapy in a contemptuous way, describing it as tyrannical and against people thinking. Implicit in her attacks was her superiority to me. I had been taken in by this tyranny whilst she remained free. At one point she was saying how she feared that I would - and she meant to say 'brainwash' her - what she actually said was that I would 'whitewash' her.

She was initially quite shocked by the idea that she was relating to me as a colonial, imperial power that could take her over with my mind. She was well read and understood theoretical constructs regarding transference and she began to 'wonder' whether her fear of brainwashing was about her fear of the therapist/mother. Her invitation to me was to interpret in terms of her internal world only. There were, indeed thoughts about an engulfing adoptive mother who disciplined harshly, of her struggle to fit in with what is around her and only able to assert herself by leaving. I felt, however, that we needed to take care. All that was in the 'brainwashing' scenario. Something more complex was expressed in that of the 'whitewash'. Something we both might be finding

difficult to face.

Staying with the subject of colour and the difference between us she began to express a disparagement of blackness. She said she had been relieved that I was white when she first met me because of a sense that a black therapist would be second rate and she wanted the best. She was deeply ashamed of these feelings as a woman who was politically aware and dismissive of the mimicry she saw in some black people. The self denigration in this was evident and illustrated how the black individual on the receiving end of white shadow projections can internalise this hostility and turn it into an attack on the self.

However, my job was to explore with her which aspects had been introjected by *her* and how this related to *her* internal world. From infancy D. retained a sense of abandonment. She was the odd one out without understanding why. She had to be good to hold onto her mother's love but she still kept getting beaten for crimes she didn't always understand. Her general feeling throughout was of not being good enough. Her sense of belonging was extremely tenuous. Her rage at this had had no expression as a child, except in fantasies of suicide. She could only cope with the situation by imagining there was something fundamentally wrong with her.

The fact of being black in a white society fitted this sense of not belonging. Her experiences of racism had provided an unconscious confirmation that she was 'bad' and deserving punishment. Despite political alignment with the black movement, her internal sense remained that of being an outsider, of being wrong and somehow dirty. White meant belonging and white meant what she was not, good, successful and of value. My whiteness meant she could get close to the source of what was good but she had to be careful that she didn't antagonise me through any exposure of her 'bad' rage.

As we explored the self-loathing inherent in her 'secret' disparagement of 'black' her comments switched from a denigration of the blackness of herself to a denigration of my whiteness. This was done largely through her accounts of the racism she had experienced. She seemed to be challenging me to take up a position. Was I allied with these white others or would I join with her in her attack, and become black like her? What was not to be allowed, it seemed, was our difference. I was to be for her or against her.

Whichever category was to be deemed superior to the other, the insistence that one *had* to be, served to perpetuate the perception of me as 'Other'. 'Other' with a capital 'O' as, this way I was being safely removed behind a shield of categorisation. Thus D could defend herself against the anxiety of her longing to become one with me and the terror of expulsion. If I rejected her it could be because she was black and bad or I was white and bad. The pain and frustration of me being different and separate from her could be avoided.

In his paper 'Working with racism in the consulting room', Lennox Thomas

(1992) describes a similar experience of a white therapist working with a black patient who was in supervision with him. Thomas says: '*...it is difficult for the therapist to recognise that the unconscious does not distinguish between colour as far as the perpetrators of pain are concerned*'.

In the same paper, Lennox Thomas cites the concept, put forward by Andrew Curry, (1992), distinguishing between the pre-transference and the personal transference. This, to my mind, is a useful distinction. The pre-transference is described as:

> *'the ideas, fantasies and values ascribed to the black psychotherapist and his race which are held by the white patient long before the two meet for the first time in the consulting room. Brought up in the society which holds negative views about black people, the white patient will have to work through this before engaging properly in the transference. The white psychotherapist too will need to deal with this when working with black patients....This pre-transference is constituted of material from the past: fairy tales, images, myths and jokes. Current material, in the form of media images, may serve to top up this unconscious store of negative attributes.' (p.137)*

Dorothy Evans Holmes in her paper 'Race and transference in psychoanalysis' (1992) notes:

