JOURNAL

OF THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS

Number 31 Vol. 1 Part 2 July 1996

JOURNAL

of

The British Association of Psychotherapists

Subscription Enquiries:

Administrative Secretary: 37 Mapesbury Road, London NW2 4HJ

JOURNAL

Number 31 Vol. 1 Part 2 July 1996

CONTENTS

TRUST, VULNERABILITY AND SURVIVAL? THE DYNAMICS OF BETRAYAL

DIANNE LEFEVRE

This paper is based on a talk given in November 1995 at a meeting of the British Association of Psychotherapists. It was one of three adumbrated by the title: Trust and Betrayal – an analytical exploration into the effect of changes in the NHS, and other caring organisations, on the consumer and the practitioner. The scope and significance of the subject was daunting and I felt that apart from being important in itself as applicable to the NHS, it was a reflection of what was happening in the rest of society and a picture somewhat dominated at this time by ugly, perverse and frightening aspects.

Converting the talk into a paper, I am more than aware of the difficulties in pulling together historical and psychological changes and attempting to make sense of the progression by using a psychoanalytical theoretical model. The dangers of becoming hopelessly lost in a maze of small detail or of disappearing into meaningless generalities are difficult to avoid. So I am writing mainly about the NHS, in particular, doctors in the NHS since I feel more entitled to be critical of my own profession than of other caring professions. Having said that, the pathology in the medical profession is not essentially different to that in the other professions and for that matter, as I have already said, in society in general. And since I am writing for psychoanalytically aware reader, I shall assume that it is taken for granted that the 'intrapsychic' institutional pathology will be visited upon the health 'consumer' in no uncertain terms.

When one looks at pathology in an institution and the individuals in it, one is shining a torch on the darker aspects. So at the outset I should like to say that there are wonderful, skilful, honest and humane carers and managers and teachers, all the more admirable for remaining healthy in a system that carries so much sickness.

I am not an expert on the workings of institutions so this paper is indicative rather than authoritative. I have more questions than solutions. My personal experience leads me to believe that the individual

* Paper read at a Conference organized by the Public Conferences Committee of the BAP in November, 1995

psychoanalytical model is applicable to both large and small therapy groups and institutions although not in an unmodified form and the psychoanalytical model is, I think, an essential tool with which to make sense of the functioning or malfunctioning of the institution.

Malcolm Pines in his 1994 Berlin lecture on the history of psychoanalysis, points out that as early as 1918, Trigant Burrow, who was expelled from the American Analytic Association of which he had been president said that: 'Society has its elaborate system of defense mechanisms, its equivocations and metonymies, its infantile makeshifts and illusions'. He recognised that the dynamics of the transference are in many ways not individual but universal and he spoke of the collective reactions of psychoanalysts as 'a special form of social unconscious.' Pines speaks for a frame of reference in groups which incorporates the vertical intrapsychic dimension, the horizontal interpersonal dimension and the 'in between' best known through Winnicott's work on the transitional space and transitional object. I personally feel that a fruitful combination of these three dimensions might be just right for a psychoanalytical model for institutions.

This paper is about a very large institution, that is the NHS. Some may take issue with my application of psychoanalytical theory to this particular type of mega group. However I have not seen the theory that has realised a solution to and a reversal of the fragmentation of this institution which is surely taking place, or a reversal of the demoralisation that is fairly widespread and spreading wider. If I concentrate on the medical professionals and their faults and fate initially it is because of my familiarity with that group and also because of time limitations.

Since trust is a key word in the title of this talk, we need to linger on that concept for a moment. Institutions invite parental transferences from those who belong to the institution and as Zetzel (1964) said, the transference neurosis reproduces the oedipal complex. For a healthy resolution of the oedipal complex, it must be preceded by a good therapeutic alliance which is pregenital and diadic.

Zetzel described the functions for the development of the therapeutic alliance as:

1. the capacity to maintain basic trust in the absence of immediate gratification;
2. the capacity to maintain the discrimination between the object and the self in the absence of the needed object; and
3. the potential capacity to admit the limitations of reality.

Thus a good therapeutic alliance allows for the possibility of

distinguishing between internal and external reality and involves the development of Erikson's 'basic trust'. It is only if 'basic trust' is established that there can be hope of establishing satisfactory triangular relationships, and a resolution of the oedipal complex. Zetzel established a link between her ideas and those of Erikson and those of Klein's depressive position. In Kleinian terms the satisfactory resolution of the oedipal complex implies a progression from the paranoid schizoid position to the depressive position and thus tolerance of ambivalence and the capacity for guilt, reparation and concern.

In the social unconscious of the institution, moving forward from the establishment of basic trust to the triangular relationship means the possibility of diversity, and of allowing the skills of different individuals to be functional and appreciated. It allows for the possibility of listening to the other, the possibility of learning and improvement by review of one's own work, by oneself and one's peers on a non blame basis. It feeds the valid needs of healthy narcissism and encourages dialogue which can lead to progressive change and can hold and limit the inevitable shame component.

It facilitates facing disappointment and loss which is part of working life, acknowledging feelings of helplessness and inadequacy masked by omnipotent fantasies and toleration of the inevitable therapeutic failures.

It allows the sort of honesty and openness that is particularly, not to say crucially, important in institutions where there are powerful countertransferences which occur when dealing with, for example, psychotic or terminally ill or chronically suffering patients. Trusting leads to the expectation of a mutuality of response. It makes possible experiences of openness and vulnerability. It builds bridges, not walls.

Failure in the system involves either an initial inability to build the bridges in the first place or the disruption of bridges already built. It brings to mind the tension arc described by Kohut (1971) between the grandiose self and the idealised parent who is the source of ambitions, ideals, aspirations and moral values – the parent, in this case, represented by the institution with its social unconscious.

If the parent/institution is too damaged and pathologically narcissistic to provide adequate mirroring, to offer a mutuality of response, the result is shaming and the accompanying regression, a fanning of narcissism and all the other results of shaming such as rage, vengefulness and the development of basic mistrust, with it's elaboration into doubt, guilt, inferiority, role confusion, stagnation and despair.

Moving to a cause of shame being the tension between ego and ego

ideal, the institutional parallel is the expectation to perform at work where overburdening is crippling and thus failure is inevitable. Here the ego cannot even approach the task of living up to the ego ideal.

This mobilises defences against shame which include blaming, rage, perfectionism or internal withdrawal consciously experienced or unconsciously played out via the more primitive defense such as splitting and projective identification. Tendencies to primitive idealisation, omnipotence, devaluation and primitive denial emerge.

Fear of actual exposure, humiliation and castrating retaliation leads to secrecy. Keeping secrets requires an enormous amount of energy which is then lost in that it is not used towards the claimed primary task. I say claimed primary task because in the teeth of the fear, despair, anger, humiliation and the rest that I have described, the primary task would have shifted to one of survival both on an individual and an institutional level.

Secrecy is a malignant tumour growing in the NHS so I should like to quote Richard Smith, editor of the BMJ, in his article entitled 'The Rise of Stalinism in the NHS' which deals with secrecy in the NHS. He quotes Milton's *Areopagitica* which gives arguments for free speech.

'Give me', wrote Milton, 'the liberty to know, to utter, and to argue freely according to conscience, above *all* liberties. Truth', he argued, 'was never put to the worse in a free and open encounter. . .It is not possible that she (truth) may have more shapes than one. . .If it comes to prohibiting, there is not ought more likely to be prohibited than truth itself, whose first appearance to our eyes bleared and dimmed with prejudice and custom is more unsightly and implausible than many errors.'

We can never develop the NHS and the health of the British people without a lively debate, which will be debased if people cannot say what they really believe. 'Where there is much desire to learn,' wrote Milton, 'there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making.'

A much earlier promotion of a desire for truth and reality is found in the simile of the cave. Plato, in about 300 BC, constructs an optimistic and beautiful picture of the power of philosophy, that is also to say the power of abstract thinking, to lead to enlightenment and truth. This is of course relevant to psychotherapists working to help patients to progress beyond concrete, primitive often delusory thinking to something more whole and less maladaptive and therefore less painful. Truth and reality and health can be equated no more so than in groups

and institutions where the reverse can unleash powerful destructive forces which can be difficult to contain.

Plato describes men in a cave which has no natural light. The men are forced to look at a wall on which shadows of moving puppets are cast by a fire behind the puppets. The imprisoned men, knowing nothing else, imagine the shadows to be real and the echoes of voices to be the voices of the puppets. There were prizes for keen sightedness and so on.

A man is dragged out of the cave into the world outside. He has to adapt to the light slowly but is gradually able to look into the sun itself without using reflections in water or any other medium. This symbolises reaching Truth, Reality, Enlightenment. Such a man would not exchange his position for that of the prisoners in the cave for anything.

However, he is dragged back into the cave where he takes time to adapt to the dark. He is no competition for the prisoners in discriminating between the shadows and is regarded as a fool. Should he recommend a journey to the sun he would be shamed and if he should attempt to release the prisoners, they would try to kill him.

No psychotherapist who has struggled to find the right interpretation at the right time can fail to recognise this phenomenon and most of us would recognise the advantages of attempting the journey to the sun which represents truth, reality and sanity.

I think we may now be ready for a glimpse of the sun, in this case a dose of unpalatable reality. What I am about to relate is the institutional equivalent of a clinical vignette that came to my attention in a communication with Dr Peter Tomlin and which seems to mirror other pathologies in the NHS. The fact that what I shall relate is happening silently and relatively uncontested is what is so frightening.

In this vignette, I should like to point out firstly some relevant effects on the medical practitioner which will resonate with the issues around trust and shame. Drs Peter Tomlin and Harry Jacobs, the secretary and chairman of The Society of Clinical Psychiatrists Study Group, are about to publish a paper about suspensions of doctors.

In the new NHS, at the present time a consultant with an expected practice time of thirty years has a one in fifty (rapidly dropping to forty) chance of being suspended. This means an often lengthy time of uncertainty. For example one doctor was suspended for eleven years with no charge laid. She was said to be whistle blowing about resources. Suspension carries with it the possibility of dismissal and destruction of a career, as re-employment is not an option in the

monopoly NHS. It also involves the perceived malice of suspending authorities trying to find a way to justify obviously inappropriate suspensions and the stigmatising effect on the doctor and his or her family.

Of a hundred and seven doctors suspended in the last ten years, in only about 10% have the suspensions proved to have any real basis. Of the rest, there is an over representation of women which in latter years is becoming less marked while there is a growing over representation of Jews and Commonwealth doctors.

Of the three categories for suspension – Professional Incompetence, Professional Misconduct and Personal Misconduct, the tribunals which are all secret, are composed differently. That of the Personal Misconduct category consists solely of managers. Thus the authoritarian brand of manager tries to fit everything into that category and can adjust the results to get rid of someone. This, by the way, is what happened in the Helena Dalley case which was thrown out after she appealed. Although vindicated it is hard to imagine that she can ever fully recover from this experience which was entirely maliciously engineered.

In general, the causes for suspension were difficult to identify as they were often multiple and with a hidden agenda. Where the cause could be properly identified, half were the result of deliberate attempts to get rid of the doctor, i.e. interpersonal conflict.

These interpersonal conflicts were of three types; those arising from conflict with, firstly administrators, secondly non medical colleagues and thirdly medical colleagues. The first equalled the third and both were vastly in excess of the second. That is to say that doctors 'shopping' doctors is a major problem and what was noteworthy in these cases was the extremely low justification rate. This unjustified shopping of doctor by doctor must be a starting point if we are to look at the psychoanalytic implications.

Before doing so and to demonstrate the cruelty involved in these behaviours let us note the following: one suspended doctor who suffered a cardiac arrest and had to be admitted to an intensive care unit, was told to transfer to another hospital as he was an embarrassment. Another suspended doctor was denied the freedom to visit his hospitalised wife who appealed to the Community Health Council to overthrow the decision. After some delay he was granted permission but by that time his wife was dead.

I have to remind you that we are talking about Great Britain in the late 20th century. Where can this savagery come from? And more

important, where does it lead? I shall demonstrate, I think, the origins of the profound ambivalence medics bear towards medics and, therefore, toward their patients and what they do when ambivalence becomes profound splitting and the savage and hostile part of the split requires a home.

The problem is that this particular psychological system is now circular and there is no beginning point. But it might be an idea to remind ourselves of the ghastly Sir Lancelot Spratt in the 'Doctor in the House' series. Historically, in the forties the surgeon had immense importance because of the difficulties of anaesthesia. He had to be very quick and skilled; and did he know it. He was arrogant, narcissistic and developed a God-like grandiosity. He (and it was always a 'he' in those days) would think nothing of arriving hours late for an operating list leaving poor starved and dehydrating patients to put up with it.

A true story goes that one such surgeon was so late that eventually his house surgeon cancelled the list, after which the great man arrived. 'Who do you think you are to cancel my list, God Almighty?' bellowed the irate surgeon. 'No,' said the house surgeon, 'God Almighty's house surgeon Sir!' at which the eminence grise had the decency to laugh.

Some of you will have laughed if not outwardly, inwardly in a sort of indulgent, affectionate way, as indeed I did at the old joke identifying and feeling *in* with the profession that produces such powerful, what does one call them, children, I suppose. Precociously bright children who have to be tended and admired, and dangerous since they are in adult form. If only when we laughed we had understood what we were avoiding in ourselves, the fear and potential for shame, the relief that it wasn't us, and if only we had had the courage to refuse to ignore the patient who was 'Nil per Mouth', that is, deprived of food and water, for well in excess of twelve hours like those poor, crated, transported calves, and terrified into the bargain at the thought of the illness and the life threatening operation and so on.

To an uncomfortable extent this defensive pernicious grandiosity can still be found as part of the medical scene. When I taught medical students I concentrated on the psychotherapeutic side of psychiatry and the medical students took to it with gratitude and often shared their fears and their experience of the training. They described the usual scene of accompanying a gynaecological consultant during his examination of a patient. The patient happened to be Afro-Caribbean and this gynaecologist said in the middle of doing a vaginal examination on this patient, 'Do you know what this patient has? The fat brown cow syndrome.' The patient started crying. Most of the medical

students remained stony silent. Some joined the consultant laughing. We discussed it in a later seminar as an example of those who laughed needing to identify with the aggressor and moved on to sado masochism in medical staff.

The same consultant in a temper threw some disinfectant into a student's eyes resulting in the need for the student to receive treatment at Moorfields Eye Hospital and there were many other similar stories with students hating being witnesses but forced to go along with things in some way in order not to be discriminated against in examinations and for future jobs.

One student tried to avoid partaking in a totally unnecessary experiment on a dog resulting in it's death and was told by the physiologist doing the experiment that she would be failed in the exam if she didn't join in. I remember the hilarity in my class as we watched a poor mouse dying in agony after an administered dose of strychnine.

Bear in mind that victims of abuse, abuse. This is all a form of abuse. The victims have to laugh and enjoy it and split off the suffering in order to survive. The medical patriarchy presides over a maladaptively functioning family in which the fathers, and of course sometimes the mothers abuse power using secrecy as a tool to keep the abuse going.

Control, both of patients and medical students is involved. Body handling and causing pain, both physical and psychological, is unavoidable in the course of practising clinical medicine. Thus the sado masochistic elements present in all of us, are aroused but never dealt with or discussed. In fact they are rarely recognised by name although they are frequently acted out towards patients and projected into groups and individuals outside.

Authors on shame state that shame is unavoidable in the learning process. It does not seem to be dealt with well in medical schools if I can believe my own experience, and that of the medical students and psychiatric trainees over years of teaching. Shaming in which sado masochism plays an integral part seems to be an inextricable part of the teaching process in medicine and the sensitive students are picked out for being sensitive. I recall in my teaching group when I was a student, one of my peers whose father had died. He came to a clinical tutorial looking as pale as a sheet and barely able to speak. Predictably he was picked upon, asked difficult questions and his appearance made fun of.

The training is brutalising. The healthy students capable of feeling, wept and suffered privately and laughed and screwed around and got

drunk publicly. The suicide and alcoholism rates amongst the medical students used to be one of the highest of the student bodies.

The less healthy who qualify as doctors, identify with the aggressor and become the power abusers with a sense of relief and have been too traumatised to even consider their motives or to ever want to give up the power role. They are too fragile to give it up. Needless to say, the people who suffer most are the patients.

Patients however, need doctors. To some extent they have to like them or at least put up with them since changing doctors is not as easy as the Patient's Charter implies. Patients are driven to respect medicine not only for its truly helpful and healing aspects but also as a mysterious and sometimes magical business which will hopefully deal with the unfaceable; like death, shit and suffering. So they are pushed into idealising doctors and splitting off their hatred and envy.

What on earth can they do if they happen across someone who is as unpleasant as the man I mentioned, a polite sadist (who causes unnecessary physical or psychological pain, or insists when not trained to do so that it is all in the mind), a seducer (who says, where is your sense of humour, it is just fun), or just a badly trained ignorant practitioner who doesn't know what he or she is doing.

I have demonstrated serious ambivalence which results in primitive splitting in both the patient and medical populations. Paradoxically, doctors have improved in recent years in their understanding of themselves and are more aware than previously of their own tendencies to let the patient carry their projections. In addition, patients are better educated about health.

So the projected mass of hostility from both groups, doctors and patients, has to find a different place. I believe that is why quite frequently, we have tended to select such poor, authoritarian management who are excellent candidates and well fitted to take on some of the bullying and thuggery roles previously passed between doctors and patients.

Let us consider the nature of NHS institutions today. The reforms are now about fifteen years old. A succession of Ministers of Health, most notably Clarke and Bottomley, have determinedly pushed what was previously central government authority to local managers and Trusts. The hot potato consists of power hungry medical professionals and genuinely caring, honest doctors, both asking for more resources in the face of increasing demand and greater expectations from the patient body. This hot potato was chucked out of the centre to the periphery much against advice given by the Department of Health.

The latter had their own agenda and were unwilling to lose their previously considerable, not always wisely wielded power, to largely non medical, unpredictable, business orientated, management bodies.

The result is that the Trusts now have grabbed the power. However, some of them don't have an understanding of clinical matters and they don't necessarily have a lot of experience of running large organisations. They have the task imposed upon them to run a Health District within limited, perhaps seriously inadequate financial limits. They may receive bonuses for saving money and they don't have much job security. People who select to work in such an environment have their conscious or unconscious reasons; some for the challenge, some to serve the patient public and some because the hostile side of their ambivalence to the medical profession and carers in general is powerful. Management jobs as they were constructed in the heyday of Health Service changes, were bound to appeal to those who were prone to be perverse and authoritarian. This would include doctors from the frightened group who identify with the aggressor and seek out power in order to remain the aggressor.

That is not to say that there are no good and caring managers and doctors. Some Trusts have good reputations and good relationships with staff. Things are gradually changing as the failures of the Health Service Reforms and new management structures become increasingly obvious.

However the picture that has emerged through various bodies such as the various Royal Colleges in different medical specialities, the Defense Organisations, the BMA, the Society of Clinical Psychiatrists Study Group, Freedom to Care, the NHS Support Federation, Concern at Work, to name but a few, indicates a profound dissatisfaction on the part of doctors with their employing authorities. Medical magazines and journals such as Hospital Doctor and the prestigious BMJ, indicate profound demoralisation amongst medical professionals and it is matched by demoralisation in other care groups.

I understand that when the Department of Health one or two years ago sent a request to all Trusts to send the department their bed occupancy numbers, they were rudely ignored by some Trusts who did not want their numbers to be known. The Department of Health could do nothing and were left not able to make reliable calculations about need.