> *'Usually a therapist has many useful points of access to a patient's transferences. Though long neglected, patient's references to race may provide an additional point of entry to transference reactions.....' Elsewhere in the paper she notes that 'often it is said that patients' racist remarks in therapy constitute a defensive shift away from more important underlying conflict....While it is the therapist's ultimate aim to help the patient understand the protective uses of defences, this aim can best be achieved only after the defences are elaborated'.*

For D the early loss of the mother, and the later felt tenuousness of the bond with the adoptive mother was the pain that lay at the centre of her self. It was this pain and her consequent rage that had to enter the therapy and be survived. White and black as placed in opposition to each other served as a vehicle to keep us apart and away from an engagement with each other.

This opposition formed a dividing line, provided by the wider society, and we were perceived to be on opposite sides. The line *both* exists in reality *and* is an internal, defensive construct. We both needed, I believe, to acknowledge its external reality and its consequences for each of us. As the white therapist I was required to explore my pre-transference and where this colluded with the racist line. My shame and guilt had also to be owned internally. D needed to know I knew about the line and accepted its reality for her. A too hasty interpretation of her response, as only a recapitulation of the original pain and the original defence, would have been a defensive denial on my part of a real divide.

However, the analytic stance required an understanding that the divide was

also being used as a defence and this had to be elaborated to give access to transference reactions. The generalities of race had to be interpreted and understood in terms of the specifics of *her* internal world and the transference. To do so we had to withstand an engagement that held the possibility of aggression and hate.

The wish to make everything all right and deny anger and hatred in the relationship was rooted in D in her original childhood scene where her anger was not allowable. She was, in many senses, the cuckoo in the nest, not a real part of the family and not conscious of why. She had had to defend against her angry destructive thoughts because she could be rejected altogether. Such a sense of not belonging was re-enforced by her move to another country but also by her experience of being a black woman in a white world. In the transference, she had to take great care that she didn't upset me for her aggressive impulses could be so destructive she could do me damage.

On my side, I didn't actually fear her anger or aggression. More problematic was the possibility of shame at having any racist thought about her. It was the fear of shame that was potentially more debilitating and paralysing. It seems to me that, in order that we could work together, D and I had to hold two positions simultaneously, of 'remembering' that she was black and I was white, and of 'forgetting' it.

Conclusion

There are, it seems to me a variety of routes the white therapist can take in our attitude to work with a black patient.

The first is to ignore the issue. This is a form of colour blindness and, in my view, a denial. A denial of difference and a denial of uncomfortable feelings this difference may invoke in both and in the relationship. It has the appearance of good therapeutic practice for it seems to be seeing the individual and not the category. A consequence of this is that, should the patient bring material of racist experiences, the therapist will interpret it only in terms of the patient's internal world. A reality is not acknowledged and an abusive situation re-enforced by the denial of the reality of the abuse.

The second is to acknowledge that there is an issue but it is one that exists for the black patient alone. It recognises that the patient is likely to have experienced overt racism in his or her life and that needs to be acknowledged and understood. This, I believe, still removes the problem to outside of the consulting room and can be a defence on the part of the white therapist against his or her own racist responses and therefore against shame and guilt. The responsibility for the pre-transference is left on the shoulders of the black patient.

The third is to recognise that, if I acknowledge a racist backdrop to our society,

then, as a white person, I too cannot be free of the phenomena. I also have inherited a prejudicial veil which forms before my eyes when I see the blackness of the individual. Such a veil is likely to include an embroidery of guilt, shame and envy given that the relationship for the white liberal as opposed to the extreme racist is complicated by the hatred of the internal racist. Such shame is likely to prevent us from working through the reality of the external situation to an interpretation of the meaning of the situation for the individual.

Following on from this is a fourth position which also recognises that racism will effect the relationship between us. That there is a power differential inherent in that relationship over and above the power relationship which both exists and is perceived to exist between any therapist and any patient. Elaboration and exploration of the reality of this differential may provide an important means of access to the transference. My argument is that we have to manage this fourth position if we are to get to the place I think we need to be. That is through to the point where the issue is not an issue.

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ERRATA

We would like to apologise to Mary Adams for wrongly describing her paper in the last edition of the Journal as a Reading-in paper of the BAP.