So it appears now that in some respects, anarchy has broken out. Trusts are out of control and have too much power and some abuse this power. The structure in the health service pits carers who want

primarily to offer the best available treatment to patients, against managers whose primary task is to work within budget if not to save money.

Both medical and management bodies are frightened and management bodies struggle to gain and retain the upper hand in terms of power. They do this by splitting the caring professionals by, for example, offering half management, half clinical jobs in return for some additional power, in particular, power over colleagues i.e. *divide et impera.* And of course the notorious merit award system keeps those hopefuls who might otherwise raise objections quiet.

The purchaser provider split allows for further manipulation of power away from professionals. A common complaint about purchasers is that they don't listen to advice from professionals. They apportion money in ways that are not clinically valid leaving the deprived bodies feeling hard done by and resentful of better off colleagues. This, by the by, has occurred notably in the discrepancy between monies awarded to the acute sector as opposed to the less generous offerings to community, including psychiatric, sectors leaving psychiatrists (the less powerful 'trick cyclist loony' doctors), fighting with their acute sector colleagues.

Secrecy, a defense against exposure and shame, is one of the major weapons used by Trusts to keep power. So called 'whistle blowing' which often just consists of doctors stating publicly their concerns about a particular service, concerns that should be known by the public which uses the National Health Service, the public which pays subscriptions to finance the Health Service, has met with draconian methods of punishment which are not even vaguely appropriate in a democratic country. Helen Zeitlin, a talented haematologist, raised concerns in public and was suspended as a result. Of course, she was eventually reinstated but life was made such hell that she left medicine altogether. Her case includes what I think will be recognised as a familiar template in time, and that is the presence of the bully colleague or colleagues and the silent majority, all of whom subtly or for that matter not very subtly aid and abet management in concocting false charges. The template must be familiar to students of the dark side of history.

Much has been written about ever more stringent 'gagging clauses' imposed by hospital authorities into contracts of employment despite, as Jacobs and Tomlin point out, their illegality under European Law. It makes one recognise the value of the Constitution in the United

States. And it makes one increasingly apprehensive of the consequences of not having such a thing here.

The need to speak out is ever greater as some Trusts are pushed by fear of exposure and shaming about not achieving required targets, into publicly distorting the truth, not to say frankly lying about their achievements, their employees, their basic motives. Professor Joad (1948) in his description of fascism quotes Hitler in Mein Kampf where he announces that it is the duty of Germans 'not to seek out objective truth in so far as it may be favourable to others, but uninterruptedly to serve one's own truth.'

I will not apologise for using this dramatic quote, for if we let these distortions be, we collude with the bully and get onto a very slippery dangerous, downward slope.

It must be fairly clear by now that the NHS is probably still controlled by a series of fragmented bodies called by the *most* unrepresentative of names, Trusts or groups of Trusts, who were until recently instructed not to collaborate but to compete. They are closed circles and as such can become sealed off to outside influence which is very dangerous. These Trusts are out of the control of both the Department of Health and the government. The process of fragmentation is reflected in the inner workings of the Trusts and their attitudes to staff whose general demoralised state tells a story.

These inner workings include assessment of the patients' and the institution's needs by dividing them into small increments which can then be costed and evaluated and bear no relation to the whole; this is literally primitive part object territory.

Chasseguet-Smirgel's (1985) description of the perverse anal-sadistic universe comes to mind. Boundaries are lost, 'extremely complex positions are built up then unmade and transformed'. She points out that the Marquis de Sade stated that matter is indestructible, true, but he then went on to say that *therefore* killing doesn't matter as the person simply remanifests as 'a thousand different insects.' There is an initial truth but the whole is perverse nonsense.

The patients' Charter is a good idea but it can't be implemented because of lack of resources. Being told that resources are not the problem, that prioritising will solve it all produces the same effect as being fed similar perverse nonsense dressed up with an element of reality. In Chasseguet-Smirgel's terms, it is offered as a genital penis but in fact is a pregenital, faecal penis.

The nature of the lie is that it is perverse, it shames and it elicits rage. It is like having something disguised as something else put inside

one secretly from behind, something that one doesn't want. In short it is abuse by buggery and I suppose that explains why so many caring professionals feel so bad while there are relatively few protests. Such is the case with abuse.

Perverse lying pervades fear filled systems. *A propos* this, the recent plans for a shop a doc system were brilliant for those keen on blood sports and rather like putting ferrets in a sack. However, you will have noted a deafening silence on that front since it was pointed out that there would be so many cases that the costs would be astronomical. Bear in mind the cost of suspending Wendy Savage who was shopped by colleagues in a thoroughly malignant fashion.

Unfortunately, all this fragmentation and perversity does not encourage the sort of competition that is supposed to generate creative innovative work. It has become increasingly difficult to do anything new. Here is a vignette to demonstrate this.

In the mid and late 80's, I got together with a talented nurse and later another psychotherapist to set up a psychoanalytical group scheme on the acute and continuing care wards. We met regularly with the then quite new managers and managed to work out a mutually beneficial arrangement which included a year long nurse training scheme, regular supervision, regular teaching seminars, a regular staff group and so on. We managed to use existing resources to develop a research project and were eventually able to demonstrate that the continuing care patients who had had a year or more of regular psychoanalytically informed group therapy showed much greater capacity to develop social networks than those who had everything else but the groups Lefevre (1994). We cost nothing and did amazingly well and got back nurse training for the hospital on the strength of our special unit. The staff morale was extraordinarily good and we worked very hard. We presented the work in the UK and abroad and in fact are still doing that.

Then things changed. Firstly, on the acute ward, there was a change of management to new style managers. The new ward manager who had falsely claimed some psychotherapeutic knowledge, waited until I took long leave and then told the psychotherapist that she was not wanted in the staff group and also discouraged the staff from attending any supervision. Naturally all the groups stopped, our research in that area stopped and there was marked demoralisation on the ward with nurses taking a stand against doctors, greatly increased violence amongst patients, secrecy about what was being done and so on. At

one stage this nurse manager told me that she could not tell me what she was doing with the patients under my care because it was confidential. It was only because this was extremely dangerous legally that she was gently disabused of the grandiose fantasy that she was entitled to keep the patients' treatment a secret from the responsible consultant.

All through this she was supported by the senior managers who looked blankly at me in our numerous meetings and said that the nurse manager was entitled to do what she liked with her nurses. (The very same managers, noted for their anti medical stance by a visiting inspecting body, refused to find a small amount of money to help a new consultant psychiatrist get a bookcase for his office so that he could clear his floor of boxes of books and get on with his teaching and research because, they said, he was cocky. He was not. He left as soon as he could, to a much better job. He was and is an excellent psychiatrist.)

As far as the offending nurse manager was concerned, eventually the numerous blots on her copy book became a threat to senior management who had been using her in their general, envious, anti medical strategy and to protect themselves measures were taken. That was three years on.

The second disappointment occurred with the chronically hospitalised patients. The group work with the continuing care ward was fine until it became apparent that we were doing well. Then we had stand up rows with another team who wanted to take over parts of the project and therefore fragment and thus destroy it. Then, once again the newer, more narcissistic, power dresser managers arrived with charts and tables with nothing about whole people on them and a penchant for denying what they had said the day before.

Again when I was on long leave the project was fragmented by splitting up all the nurses on the team who had had the group psychotherapy training and putting them on different wards, leaving me with one of our wonderful trained female nurses on a ward full of staff who were openly antagonistic to any idea of psychotherapy.

To this day the psychotherapy project nurses have not recovered from their distress about the way things were done. One man took retirement, the female nurse was bullied and hounded to a point that she had to take prolonged sick leave. The project manager is luckier as he has chosen to take early retirement to complete an MA in psychotherapy which he was stimulated to do because of our project. The project was destroyed and those who were part of it were humili-

ated and pilloried. A far, far cry from being appreciated for work well done.

I have published a paper on the countertransference problems occurring when working with the chronically ill. The project manager has always said to me that keeping the institution at bay was in every way as hard as coping with the overwhelming countertransference from psychotic patients. I wonder now if the negative effects on staff were from the 'social countertransference' rather than the countertransference arising within the groups. Certainly the destructive envy of members of staff (clinical and management) towards our staff who worked closely and well together and the constant battle to keep the project going was exhausting.

Of course it was a group psychotherapy project and groups are subversive in that secrecy is discouraged while openness, frank expression of vulnerability, shame and whatever else is encouraged and can be dealt with by a trained, skilful group facilitator.

I worked previously in a very demoralised, small hospital in East London in which, for three years the management refused to allow me to run a large group for the staff. The purpose of the group was expressly to deal with the demoralisation and to make staff feel valued. This hospital is now locum run and has a high turnover of staff, which is demoralising for staff and patients. Recently a person I had only just met and who did not know of my previous job described the hospital as having a 'hell on earth' reputation. Management were too frightened to allow an attempt at healing, possibly because they feared that they might be faced with some preparatory diagnosis.

So here in essence is an example of a betrayal and although I have not spoken about it by name, it is implicit in what I have said up to now. It is the betrayal of all of us here since we are all patients and we have been betrayed by none other than ourselves. It can be likened to an attack on the self. On an institutional scale it can be seen as the sort of social destructiveness evident when there is a breakdown in the civilising structures of an institution or society and this surely should be cause for alarm.

I haven't left much time to discuss solutions and that may be because I am not sure that I know of any and discussion around the subject could well be the subject of a week's seminar. In addition any solution would have to be posited in the light of recognition that there is a problem. And since the prime movers to destroy the NHS – as an institution designed to provide as a priority as much in the way of health care needs for those who need it as possible – sit in parliament,

many would wish to deny that any problem exists despite what appears to be overwhelming evidence to the contrary.

To even start to agree on the diagnosis or diagnoses of the sickness in the NHS would require some therapy to free up the patient and healer/therapist/doctor in order to allow for the proper examination, the openness of thinking and frank discussion, the thorough investigation that will nevertheless not kill or damage the patient, in order to allow us to describe the symptom complex. As it is we start with a biased doctor and a terrified patient and this militates against an objective diagnosis.

So treatment of such a huge body has to start on macro and micro levels simultaneously. For example, taking the medical professionals, changes should start in the medical schools, starting with the selection process and going on to including more psychotherapy teaching and practice in the undergraduate courses and building in an expectation that all students attend group or individual therapy for a reasonable period before qualifying. Of course many will say that is unrealistic but it depends where the priorities lie. (One might hope that the recent beef crisis which resulted from a failure to regard respect for species difference – ruminants vs carnivores – and the need for compassion as a priority over financial gain provides an object lesson but my own view is that in the current social climate we select split and perverse leaders who are unable to integrate enough to learn this sort of lesson.)

In all hospitals there should be routine multidisciplinary groups at which both management (including purchaser and provider) and clinician can learn to speak to each other in ways that respects the others' skills, training, regulatory bodies and so on.

More time and skill needs to be invested in the study and application of the 'psyche' of institutions including vertical, horizontal and transitional space dimensions. We need to develop an understanding of how the negative countertransference works in the social unconscious and other such issues.

It hardly needs to be stated that we need more clinically sensitive management, and that bullies and scapegoaters need to be recognised as the threat that they are and weeded out of positions of power. In the same breath we all need to avoid becoming the silent majority colluding fearfully with the bully as the colluding silent majority keeps the bully in the position of power and the result of this can be seen historically in the second great war and the development of all fascist regimes. It would be foolish to underestimate where our current destructiveness can lead us.

When, some months ago I was approached about doing a talk on this subject I agreed enthusiastically and gave this title. Months later I had an extremely painful experience of being betrayed in the form of being scapegoated publicly in a case of a homicide in a very poorly resourced district by a voluntary patient who had never been on my ward and who refused to see me. I am not going to write about that, but in terms of the workings of the unconscious, my choice of title, made prior to the event, certainly indicates something.

Being so close to this shaming and painful experience made me wary of giving a talk as I feel one needs to distance oneself, preferably by helicopter, from the bomb crater in order to honestly and objectively assess the effects of the explosion.

I don't regret the experience as I have learned a lot from it and perhaps been forced to look into the face of the sun. I hope I have been able to impart the positive aspects of the experience, even if some of it is unpalatable. I hope at the very least I have stimulated some deep thinking and constructive concern and an awareness that we are all to some extent responsible for current events. And most of all I hope I have stimulated thoughts about the need for the care and healing of the carers.

References

Chasseguet-Smirgel, J. (1985) *Creativity and Perversion*, (Chpt 1 and 7). London: Free Association Books

Joad, C.E.M. (1948) *Guide to the Philosophy and Morals of Politics.* (Chpt XV1). London: Victor Gollanz Ltd

Kohut, H. (1971) *The Analysis of the Self.* New York: International Universities Press

Lefevre, D.C. (1994) *The Hawthorn Project – Group Psychotherapy with Chronically Psychotic Inpatients.* Talk given at the X1th International Symposium on Schizophrenia, Washington, 1994

Pines, M. (1995) 'Schisms and the history of psychoanalysis'. In *Dissent in Context: Schisms in the Psychoanalytic Movement.* Ed. Hermans L.M., International Association for the History of Psychanalysis – Tubingen. (In German.)

Plato. (427 B.C.)*The Republic.* pp. 316–324. London: Penguin Books

Smith, R. 'The rise of Stalinism in the NHS'. *British Medical Journal*, vol. 309, pp. 1640–1644

Zeitlin, Helen (1994). In *Hospital Doctor* February 10

Zetzel, E.R. (1964). 'The analytic situation' in *Psychoanalysis in the Americas.* (pp. 86–106) New York: International Universities Press

FROM BABY GAMES TO LET'S PRETEND: THE ACHIEVEMENT OF PLAYING*

JULIET HOPKINS

I first met Dr Winnicott in 1960 when I had the opportunity to observe him performing 'snack-bar therapy'. This was his name for the provision of the least help needed to release a child from an impasse in development. Winnicott did this work in his role as child psychiatrist at Paddington Green Hospital. On the day that I visited, the last child patient was what was then called 'an illegitimate child', a boy of seven years who was brought by his voluble Irish mother. When the interview with Winnicott was over the boy ran off to the toilet. As he emerged to rejoin his mother I was amazed to see Winnicott stand up and bar his way. I was still more amazed when, in a flash, the boy climbed straight up Winnicott, slithered over his shoulder and ran to his mother's arms. We all laughed and Winnicott said something about the boy's courage standing him in good stead.

Winnicott's playful use of an Oedipal challenge to this fatherless boy was a startling contrast to the exclusively interpretative approach to which I'd been introduced at the Tavistock Clinic. As students of child psychotherapy we were not expected in those days to initiate play with children. Perhaps Winnicott enjoyed having presented an unorthodox challenge to me as well as to his small patient.

A year later I was fortunate to have Winnicott as the supervisor of one of my training cases. As far as I know, no other student child psychotherapist ever shared this good fortune, since doctrinal differences dictated that students should be supervised only by the orthodox. However, the Tavistock training, though Kleinian in orientation, allowed some lee-way to its few 'middle-group' students like myself to select our own supervisors. I needed my training analyst's insistence to gain courage to approach Winnicott and felt over-awed when he agreed to see me. My anxiety increased when he fixed a regular appointment at lunch-time and sat listening to me with closed eyes. I felt sure he would have preferred an after-dinner nap. However, when he shared his thoughts I found he had not been asleep but had been

*To be published in *The Centenary Papers of Donald Winnicott* Ed. Brett Kahr. In press Karnac Books

listening intently. There was nothing doctrinal about his views. He never told me what to do or say. He listened with closed eyes and then shared his thoughts, letting me see how he played freely with alternative ideas and encouraging me to do the same. I had to tolerate much uncertainty.

My intention in this paper is to give a brief account of the therapy which Winnicott enabled me to do with a little boy who could not play. I intend to use the development of this child's capacity to play to illustrate Winnicott's thoughts on playing. In this way I hope to show the sequence of stages through which a child achieves the full capacity for playing and at the same time to recapitulate Winnicott's own original achievement, his revolutionary theory of playing.

My patient was a little boy of three years old called Paddy. He had no speech and was not toilet-trained. His parents reported that he had never shown signs of attachment to them and often wandered off and got lost. He showed no awareness of danger, no response to pain and regularly ate dirt and rubbish. He had never learned to play but simply wandered about 'getting into things'. Paddy's birth and early history had been normal but his development was so slow and so deviant that the referring paediatrician was uncertain whether he was mentally handicapped or psychotic.

Paddy was the only child of a very disturbed and unhappy couple. His mother was a seriously depressed and anxious woman, preoccupied with thoughts of suicide. She suffered from severe eczema and explained that she had always avoided touching or holding Paddy in case his germs infected her skin. Paddy's father was a very eccentric man who read philosophy all day and had never been able to find a job. Neither parent had ever thought of playing with Paddy and they were at a loss as to how to relate to him.

It was arranged that Paddy should come to see me five times a week, the expected frequency for child analysis in those days; weekly casework was provided for his parents. The developments which I shall describe in Paddy were facilitated not only by his own psychotherapy but by beneficial changes which his parents became able to make.

My first encounters with Paddy were utterly bewildering. He wandered cheerfully around the room, clambered over furniture, dropped and threw toys and made a lot of noise by banging and shouting. I found myself entirely unable to think of any of the interpretations I had been learning how to give. Winnicott was later to write 'Interpretation when the patient has no capacity to play is simply not useful or causes confusion' (1971. p. 51). In supervision he warmly

supported my intuitive response which was simply to verbalise what Paddy was doing and feeling. Winnicott spoke of the importance for children of naming their emotions, intentions and body-parts. Naming, he said, makes shared and therefore socially acceptable what previously was only private fantasy. Putting children's experiences into words gives them greater self-awareness and hence greater control; it allows fantasy to be checked with reality, it increases the capacity to remember and it reduces guilt. So 'naming' was not simply the failure to interpret which I had feared it to be.

Since naming can elucidate latent meaning Winnicott might well have considered it to be a form of interpretation, but, like other child analysts of his time, he reserved the use of the term interpretation for the classical transference interpretation. My Kleinian teachers believed that only transference interpretations could bring about lasting change. However today most Kleinians (e.g. Alvarez 1992) recognise naming as a valued form of interpretation, suited to an immature child's developmental level. Like Winnicott, Anna Freud always recognised the value of 'verbalisation and clarification' (A. Freud 1965 p. 228), but she saw it primarily as a preparation for analysis proper, rather than recognising its full therapeutic potential.

Fortunately Paddy warmly welcomed my attempts to feed back in words what he was feeling and doing. He began to look eagerly at my face to see my interest in him reflected there. Much later, in a paper on 'The Mirror-role of Mother' (1971 p. 111), Winnicott described how vital it is for the infant to see his mother's face reflecting and responding to his own state of mind, not frozen or preoccupied. Paddy appreciated that my face and words mirrored his experience and so confirmed his existence. He began to talk, to point to himself when he wanted something and to call himself 'Paddy'. He seemed touchingly overjoyed to discover that he possessed his own thoughts and feelings. He had arrived at feeling 'I am'.

For Paddy, the discovery of 'I am' was accompanied by the parallel exploration of 'We are'. Paddy took great pleasure in having or doing the same as me. He was thrilled to discover that we both had blue sweaters, both had buttons and could both draw circles. He liked to imitate me and be imitated. We 'clapped handies', blew raspberries and made animal noises. Thus we established mother – baby games which normally originate within the first year. These games express a mutual identification in which the infant distinguishes between the 'me' and the 'not-me' while retaining through play the potential for assuming either the mother or the baby role. Winnicott thought that

such early playfulness within the holding relationship took place in the transitional space, the overlap between mother and baby at a time when the baby was not yet fully aware of the mother as a separate person upon whom he depended. Certainly at this early stage of his therapy, Paddy had not yet begun to experience me as a separate person whom he missed between sessions or whom he could imagine to have a personal life of my own.