The Editorial Board

Book Reviews

Welcome to My Country

By Lauren Slater. Hamish Hamilton, London, 1996, pp. 224. h/b £16.00

Schizophrenics are most people's nightmare, with their lurking violence and incomprehensibility. Lauren Slater was assigned to a group of six male schizophrenics in a long-stay residential unit in downtown Boston. She arrived on her first day with a MA from Harvard and a doctoral thesis from Boston University. 'I am your new group therapist. We'll be meeting once a week to talk things over, see how your lives are going, confront problems, think up solutions, play some games, even. How does that sound?' Her voice, she admitted, was cracking from fear.

She was met with resounding silence. Oscar sat on the floor, surprisingly delicate snores emanating from his lips, others sat pressed against the wall staring into their private space like strangers on a train. As time went by, her group seemed like a microcosm of contemporary USA - Charles, a moribund AIDS sufferer, Leonard, a deeply alienated black, Moxi, a Vietnam victim, Oscar, obese and catatonic, sexually abused by his father, Joseph, an Italo-American, a stark failure of the American Dream.

Group sessions were slow to get moving. Joseph brought his military helmet with him, which he always peered into. Slater asked what was inside. 'Blood be gone and hell swell saboose. A girl curve feminine adventure.' Language, its byways and detours, was the road along which the group travelled. Schizophrenics are often beguiling and enticing, promising so much, the Ancient Mariner at one's elbow. Their 'word salad' disguises much of their communication and sometimes their real feelings. It's used, too, to check whether a paid professional is listening or has already switched off.

Slater took them on - part courage, part compassion. She lowered her professional armoury, put aside notions of progress and development, and listened. Oscar would tell her about the albino girls waiting for him in the night sky ready to slip in through his window. Others fantasised just as vividly. Yet, beneath it all, Slater sensed their terrible loneliness, masked by the language, which, for all its colourfulness, was, as one of them put it, like 'being trapped inside the dragon'. She was alert to it, following it like a surfer, riding the waves which too often 'fizzled into foam'. It was unrewarding work. But that, she realised, was precisely the point - a world without rewards, treatment as meaningless. She used her imagination to animate the group, playing at riding inside a spaceship, singing an impromptu Sinatra song, a fellow patient offering his fist as microphone. The group came together 'like

a waking animal blinks and stretches'. Moxi emerged from his isolation and insisted on shaking everyone's hands ['welcome to my country']. He showed them his disfigured penis and missing testicle, an act of self-mutilation after witnessing his family being killed in a village in Vietnam.

Slater took the group on an outing to a pizza parlour. On the way back they had to push Oscar manually uphill, so obese was he. Once back, he peed uncontrollably, the single activity that made him feel warm, alive and real. Slater tackled Joseph's obsessive word writing. He was an ex-Princeton undergraduate, who had cracked up and never recovered. Now he wrote everywhere, on walls, on other people's necks, on scraps of paper, and in his own multiple spirally-bound notebooks - producing Lorca-like flights of fancy: 'Ah! golden pods. Heaven of flying dirt'. Slater once added something of her own to one of his notebooks and Joseph suddenly stopped in his tracks, entranced, caressing her words, raising them up to his cheek in a gesture of lost maternal affection that recalled his favourite son status with his Italo-American 'mamma'. The latter had been his undoing. He soon recovered enough to enrol on a local creative writing course, leaving the unit each morning, spruced up, new shoes, clean shirt, no drool in his beard. He even passed his exams - once he had learnt not to circle every answer in his multiple choice tests.

Slater's therapy was participative, drawing on her own experience. With another patient, Peter, a compulsive masturbator, whom she had to see in her tiny office, knees almost touching, she thought back to her own adolescence and the abuse she had subjected her own body to. She realised that they were both - Peter now tyrannised his girl friend's body - 'victims of our culture's fear of the feminine. We did not know how to trust what we could not dominate'. She came to understand Peter's terror of himself, as he did too, eventually.

The book's narrative strength is such that the reader becomes anxious on behalf of the characters described. I found myself in a state of suspense wondering what was going to happen next. This is story-telling at its best, with language and imagery, mostly physical in content, to match. The catatonic Oscar is given a section of his own towards the end of the book, and Marie is introduced, a young mother with a heart-rending struggle against drugs and depression. Slater stays with the pain, and it makes compelling reading.