Winnicott had observed that the development of play depends upon trust. Paddy's first venture into play with me must have been based on his growing confidence that I would continue to prove reliably friendly and emotionally available, able to respond to his spontaneous gestures.

I remember asking Winnicott how I could enable Paddy to move on to the next stage of development; surely interpretation was needed now? But no, it seemed that one form of playing could lead spontaneously to another. Playing could be both a reflection of the therapeutic process and a means of bringing it about. Paddy began to pretend. His first pretend play, like that of many babies, took the form of pretending to feed me and inviting me to pretend to feed him. Plasticine and water became 'nanas and mook' (bananas and milk) and part of each daily session became a mutual feast.

Winnicott knew that this new capacity for togetherness was essential for providing the context in which Paddy could risk discriminating and tolerating differences. Paddy started to become interested in observing and exploring my body and focused on differences in our clothing and anatomy instead of on our similarities. All the toys had previously been held in common, but now he selected 'his' cars and bricks and allotted me the others. He would sit surrounded by his chosen toys and indicate that I should not let mine intrude upon his boundaries. The difference between 'me' and 'not-me' was becoming increasingly delineated.

During this period Paddy gradually developed a powerful attachment to me. He greeted me with enthusiasm and felt very rejected when it was time to go. Disillusionment was painful. He was forced to confront my separateness and to face his anger about it. Hide and seek became his favourite game. This allowed him to play out his anxieties about separation and loss of contact and about retaliation and attack. He would jump out of his hiding place to frighten me and liked to kick me on occasion. These games of hide and seek enabled me to verbalise his hopefulness that he would not be forgotten when out of sight and that I would want to find him when he disappeared.

I was becoming for him both a mental image which he could recall in my absence and a separate person in the external world who came and went.

During my supervision I gradually realised that Winnicott's approach to children's play was different from Melanie Klein's. Klein used play to understand and interpret children's anxieties. Winnicott did this too, but he was more interested in the way that children themselves use play to reflect and facilitate the development of the self. He decried 'running commentary' analyses, which, by verbalising everything, steal the child's experience of his own creativity. For Winnicott, the significant moments in child analysis were not the therapist's interpretations but the child's use of play to surprise himself with new awareness, just as adults make self-discoveries by talking problems through with a friend. Winnicott recognised that, through playing, therapy of a deep-going kind may be done without interpretative work. This enabled him to appreciate fully the work of play therapists (1971. p. 51).

Paddy's next forward step was his attempt to integrate his aggression through symbolic play. He intended that we should both enact crocodiles. Instead of the mutual feasting we had enjoyed, we voraciously attempted to eat each other. This play was not playful, but urgent, compulsive and aggressive. Such play is likely to be motivated by the repetition compulsion (Freud 1920) with the aim of mastering unresolved trauma.

It was at this point in Paddy's therapy that interpretation began at last to play a significant part. When repression has rendered conflicts deeply unconscious they cannot be spontaneously resolved through play, which may become unplayful and repetitive as Paddy's play did. Interpretation aims to help children understand what they are worried about so that they can recognise it and work it through.

Paddy's crocodile play could be understood in many ways, but it was particularly meaningful to him when I likened the crocodile's scaly, wounded skin to his mother's eczema, and spoke of his feelings of responsibility for causing this. Klein had taught me that children's imaginary monsters were projections of their own aggression, but Winnicott's view that playing takes place in the overlap of the 'me' and the 'not-me' led me to the realisation that Paddy's crocodiles reflected not only Paddy's own aggression but also the experience which had aroused it (Hopkins 1986); in this case, his mother's physical rejection of him on account of her eczema. Playing out these aggressive themes helped Paddy to separate fantasy from reality, to

recognise that wishing to hurt is not the same as doing and that thought is not equivalent to action. But Paddy's feelings of responsibility for his mother's eczema and for her rejection of him ran deep and proved very hard to mitigate.

Interestingly, it was after Paddy had tested my capacity to contain the crocodile's aggression that he ceased to be oblivious to physical pain. Perhaps he now allowed himself to cry when hurt because he could rely on my survival and so on my availability to comfort him (Fraiberg 1982).

After fifteen months of therapy had passed, Paddy was talkative, toilet-trained and no longer eating rubbish. His parents had been greatly reassured by the improvements in his development and he began to develop an affectionate attachment to them both. A nursery school agreed to give him a place and so he gained his first opportunity to play with other children.

One of the benefits of my supervision with Winnicott was the extension of my imagination beyond the range of children's unconscious fantasies as described by Freud and Klein. For example, Winnicott was fascinated by children's response to gravity. He thought of gravity as posing a male quality to be mastered and a female quality of uniting with earth, whether in love or despair.

From early in his therapy Paddy worked at defying gravity by erecting great piles of wobbly furniture. He wanted to put a cushion on top and sit there. Winnicott thought that Paddy was aiming to recreate mother's lap, to climb up into her arms and resist being dumped on account of her depression. Paddy was asserting his determination to keep himself up even if mother let him down. He developed games of climbing round the room without touching the floor. These games were very exciting and here he illustrated Winnicott's thesis (1971. p. 52) that playing is inherently exciting and precarious, not on account of instinctive arousal as Klein believed, but on account of the precariousness of the interplay in the child's mind between what is subjective and what is objectively perceived. Paddy was excited by managing the interplay between fantasies of falling and of flying and the realities of his limited powers to master gravity. And, when he mismanaged the interplay, he fell.

I now know that Winnicott's sensitivity to the effect on Paddy of his mother's depression was based on his own experience of a depressed mother (Phillips 1988). His personal mastery of this childhood experience has provided us with some of his most profound insights.

Paddy had yet to achieve the capacity for role-playing. This first

began at the age of four-and-a-half years when he called himself 'King of the Castle' and called me 'The dirty rascal'. From there he went on to role-play various admired daddy-figures: the coal man, postman, milkman and dustman. This make-believe led us into themes of Oedipal rivalry and jealousy. Later he risked reversing roles with me, for example, saying, 'You be Paddy. I'm you. I go home to my daddy-man and you cry'. This was clearly a means of mastering his jealousy, but it was also the first step towards putting himself in another's shoes, a development which Winnicott later called 'inter-relating in terms of cross-identifications' (1971. p. 119); This represents the creative aspect of introjective and projective processes.

Paddy's capacity to verbalise his fantasies increased. When I told him of my coming summer holiday he clutched his genitals and told me that his willy was a baby camel with two humps which would feed him in the desert. This symbolism was meaningful to me but Paddy's distress about my holiday ensured that he used the symbolism in a literal way; he could not allow us playful space to think about it. A year later, rising six years old, he remembered this fantasy with much amusement and told me, 'I really believed my willy made milk! Now I pretend my willy makes me fly – but not *really*!'. Paddy had now achieved both a sense of humour and a more mature capacity for playing, a capacity which Winnicott distinguished from the physical activity of play. Playing denotes the ability to distinguish reality from fantasy and past from present, while giving playful rein to a creative imagination which is neither delusional nor literal.

Today, the cognitive aspects of this development are being explored by researchers on the 'theory of mind'. Winnicott could have told them, what so far their research has ignored, that the capacity to think flexibly and imaginatively about thinking, to play with reality, depends upon a facilitating environment. In ordinary good-enough homes this capacity develops naturally enough. But in homes where the baby finds no mutuality, where the parent's face does not reflect the baby's experience and where the child's spontaneous gesture is not recognised or appreciated, neither trust in others nor confidence in the self develop and play is stunted. During his therapy Paddy had gained enough trust in me to play and had used his play and my reflection upon it to develop both a capacity for imagination and for self-reflection. He had also developed affectionate attachments, lost his symptoms and become able to prosper in a mainstream school. When therapy ended he was not free from problems but he was able to cope.

In the thirty-three years which have elapsed since then, children's

toys and games have changed, but the way in which children use play to find and become a self remains as Winnicott described it. Winnicott was alone among psychoanalysts in recognising that playing was at the root of our capacity for creative living and for the enjoyment of life. He expanded Freud's view that mental health is reflected by our capacity to love and to work. He saw that our mental health also depends upon the establishment of a transitional realm in which subjective and objective overlap and in which all playing, all culture and all religion belong. He recognised that our mental health depends upon our capacities to love, to work and to play.

References

Alvarez, A. (1992) *Live Company. Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children*. London: Routledge

Fraiberg, S. (1982) 'Pathological defenses in infancy'. *Psychoanalytic Quarterly* 51. 612–634

Freud, A. (1965) *Normality and Pathology in Childhood: Assessments of Development*. The Writings of Anna Freud VI. New York: International Universities Press

Freud, S. (1920) 'Beyond the pleasure principle.' *SE 18* London: Hogarth Press

Hopkins, J. (1986) 'Solving the mystery of monsters: steps towards the recovery from trauma.' *J. of Child Psychotherapy* 13 61–72

Phillips, A. (1988) *Winnicott*. Fontana Modern Masters. Ed: Frank Kermode. London: Fontana Press

Winnicott, D.W. (1958) *Collected Papers: Through Paediatrics to Psychoanalysis*. London: Tavistock Publications

—— (1965) *The Maturational Processes and the Facilitating Environment*. London: Hogarth Press

—— (1971) *Playing and Reality*. London: Tavistock Publications

FALSE SELF: SOME THOUGHTS ABOUT THE DIFFICULTIES FOR THE PATIENT AND THE THERAPIST

RUTH BERKOWITZ

> Pelagia wept real tears. She had never felt so crushed and humiliated. Her father had reduced all her rosy reveries to common sense and medical sordidities. (Her father tries to placate her, telling her he was young once.) 'Not everything was different in your day, then' she said tartly as she left the room. Her father smiled with satisfaction at this Parthian shot, and sucked very tentatively on the pipe; he had judged that a pert response signifies an undiminished daughter.
>
> Louis de Bernieres: *Captain Corelli's Mandolin*