The book is well-structured so that only at the end do we learn of Slater's own 'tangled past' and how this has underpinned her work. In the final chapter she returns as a professional to the hospital where she was interned as an adolescent. The ward sister queries her surprising knowledge of the patients' loos. 'Use the staff ones in future'. Slater is mightily relieved no one had recognised her.

Schizophrenics inhabit a word-driven universe of great intensity, a labyrinth whose entry point has been lost, so that they cannot now remember where, or what, it was. Here Slater's intervention has made a difference. Each of her main characters suddenly talks lucidly for a few minutes, articulating with astonishing clarity the situation he is in. These moments of lucidity, she feels, are all one can hope for - as Dostoievsky said: 'If one has one good memory left in one's heart, even that may be the means of saving us'.

In an age where quick cures are sought - via Prozac, the hurdle jumper of new wonder drugs, or via the 'managed care' system that Slater describes, where in-patients are asked the early morning question 'Are you feeling suicidal or self-destructive today?' and, if the answer is negative, are propelled out into the street to make way for another emblem of fiscal pressure, *Slater's book* stands out as a timely reminder of what 'treatment' should be about, addressing the human condition in all its pain and uncertainty. Working with the severely 'mentally ill' is always a difficult assignment, making the participant see, feel and hear things he, or she, would rather not have to. Yet Slater's optimism remains surprisingly high. She sees a need for the 'slow learning about connection and separation, the visceral study of painful lacunae' and of the need to work with the other at the vector points where each meets, above all to 'keep company with the person who hurts'. At a time when pain, and understanding, are frequently avoided - Americans, as she points out, now seem to expect a pain-free existence as a constitutional right - her conclusion is well worth respecting.

JOHN CLAY

The Making of a Psychotherapist

By Neville Symington. Karnac Books, London, 1996 pp.256. p/b £18.95

Neville Symington's book is an interesting and readable account of what it takes to be a psychotherapist. In the Acknowledgements the author tells us the book is made up of papers given to mental health professionals, especially psychotherapists, over an eight year period, mainly in Australia and New Zealand, and in doing so answers a question that was in my mind throughout my reading. Who is this book aimed at? The question remained because there were times when the content seemed to be aimed at trainee therapists, or those who have not trained, and at other times contained new or controversial material. for example in his chapter 'A question of conscience.'

The book is divided into two parts with a foreword by Anton Obholzer who describes the book as 'a record of a personal journey of professional development.' Part One (chapters 1-7) is about the personal qualities that Symington believes are necessary to make a good psychotherapist. The second part 'Professional Dilemmas' (chapters 8-16) outlines theoretical models and analytic concepts. It is in this second part that Symington is self-confessedly controversial and it was in this area that I found myself disturbed at times. I will return to this later.

Throughout both parts of the book there are two themes that the author returns to many times. The first theme is the one of theory and ideology. Symington urges us not to stick to one clinical theoretician and reject others because they may challenge our preferred theory. The second theme is the one of how we approach our work with patients. Is empathetic understanding in itself enough to help patients make real changes to their internal structures, or do we also face the patient with his or her contribution to the situation they find themselves in? In other words is the patient victim of the environment or his own actions? Symington describes these two models as the medical and the moral. In his answer he links the two major points he makes, namely that both are required. The medical model on its own doesn't go far enough to effect change and the moral model alone is very persecutory. This is either a basic lesson to learn or a reminder, depending on whether the reader is an experienced psychotherapist or an untrained worker in the area. As a Jungian reader the test of whether Symington, a psychoanalyst, is putting theory into practice as regards taking theories that suit rather than because of dogma, is whether he takes account of Jung. He passes this test on page one of his book and similar references follow.

In Part One Symington outlines what he thinks a good intellectual training requires. He is disparaging of our part time trainings tacked onto the end of a

long day and suggests that if it takes six years to become a doctor then it will take at least eight years to become a psychotherapist. The training would be multi-disciplinary and cover all the different theories so that the trainee may 'follow the inner light' and be able to speak from the True Self, thus making emotional contact with the patient rather than passing on theories when making interpretations. He calls this the Invention Model. The chapter called 'Imagination and Curiosity of the Mind' develops this model. Symington says *both imagination and curiosity are the most important transforming elements* in psychotherapy. Of course this is another way of saying 'don't stick to a theory' and 'follow the inner light'. These ideas are neither new nor controversial but are helpfully described and serve as important reminders. Symington says that curiosity can be developed *a great deal but unfortunately* does not tell us how. The chapters that follow are entitled 'Mental Pain and Moral Courage', 'Self-esteem in Analyst and Patient' and 'Transference' and this brings the reader to the end of Part One.

In Part Two, 'Professional Dilemmas', Symington returns to the theme of whether as human beings we are acted upon by our environment or whether we fashion that environment. As he has said before, it is a mistake to emphasise one over the other and we learn that at the Tavistock he found it necessary to emphasise the first and in Australia the second, in order to redress the imbalance in each group of psychotherapists as he saw it. In Chapter Eight, 'Modes of Cure', he links this theme to cure. The cure is described as two theories: Cure through Understanding and Cure through Knowledge. Both are necessary and therefore we cannot work with one alone, but Symington seems to think that many use only the cure through understanding model and therefore will not make possible a permanent change in the internal psychic *structure* of the patient. In other words we are not facing our patients with the fact that they have a part to play in the making of their environment. If this is the case, this chapter will be helpful but it is not my experience of colleagues when they talk about their practice which makes me wonder again about the *audience Symington had in mind when he wrote the* book. Chapter Nine 'The Seductive Therapist' gives examples of attempts at cure through understanding alone.

Chapter Ten, 'Mimesis in Narcissistic Patients', is very interesting and a subject perhaps little talked about. *Symington borrows the word from natural* historians and uses it to describe patients who mimic their therapist and strive to be like him or her rather than being themselves and in so doing defend against self-knowledge and individuation. Interpretations by the analyst are ingested rather than digested by the patient. The ego remains weak.

In the chapter called 'An Analysis of Greed' Symington reminds us that greed is often hidden and it results in the patients grabbing interpretations

rather than being nourished by them thus preventing the therapist from giving. He also describes how parts of the patient are prevented from giving to other parts in the same way.

Chapter Fifteen is called a 'Question of Conscience'. I found myself feeling uneasy when reading this chapter and kept wondering if I was feeling the blast of Symington's superego here. He makes a distinction between conscience and superego by saying the superego is destructive and anti Life Forces. He begins the chapter as follows 'I begin with a simple statement. It is this: that when a patient follows his conscience, his ego is strengthened'. I wondered why he was introducing the word conscience at this point and saying it was not superego when Self would have done for what he was describing. This theme is continued in the last chapter called 'Psychotherapist and Religion' where he traces the development from Calvinist sin and punishment to psychotherapeutic understanding and acceptance. He believes we do this without reasoning and therefore 'the psychotherapy movement is now in a state of crisis'. He believes the individual has within him 'the guide to moral action' which he has called the conscience in this and the previous chapter. In the conscience resides The Good, a psychic reality which is inner and outer. Almost his last words in the book are "The psychotherapy movement needs a religious principle if it is to pull itself out the moral confusion in which it now exists'. Despite my reservations I was very interested in Neville Symington's views - the controversial and the not so controversial. It is a human book and not too steeped in theory which makes it very appropriate to trainees and others who want to know about the making of a psychotherapist.

HARRIET LOEFFLER

Hope: A Shield in the Economy of Borderline States

By Anna Potamianou. Routledge. London 1997 pp120 p/b £13.99p

This is a short book translated from Greek by Philip Slotkin: the use of very technical language makes it difficult to read. It is however worth the effort, not only to gain an understanding of the author's interesting thesis expressed in the title but also as a clear exposition of the psychic structures of borderline patients. Anna Potamianou illustrates her ideas with Greek myths, religious beliefs and clinical material.