The term 'false self' is one which has eased itself into the language of psychoanalysis and there seems to be a belief that there is a shared understanding of its meaning. The concept itself, introduced by Winnicott (1949a; 1949b; 1949c; 1960; 1962; 1968), has not been a fertile source of further papers although its precursor the 'as if' personality appears to have generated more thought (Deutsch 1942; 1955; Greenacre 1958; Katan 1958; Kaywin 1968; Riesenberg-Malcolm 1990; Ross 1967; Weiss 1966). The reason for the interest in the 'false self' in this paper is that Winnicott sounds a warning note for those who work with patients presenting with this type of disorder. He says that such patients should not be seen by candidates in training:

> '. . .it is important that patients who are essentially False Personalities shall not be referred to students of psycho-analysis under a training scheme' (1960 p. 143)

and that in certain cases, his third category of false self, he states that where the conditions cannot be found for the true self to come into existence 'the clinical result is suicide.' (1960) This is how he describes his third category:

> 'The False Self has as its main concern a search for conditions which will make it possible for the True Self to come into its own. If conditions cannot be found then there must be reorganized a new defence against exploitation of the True Self, and if there be doubt then the clinical result is suicide. Suicide in this context is the destruction of the total self in avoidance of annihilation of the True Self. When suicide is the only

> defence left against betrayal of the True Self, then it becomes the lot of the False Self to organise the suicide. This, of course, involves its own destruction, but at the same time eliminates the need for its continued existence, since its function is the protection of the True Self from insult.' p. 143

The idea that I would like to explore is that in this type of False Self the issues are nothing less than life and death, or more appropriately life or death which may be revealed in several ways. I would like also to illustrate this with some clinical material from work with such patients and to consider some of the difficulties faced by both patient and therapist in the therapeutic encounter.

Put more succinctly, I would like to think about what the conditions might be for the True Self to come into existence and equally, what the impediments to this might be.

The concept of true and false self

Of the terms, 'true', 'false' and 'self', the most difficult to grasp is 'false'. The other two are not entirely straightforward but more accessible. The term 'true' is an interesting one for Winnicott to choose and I wondered why not 'real'. The Oxford English Dictionary defines true in terms of real but not the other way around. It is in the definition of the term 'real' that there is the sense that Winnicott appeared to wish to convey, the idea of 'existence'. The True Self according to Winnicott comes from the aliveness of the body tissues and the working of body functions, including the heart's action and breath. It appears as soon as there is any mental organisation of the individual at all, and for him it means little more than the summation of sensori-motor aliveness (1960). Why not 'real'? Freud said the 'opposite of play is not what is serious but what is real (1908 p. 144) and Winnicott juxtaposed these two in his title of his book 'Playing and Reality'. Is 'play' then not available to the False Self? Winnicott suggests this when he says that when there is a very great split between the True and False Self, there is a poor capacity for using symbols and a poverty of cultural living.

> 'Instead of cultural pursuits, one observes extreme restlessness, an inability to concentrate and a need to collect impingements from external reality so that the living-time of the individual can be filled by reactions to these impingements' (1960 p. 25)

Before attempting to explore the concept 'false' there is the question of the meaning of self. A definition by Greenson, for example, indicates that 'self' like 'true' is closely linked to internal experiences.

> 'Self representation is derived from direct awareness of our inner experiences, and on the other hand from indirect perceptions of bodily and mental reactions viewed as an object. The earliest self images come from our body sensations and body images.' (Greenson 1954 p. 202)

From the Oxford English Dictionary the definition of 'false' is to do with being 'purposely untrue' 'mendacious' 'counterfeit' 'sham'. There is, however, more to the meaning of 'false' in the context of 'False Self' as Winnicott intended it to be understood.

The false self

The notion of the 'False Self' was perhaps most clearly described by Deutsch although she wrote about 'As If' personalities. In her very impressive paper (1942) she describes a kind of emotional disturbance in which the individual's relationship to the outside world and to his own ego appears impoverished or absent. She describes the 'As if' personality in the following terms:

1. The individual's whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along 'as if' it were complete.
2. The initial impression made is one of complete normality, bringing understanding to both intellectual and emotional problems but without any originality.
3. Relationships are usually intense but without warmth, a good actor but without the necessary spark.
4. Outside life is conducted 'as if' there were a complete and sensitive emotional capacity.
5. There is an absence of object cathexis but an apparently normal relationship, which although appearing to be an expression of an identification with the environment is a mimicry, which results in an ostensibly good adaptation to the world of reality.
6. There is a completely passive attitude to the environment, picking up signals from the outer world and moulding oneself and behaviour accordingly.
7. Initially there is warmth but then a lack of warmth.
8. Relationships have an adhesive quality, loss brings a rush of spurious emotion but then the object is exchanged.

9. The same emptiness and lack of individuality in emotional life appears in the moral structure so that ideals are simply a reflection of another person.

Winnicott, to my knowledge, did not link his thoughts to those of Deutsch when he wrote about the 'False Self' in several papers. (Winnicott, 1949a, 1949b, 1949c, 1960, 1962, 1968). It is not the intention here to try to draw out similarities and differences and it would appear that several writers use the two terms interchangeably (Chasseguet-Smirgel 1985; Gaddini 1992). In a paper entitled Ideas and Definitions, Winnicott (1990) gives the following description:

> '. . .a defensive organisation in which there is a premature taking over of the nurturing functions of the mother, so that the infant or child adapts to the environment while at the same time protecting and hiding the true self, or the source of personal impulses. This is similar to the function of the Ego, in early Freud, turned towards the world, between the Id and external reality.
>
> In typical cases the imprisoned true self is unable to function and by being protected, its opportunity for living experience is limited. Life is lived through the compliant, false self, and the result clinically is a sense of unreality. . .' (p. 43)

Some of the important ideas inherent in the concept of the false self are to do with:

1. *Compliance* of the False Self: Deutsch points this out when she comments on the picking up of signals from the outside world and moulding oneself and behaviour accordingly. Greenacre (1958) in discussing Deutsch's paper talks about the 'need to please'. Kahn (1971) writes of passive adaptation to reality, Reich (1953) of the need to appease external objects by becoming like them, Ross (1967) describes such patients as being 'regular schlemelions'. This compliance, according to Winnicott, is the earliest stage of the 'False Self' and belongs to the 'mother's inability to sense her infant's needs' (1960, p. 145) Elaborating and explaining this idea of Winnicott's, Schacht (1988) writes:

> 'The not good enough mother is incapable of implementing the infant's omnipotence and misses again and again the infant's gesture. Instead she urges her own gesture onto the child. This forces the child to adapt to the mother's gesture. This adaptation of the child to the mother which corresponds to a reversal of the conditions postulated for the relationship between baby and good-enough mother, Winnicott calls compliance. This leads to the early stage of the False Self. The infant is being seduced to adapt, or the infant is seduced into compliance.' (p. 523)

2. *Impingement:* Winnicott (1949a) describes impingement in terms of environmental disturbances which go beyond a certain degree, that is, they are as he puts it unhelpful because they bring about a reaction. According to him at the early stages, there is not enough ego strength for there to be a reaction without a loss of identity. The kind of experiences which he considers to be impingements are coincidences and those which are beyond the infant's ability to comprehend.
3. *Response to impingement:* Impingement is central to the development of the false self. One response may be, as Winnicott puts it, a pathology of the process of thinking. Thinking in the normal way is part of the mechanism by which infants tolerate both failures of adaptation to ego need and the frustration of instinct which produces tension. In the case of the 'False Self' the process of thinking is stepped up so that mental functioning becomes a thing in itself, an intellectual defence, practically, he says, (1968) replacing the good mother and making her unnecessary. The 'False Self' thus can become a caretaker of the True Self, a premature taking over of the nursing function of the mother.
4. *The nature of the anxiety:* The anxiety is about annihilation rather than castration, and is, to use Winnicott's language, annihilation which has already been experienced. As he points out, the False Self, is a protection against the unthinkable, that is, the exploitation of the True Self which would result in annihilation. What he goes on to say is that, 'if the True Self ever gets exploited and annihilated this belongs to the life of an infant whose mother was not only 'not good enough'. . .but was good and bad in a tantalizingly irregular manner here.' (Winnicott 1960 p. 147). Khan (1971) reiterates this idea when he writes that these patients have actually experienced annihilation in terms of their autonomous development. Similarly, Riesenberg-Malcolm (1990) comments on the dread these patients have of their internal world which, as she puts it, is experienced as a menace to their sanity, and their choice is either to capitulate or comply.
5. *The nature of the affect:* The compliant False Self is often charming and engaging in the manner described above by Helene Deutsch. Yet she indicates that aggression is masked by passivity, and several authors agree that underlying this superficial exterior is the most intense rage. According to Khan, (1971), this rage is linked to the earlier capitulation, where the choice was between annihilation and passive adaptation to the regime established by mother. He seemed to be suggesting in the clinical material, that his patient transformed his violent rage about this into the service of manic defences and

precocious mental function. Ross (1967) in his review of the 'As If' personality quotes both Jacobson and Deutsch who also refer to the underlying aggression in these patients. He says

> 'Perhaps what we mean by affectlessness in them is their lack of libidinal cathexes, whereas there exists in them an enormous reservoir of aggression.' p. 75

Ross talks about the sidetracking of affect and perhaps the sidetracking is what Winnicott means when he refers to the collection of impingements which may, as well as serving to fill the living time, be a way of displacing the rage onto the external environment.