The two issues on which the author concentrates are the difficulty of the borderline patient in sustaining a continuous view of himself and his object and the uncontrolled outbursts of feeling which we witness in these patients. Potamianou explains the first in terms of an incapacity to maintain a manageable investment in the object and the second in terms of diffusion of drives. Along with these deficiences go failure to tolerate difference or separateness between self and the external world as well as between the superego, ego and id. Inadequate formation of boundaries, she reminds us, means that the superego is not properly formed and becomes merged with the ego ideal; this fits Chasseguet Smirgel's ideas and reading this book encouraged me to consider again the far reaching consequences of such a defect.

Change, writes the author, brings about awareness of difference and a feeling of loss of control but above all the need for psychic energy to differentiate and take cognizance of the known and unknown; it is this energy which borderline patients feel they lack. They therefore resort to repetition of the familiar, often through sudden discharge of excitation which may involve no representations or which may repeat painful experiences of loss and attempts to regain the internal object. The diffusion of drives makes these repetitions all the more powerful. If the patient is able to allow some recognition of the familiar, there is a possibility of compromise but this is hard to maintain when unfamiliarity brings feelings of complete loss of the object and the self. Perhaps as Giovacchini indicates some of the lack of energy is also augmented as a welcome defence against releasing destructive forces which the subject has no strength or powers of organization to control.

The book describes how the borderline patient is able to keep some equilibrium and a sense of reality as long as the outer world sustains his projections but when there is disillusionment or too much disappointment the object is abandoned and severe narcissistic regression takes place leading to a feeling of resourcelessness: the outside world is seen as draining rather than nourishing. Perhaps more of a mention of mothers seen as very

narcissistic might have put these patients in a firmer context at this point. The author says that abolishing the relationship with the object is felt by the patient to amount to murder and unconscious guilt is aroused. I found this idea useful when considering negative therapeutic reaction: to allow the object to live means owning up to attempted murder and the loss this has brought about.

Potamianou has much to say about the void and loss of self that borderline patients experience in the absence of the object; they feel they cannot survive without it because it is undifferentiated from the self. In order to avoid experiencing unbearable emptiness the patient may invest in an idea or feeling: hope is sometimes used in this way. She ascribes these patients' inability to repress or to symbolize to the absence of a watchful mother in babyhood. There is no containment or environmental mother as described by Bion or Winnicott. Nothing is stable, feelings are unregulated and the object is not constant. To cope with the consequent fear of psychic collapse some patients may cling to an idea of an idealized self and object and it is in this context that hope may play an important part.

The most important reason for narcissistic withdrawal from the object, insists the author, is not separation anxiety, fear of engulfment, avoidance of pain or inability to relate to an internal object because of splitting but the need to maintain the phantasy of omnipotent control over resources on which the subject is dependent. She also sees withdrawal from the object as indicative of the death drive; it cannot, she says, be accounted for by lack of libido because this evidently is not deficient when links are so ferociously attacked by borderline patients. Personally I find her wish to circumvent object relations theory here somewhat unnecessary; it could be used to explain the need for a wish for omnipotent control. The idea of some patients relying on hope rather than an object is, to me, very useful, and gives much to think about.

The author describes the advantages of cathecting hope if helplessness and mourning are to be avoided, limits unrecognised and the superego outwitted. In order to make this investment, however, masochism must be deployed and the pleasure principle is put aside. Hope for perfect plenitude in the future takes the place of desire in the present: guilt arising from hatred and rejection of the object is assuaged by the suffering brought about by masochistic self denial and becomes, as Rosenberg described, an unconscious source of pleasure. Hope therefore acts as a shield for masochism. Self esteem is assured by the fantasy of forthcoming goodness and deprivation is endurable with the promise of future plenitude. This notion of hope is different from the hope sustained by knowledge of the breast to come. These patients have never experienced this knowledge and therefore for them hope is subservient to magical control over fate: the pain of waiting is worth the assurance of

expected bliss with which reality cannot interfere and the idea of the subject as a worthy recipient of this goodness helps to maintain naricisstic supplies.

Investment in this kind of hope constitutes a massive negative therapeutic reaction. It obviates the need for the object and for change; it is compatible with a narcissistic world. It is also infiltrated by the repetition compulsion; the fantasy is of rediscovering the ideal object in union with the ideal self and every object encountered during the waiting is therefore unsatisfactory. The possibility of transformation and change through experience in the present is precluded, nothing moves and the future does not contain the unknown.

In hopeful waiting the death drive which mitigates against life in the present is active but so is a drive towards life albeit a life in the future. The waiting therefore constitutes a point at which these drives can meet. 'Hoping with the masochism it protects', writes Potamianou, 'constitutes a hearth in which the flame of the fused drives can continue to burn'.

The split state of the borderline patient's ego which avoids both the pain of tolerating ambivalence and the need for commitment with its consequent acceptance of limitation, prevents emotional growth and fulfilment. It is in considering how such a patient may be helped that the author most fully tackles the fluidity of identifications which characterises these patients. There is a need, she says, for the unfolding in the transference and counter-transference of a network of identifications and the initiation of creative work on a bi-personal basis. She refers to Winnicott saying that the patient must have the *capacity* to use the object, the object must have an independent existence and not just be a bundle of projections. However in order to achieve this, firstly the patient must be seen in every aspect and held in mind by the analyst as an independent and coherent being; the medium for achieving this is play.

Providing a different angle to the ideas of Winnicott, Balint and Sandler and many previous theorists, Potamianou focusses on a lack of maternal watchfulness as the failure suffered by borderline patients. In watchfulness ego and superego combine, feelings are contained and made manageable and a capacity for individuation installed. The borderline patient's tendency to expose himself to trauma and disorganising excitation betray a failure in the ego to assume its own watchfulness; as well as this a caring superego has never gained its place.

The analyst, she says, must alternate between suspended attention and watchfulness (I am not quite sure why these need be one after the other as she seems to suggest and not concurrent). These two activities, linked with words standing for excluded representations and affects help to make difference tolerable. The patient is enabled to gain a sense of himself as a continuous and coherent being; he 'becomes open to traffic with the obscure, unrepresentable, different and alien within him'.

It is a pity this book is not more easily readable but I enjoyed it. I found it theoretically interesting and clinically helpful. The author vividly conveys the borderline patient's world of chaos and unthinkable threats, while describing a costly attempt to make it manageable.

ANNE TYNDALE

Ending Analysis: Theory and Technique

By Gilda de Simone. Karnac Books, London 1997 pp176 p/b £11.95

In the two Forewords to the English and Italian editions of this book it is variously described as "brief, clear, precise and profound" and "agile", and the descriptions are apt. The book consists of six short essays on the termination of a psychoanalytic treatment, it is brief enough to be read over a quiet weekend and important enough to keep it handy. The writing is clear if idiosyncratic, the clinical examples vivid and the issues addressed are serious; in addition to the usual referencing, there is a chapter-by-chapter Bibliography of recommendations for further reading, which I found and will continue to find very useful.

Gilda de Simone comes from a psychoanalytic tradition, at once familiar and different from that in Britain. The network of references she uses are often Italian but she draws on Etchegoyen, Melzter, Rangell and others whose work is international and therefore part of one's own culture of psychoanalysis. She works within a Kleinian object relations model but she is a European if not Italian Kleinian, rather than a British Kleinian, her psychoanalysis is familiar - a foreign rather than alien approach.

There are two underlying themes throughout the six essays, one is the problem of separation which the termination of analysis arouses for the patient and the second is the central and paradoxical role, within clinical psychoanalysis, of the experience of time. The analytic experience immerses the patient in a timeless universe whilst simultaneously the daily experience of the analytic setting strictly controls time in the frequency, patterning and duration of the sessions. The awareness of temporality is, the writer argues, 'consubstantial' with the study of the analytic cure which is conceived of as a process therefore temporal - moving through developmental time. The analytic situation enables the patient to create new temporal forms which, of course, in turn stimulates the creation of new symbolic forms. I learned a new word, 'chronopoietic', for the creation of new temporal modes.

There are three chapters directly concerned with clinical and technical matters about the ending of an analysis, Chapter One 'The Elusive Criteria for Ending Analysis', Chapter Three, 'The Concluding Phase of Analysis' and Chapter Six, 'The PostAnalytic Phase'. The other three chapters are discussions of closely related topics; Chapter Two, 'Time in Psychoanalysis and the Concept of the Psychoanalytic Process', Chapter Four, 'Difficult Conclusions' and Chapter Five, 'What should we think of "Analysis Terminable and Interminable" today?'