6. *The failure to internalize:* One of the main features of this type of patient, is the lack of, or loss of, an object cathexis so that there is a failure to internalize. This was pointed out by Deutsch (1942) when she described the apparently normal relationship which she saw as 'mimicry', leading to an apparently good adaptation to the world of reality in spite of the absence of object cathexis. Chasseguet-Smirgel (1985) writes of subordination to 'the wishes and commands of an authority which has never been introjected' (p. 318). Katan (1958) describes what he calls a primary identification by which he means the patient becomes what he thinks the other person wants her to be (p. 266). He goes on to describe the fate of this primary identification which is

> 'such that a relinquished relationship is not followed up by an identification, but contrary to such sequence, the identification disappears with the relationship.' (p. 266)

Khan (1971) in a different way talks about a rigid, premature structuring of internalized primary objects and fantasies and

> 'negativity towards all new experience and object relations. Thus through puberty and adolescence such persons experience little that enlarges or enriches them and live in a shut-in, unreal world of their own concoction.' p. 247

Many authors agree that the nature of the relationship of these patients to the object world is one of imitation rather than identification. This idea is suggested by Freud in his paper 'Those Wrecked by Success' in which he makes a distinction between 'having' and 'being'.

> 'Having is the later of the two; after the loss of the object, it relapses into "being". Example the breast, "the breast is a part of me, I am the breast" Only later "I have it – that is, I am not it."' (1916, p. 229)

Gaddini (1992) elaborates this idea, taking the position that in 'As If' patients there is a regressive defence from relationships which would involve identification:

> 'The seriousness of these patients is equal to the entity and to the extension of the imitative phenomena which substitute identifications, and to their primitive character. . .They lead to what one could correctly define as an attempt to gain a vicarious identity, magically acquired through imitation.' (p. 24)

Limentani in his Introduction to Gaddini's book makes some useful points in relation to aspects of internalization saying

> 'Precocious conditions of oral frustrations cause disturbances in the psycho-oral area and, more precisely, in the introjective mechanisms. This results in the activity of imitating introjects which can be substituted for true introjections. By imitating one magically becomes the external object but unhappily this will not lead to internalization. To be is not to have. What is lost can therefore be spuriously maintained. . .' p. 4/5

Imitation as a mode or relating is described by several authors including Winnicott when describing 'As If' and False Self personalities. Riesenberg-Malcolm (1990) construes the problem with internalization in 'As If' personalities in a somewhat different way, in terms of not learning, keeping the situation immobilized and in terms of hating the analyst for providing understanding and trying to bring new meaning.

I am aware that most of the aspects I have outlined may be well worn paths and probably very much part of the understanding of many therapists and analysts. It felt necessary however, to set a backdrop for the main purpose of the paper which is to consider some of the difficulties in working with such patients. One of these is that these individuals are extremely fragile, described as 'borderline' by Kernberg (1985, p. 13), prone to breakdown, Reich (1953, p. 42) 'disintegrate completely' (Riesenberg-Malcolm 1990) or as Winnicott says potential breakdown dominates the scene. (1986, p. 33) As mentioned earlier he indicates that suicide is a serious threat in certain types of False Self personalities.

Secondly, there appears to be very little work apart from Khan's which addresses the difficulties in conducting an analysis or a therapy with such patients: what for example of the transference, the countertransference, the reconstruction in the therapy of the earliest times in the lives of these patients? How possible is it to work against the powerful function of the False Self which as Winnicott says is to protect the True Self which has been traumatised and must never be found and wounded again? And yet some of these patients come to therapy and analysis. Why? Is it as Riesenberg-Malcolm (1990) suggests that the 'experience of not learning and being in analysis offers these patients a modus vivendi' (p. 391) or is there a search for the

conditions which will make it possible for the True Self to come into its own (Winnicott, 1960), or both?

Clinical material

The patients on whose material I will draw came to therapy with a variety of presenting problems. They were all good-looking, charming and talented, even successful in their own fields. What distinguished them in terms of their history was a story of a mother who 'chose' this child to be *her* mother, who inverted the relationship. What distinguished them in terms of the transference, particularly at an early stage, was a demand for the finest attunement on both sides. They were in a state of acute vigilance keeping an eye on me to ensure that they, divining from my response, had got it right and that I did not lapse in my attention to them. Such a lapse may be a brief breach in eye contact for those who did not use the couch and for those who did, changes in my breathing pattern, what they thought (and maybe had been) a sigh or a yawn from me. This, to them, was a certain sign of boredom. What I came to realise was that underlying what could be seen as this 'tyranny' were the most profound rage and shame and an anxiety of such annhiliating proportions that these events could be experienced as a catastrophe. The essential struggle from a therapeutic point of view is how there can ever be two people in the room. In the situation of a False Self personality and the object, the existence of one seems to preclude the existence of the other. In the countertransference, which I hope to describe in greater detail, there may equally be dangerously good feelings of 'getting it right' and a narcissistic blow of annihilating proportions when things go wrong.

I called this paper 'The False Self: Some thoughts about the difficulties for the patient and the therapist' and what I hope to do is to explore, unravel some of these and to convey the profound struggle on both sides to give life and reality where there has been so little. I would like therefore to think about some of the problems which seemed to me to present the greatest obstacles to the work, aware that many are being left out and link them to areas I have already touched on above:

1. *Compliance:* Although we may see the setting as holding, it may not only be that. The setting demands a high degree of compliance, a Truby King type of feeding arrangement, sessions are at this time and not that time, for 50 minutes and no longer and although the funda-

mental rule seems to some a possibility of freedom to say what they feel and think, to the False Self it may represent a hidden communication from the therapist that really there is a right way to do it if only they can find out. The path to discover the right way is by 'eternal vigilance' and doing the job they are most familiar with, tuning in with the greatest sensitivity to their object.

To one of my patients, Miss L, a young woman in her mid thirties, her dedicated watchfulness was closely connected with anxieties about survival, hers and mine. By being so attuned to me, bringing me material and stories to entertain me, she was my special patient and so I would continue to take an interest in her, keep her alive. But in order to keep herself alive (whatever that might mean in this context) she had to work very hard to keep me going and this was part of her compliance. What, she often asked, could possibly keep me in the relationship if she did not. Worse was the idea that something else, someone else other than her might keep me going, do the work, because once again she then would have no life. In the countertransference there are obviously feelings of being controlled but it is control of a particular kind. To sigh or to avert ones' eyes is extremely dangerous. There are also feelings of cosiness, this is nice, we are together doing a good job, the patient is intent on getting it right and so am I. Some of the time one does get it right. This feeling of being a good therapist is one of the great threats to the whole project because when the blows fall, the rage is of such proportions that the shock to one's narcissism may be too much to bear.

The compliance, the getting it right, might turn as the therapy progresses from a demand that is 'life giving' to one that is 'death dealing'. The setting may begin to be experienced as one which serves the needs of the therapist to the total neglect of the patient, recreating the earlier situation of the maternal object who was experienced as using the patient in the service of her own needs.

Miss M, a beautiful and talented young woman had been coming to me for several months. She of the two children in her family had been the one who had always cared for, attended to mother. She began to complain in the therapy about the beginning of the session, how she needed to hear my voice before she could begin. I interpreted her fears of being left alone of being abandoned for some time and one day she came in and said 'I have done my duty, now you talk.' Based on my interpretations, she said, yes, her problem was that she felt abandoned and unless I could reassure her every time, it was useless. She became more and more enraged as she spoke and, finally, throwing the box of tissues at me, left the room telling me she was ending. I went after her saying 'Please don't go, this is not a good way to end, come and sit down

and let's talk about it.' She came back and said 'I will explain once more. I cannot stand it if you don't talk to me at the beginning of the session. I feel like an object. I need to know I am human. If you cannot break the rules, I can't stay. Not only must you do it, you must do it freely, like a gift. It is such a little thing that is all I ask.'

I will return to the issue of the rage later but at this point want to raise the question of the breaking of rules in such a situation and what it might mean. I did break the rules, I did begin the next session with 'How are you today?' but had, at the same time, to understand that she wanted to be the one whose needs were attended to. Although I had previously interpreted her desperation that I should attend to her needs and not, as she experienced it, to my own, the interpretation was not enough. Perhaps my *doing* something conveyed to her that she had made an impact on me, in the way that Carpy (1989) suggests.

It was a short therapy because she did not live in London and when she came to end, she told me this change in my behaviour had been the most important aspect of the therapy for her, to know that I had heard her, heard her protest. It is also worth noting that my beginning the sessions was a short lived experience and for most of the time she would begin herself. I am aware that I have somewhat artificially separated aspects of working with such patients but they are obviously interrelated. Compliance as I have tried to consider may be experienced as imposed by the Truby King type setting, mimicking a rigid feeding schedule, meeting the demands of the mother/therapist; it may be revealed in the vigilance of the patient and experienced in the counter-transference both as a form of control and/or being a 'good' therapist. While there may be some recognition that the patient is a False Self, there is hopefully the aim, explicit or tacit, that it is the True Self that both patient and therapist are after. However, the emergence of the True Self may happen with such force and intensity, that instead of celebrating its emergence, the response of the therapist could be, like the original maternal object to attack, to demand the return of the good compliant child/patient.

2. *Impingement:* I have wondered whether the absolute necessity for the therapist to get it right, so to speak, is *only* an attempt to control the object. It is well known that many patients who are considered borderline may become enraged by some comment which the therapist considers entirely benign and by which the patient feels hurt or angered. Could it be that there is such an intense search for authenticity that anything less than a perfect match is experienced as an attempt

to destroy the True Self? After what I thought had been a session of some value in which Miss B could tell me how let down she felt by me and her relief at being able to say so, I used the word 'despair'. This did not feel right to Miss B and she told me that everything was ruined. This form of impingement may feel like abandonment, the reflection held up was not of her but of her object. Going even further, where the understanding of these extreme responses is that it is an attack on the therapy or the therapist, this too could be an impingement. Giving the rage this meaning may be experienced by the patient as being of an impingement of such magnitude that it is felt that all is lost, rage increases and the small and struggling True Self, the identity is snuffed out and as Erikson suggests 'the destruction of identity can lead to murder.' The failure may be that the regressive aspects of the rage are ignored. Miss M conveyed how misunderstood she felt when others only understood her rage as attack. She needed she said to express this towering rage that belonged to her and needed others to understand it not only in terms of it being a response to, and attack on, them.