Gilda De Simone begins her first essay by asking the question which Freud himself asked in 'Analysis Terminable and Interminable' which is whether an analysis is in fact ever terminable and if so how and it what sense. This is an issue closely linked to that of the aims of psychoanalysis and the question of what it is that an analysis can achieve. In her view, these factors tend to be the analyst's concerns, the patient is concerned fundamentally with separation. the wish to be dependent and the terrors of separateness and dependence. The patient's fear that the analysis will be interminable can often lead, she suggests, to the treatment being interrupted or ended prematurely. When the ending of the analysis becomes thinkable it is often the beginning of a fruitful period of the work. She suggests that there is a certain point when the analyst realises that the issue of termination has to be dealt with not within transference interpretations but 'in the plane of reality'. She calls this an *'acte de passage'* and says it indicates a shift of register in the work, real time enters the consulting room and brings with it the final phrase of the analysis.

She is straightforward in her view that the patient should decide the date of termination and that in the termination phase the analyst should not change technique or way of working at all, interpretation in the transference should continue right up to the end and the very last session. In considering the post-analytic phase, Chapter Six, de Simone gives, as she sometimes does throughout the essays, direct and straightforward advice, the analyst should not suggest any further meetings but should indicate that he or she is available for any further contact if necessary.

As is perhaps clear from what I have already said, I have a particular interest in the concept of time in psychoanalysis in relation to the psychoanalytic process - a rather under researched topic I fear, so I particularly enjoyed Chapter Two which is an essay in time. The emphasis is on the experience of deferring action, Freud's *'Nachtraglichkeit'*, where the linear time of consciousness can be reconciled with the timelessness of the unconsciousness - a central aim of clinical psychoanalysis. Chapter Five is a scholarly consideration of Freud's paper 'Analysis Terminable and Interminable' (which sent me back to the book of essays on the same paper in the Yale series Turning Points and Critical Issues) where she wipes away the tears about the concept of 'penis envy' with the acceptable concept of the repudiation of more femininity. She reminds us that this was what Freud felt was the bedrock of unanalysability, an assumption she vigorously challenges. She concludes this challenge by arguing that whilst every individual has his or her personal bedrock of unanalysability which is consciously or unconsciously held, she declares that we do not have the right to think of split-off areas in the mind as unanalysable for ever, clinically or theoretically.

The chapter called 'Difficult Conclusions' considers the obstacles which can impede the progress of a psychoanalytic treatment and she follows Etchegoyen (1991) in singling out as obstacles, acting-out, negative therapeutic reaction and reversible perspective, the first puts action in place of thought, the second annuls insight and the last goes directly against the project for transformation by attacking the bond with the analyst and the emergence of the psychotic part of the personality. To this list she adds the perversion of the transference, where the patient is devoted to the analysis and its setting but this devotion is to preserve it in order to attack it and deny it, in other words a patient using this defence is having an analysis in order to avoid having an analysis. She argues that a modern approach would be to see all of these processes combining in an impasse. I thought this was a particularly good discussion.

I did enjoy this book very much: I found it stimulating and engaging. I agree with Chasseguet-Smirgel when she says in her Foreword that de Simone's emphasis on time and process enables her to consider the differences between psychoanalysis proper and psychoanalytic psychotherapy. "Not that analysis is simply a therapy of greater duration but that analysis allows for a working through process that psychotherapy and its setting only induce to a lesser extent and at a shallower level". It is, of course, only after many years of working as a psychoanalytic psychotherapist that one's long term analytic patients begin the process of termination and working through that is discussed in this book. I was also left vividly aware that termination as a significant issue in clinical work cannot, by its very nature, be taught - except in theory - in an initial clinical psychoanalytic psychotherapy training.

I do recommend this book.

ANNA WITHAM

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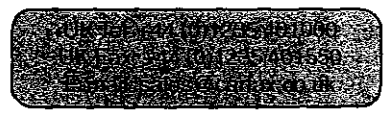

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