There is an indication in the literature that the emergence of the True Self will be accompanied by the kind of behaviour that requires 'management', a taking over by the therapist of the caretaking responsibilities always carried out by the False Self. The impression is conveyed that the regression will take the form of a loss of function, a retreat to an early state of dependence. What I have wondered is whether this regression might at times come in a different guise, a break through of the most primitive and intense protest. Instead of recognizing the regressive aspects, the therapist may now at this most crucial time engage with the False Caretaker Self as an ally against the unruly True Self. This may be a wish in the countertransference to return to those times when things were good, a re-enactment with a mother who might have felt and said 'you are destroying me' 'don't do this to me.' So that rather being seen as the seeds of the True Self, the aggression is seen as the destruction of the object. Bollas (1987) talks of the hate experienced by some patients which is an attempt to emerge from a vacuum, from emptiness into object relating.

What I have been trying to consider is that for these patients seeking the right conditions for the emergence of the True Self, the smallest misunderstanding is not an opportunity for further searching but may represent and be experienced yet again as a reflection of the needs of the object and attempts to meet those rather than the needs of the patient/child, that is a demand for the False Self response. This may

lead to a profound loss of hope and how much more so when the rage is seen only as destructive and not as a bid for life.

3. *Response to impingement.* As I have been trying to indicate, protest in the form of the most intense rage is one of the responses to impingement. If this rage is interpreted as destructive to the therapy and the therapist, this may be the end of the therapy although the therapy may continue. It may be the end of a real therapy and the continuation of a false therapy, death to the possibility of the True Self, the termination of the therapy, or perhaps suicide. The rage can have a terrifying intensity and while it may be experienced as destructive, it may not be the whole story or may not be the story at all.

It was Winnicott (1950) who said that aggression is part of the 'primitive expression of love' p. 205 and later that the primitive love impulse has a destructive quality 'though it is not the infant's aim to destroy since the impulse is experienced in, what he calls, the pre-ruth era', p. 211. What is so important in this paper of Winnicott's is the idea that aggression feels real, much more real than erotic experiences but additionally, aggression gives no satisfaction unless there is opposition from the environment. The problem for the therapist is what the nature of this opposition should be particularly in the light of the thought that there is a need on the part of such patients for environmental impingement. If we consider this more in terms of projective identification, a communication about the patient's objects, this could be more helpful. If we consider once again Miss M, my experience of the session with her was one of the most profound response of rage myself. I felt I hated her, it was not she who was the object, to use her word, but me. I hated her most for not appreciating my so-called help and for telling me what to do. I had become a patient and in those moments there were two 'patients' in the room, just as there had been two 'infants' in her early maternal care. 'Look what you are doing to me' went through my mind. 'What about me?' I saw her despair and felt my own, her hopelessness and mine. By my continuing to interpret and waiting until she began her session, she had experienced me as her mother whose every need she had to meet, enacting in a sense a demanding, unyielding mother who would not hear her daughter's pleas until she screamed and hurled the box of tissues at the unresponsive object mother/me. It was only then that I could experience the objects in her world, the rage with a daughter who would not do my bidding, my own impotence and concern for myself. In the moment of her leaving, I reminded myself that it was she who was the patient, not me. She wanted to destroy me, but not to be

destructive, more in order that I could survive, and so could she, to use Winnicott's language.

One of the other responses to impingement is what has been called the intellectual defence. If the object does not provide the conditions in which the True Self can emerge, this may lead to the hatred and rage. Equally there can be no separation from the object because that way is death. The solution then is to find a place in the mind in which to try to make sense of what may have been experienced as an overwhelming trauma and this solution is often an intellectual defence, an attempt to deal with the overwhelming experience. These patients describe feeling suffocated in the presence of significant objects and restless and lonely on their own. In the therapy this dilemma may be re-enacted in the rather theoretical nature of the dialogue.

Mr P, a talented artist, initially in the therapy wanted explanations, why and how and what; then began to say that the insights did not help him, he felt nothing and later spent one whole session holding his head saying 'I don't understand; I don't understand' conveying to me a traumatised infant or child who could make no sense of a world in which *his* maternal object had from his earliest days demanded that he be her confidant, both in her unhappy marriage and her adulterous affair. The split between the emotional and intellectual life of the False Self is a profound and the mind may become a place of retreat. These patients are secretive and guard aspects of their life from intrusion, from being colonized once again by external objects. But as we said earlier, they are restless and will describe feeling lonely in their secret places. In the therapy, what seems to matter is not the bringing of the secrets, but the bringing of the possibility of being in a secret place IN the therapeutic setting. The therapy often begins with wall to wall words, keeping mother/therapist entertained and engaged and to be silent in the session, to turn to their own inner worlds, is felt initially to be very dangerous. With Miss L the anxiety was that I would completely lose touch with her in my mind if she were not talking, that she would feel abandoned, and, therefore, it felt necessary to check that I had her in mind. The struggle is that if they remain vigilant, they feel they have been invaded, but if they drop the vigilance, they feel alone. Both she and Mr P expressed this dilemma and later, enormous relief at being quietly with me. One response then to impingement is to find a secret place, often the mind, which is a failed attempt to 'understand' as well as a failed attempt to separate from the object since there are fears of being abandoned. One of the important conditions for the emergence of the True Self may be a

receptive silence. However, the more silent turning inward to the internal world brings its own horrors and anxieties.

4. *The nature of the anxiety:* The ongoing anxiety is of annihilation. Miss L after some time in therapy was able to recognize and name the experience of her False Self. But with this recognition and naming came the contact with and experience of the most profound fears. Time and again she would come to her sessions saying she didn't think she could make it, the fears were too great. Whichever route she took, she felt that she faced death. On the one hand she said, 'Collusion is death' by which she meant my going along with the 'good girl' aspect of her False Self, the sweet compliance which suffocates the True Self. Yet, on the other hand, the aggression of the True Self, she continued to feel, would never really be acceptable either to her mother or to me. In fact, quite the opposite. If this side of herself were revealed it would destroy the relationship between her and her mother/me and she would experience total abandonment. This fear that her emergent True Self will be destructive, ending in abandonment, is only one form of the annihilation anxiety. The other is that the giving up of the False Self will reveal a barren inner world, unnourished or 'hollow' as my patient put it. The role of the False Self is to fill up the hollows so that neither she nor her objects 'know' about this. This 'not knowing' is closely linked both to the affect and the difficult with internalization experienced by such patients.

When the False Self begins to crumble the internal world may be experienced as a terrifying terrain. Patients describe it in a variety of ways, a maelstrom, treacle, sand dunes, sinking sand, a featureless place in which they fear they will get lost. The anxiety increases 'tell me will I ever get out of this', 'how can I ever find my way', 'do you know what you are doing', 'tell me what to do'.

In the countertransference there are anxieties about having led the patient down this path into a kind of no-man's-land and to remain in the nightmare with the patient is very difficult. There is a tremendous pull back to something reassuring, 'of course you will', or to indicate in some way to the patient that he ought to take charge of himself and thus the old situation is re-enacted. If the mother/therapist cannot bear it, cannot endure the pain, the child/patient must stop it to spare mother/therapist. Being with instead of doing to is all that is possible at this time and almost unbearable for both patient and therapist.

5. *The nature of the affect:* I have touched on the issue of the rage of the False Self, the fear of the destruction of the object and the recognition that life itself for the True Self may only begin when the object

has understood the rage as a source of life and not the end of it. The other affect which I came to recognise as a very important aspect of our work was shame which my patient Miss L was gradually able to reveal. She addressed the subject with terror and a degree of bravado. It was so awful to have it discussed in the open. Shame was attached to a variety of experiences, the feeling of being so little and so dull which could not possibly be of interest to me. Her shame echoes the story which Chasseguet-Smirgel (1985) tells of the Emperor and the Nightingale in which it was the mechanical nightingale which caught the attention and imagination. It was the little grey nightingale, however, which sang with such purity and sweetness although it was so drab. For my patient, there was fear that her little grey True Self would not be of any interest to me, how could I possibly sustain a relationship with her without her efforts to captivate me. What, as I said before, could possibly keep me there because if she did not work at it, I would vanish. She described herself as blind mole always seeing for others. There was also the shame at the extent of her need because she had given the impression to others of her large confident False Self.

In addition, there was the shame of not knowing. It was not a question of uncertainty, or ignorance, but more the shame of not doing her life's work which was to lead the way for mother, *as if* she knew. The precocious development of the ego is often mentioned by writers in this area and she would describe herself as always having to be in the advanced party in relationships and on journeys, having to go first as if she knew the terrain. What she could not bear to know was that she did not know. Sometimes she would cover her face in mortification at this state of affairs, saying 'I can't bear it. I am so ashamed.'

6. *The failure to internalize:* All this brings us to what is a central problem in the work with such patients, that is the failure to internalize. As the therapy went on Miss L began to talk about food, about the opinion in the family that there was something very special about the food, nothing like it and no one but they could make anything as good. She had always 'adored' everything her mother made but had no sense of whether she liked it or not and had begun to think differently about her mother's food. She now felt it was poison.

The nature of the relationship of the False Self to the object is one of being like, (imitation) and not having (identification) Gaddini (1992) makes a distinction between early identification and imitation on the basis that

> 'early identifications can be distinguished from imitations by the important fact that a reality, even though fragmentary, becomes integrated and assimilated' p. 19

He links imitation to the pleasure principle and identification to the reality principle. Imitation, Gaddini suggests, happens in the absence of the object not in its presence and

> 'precisely because of this, its aim seems to be establishing in a magical and omnipotent way the fusion of the self with the object'. p. 21

I have touched on Miss L's shame of not knowing, that she ought to be in the vanguard. In the therapy this can lead to omnipotent behaviour and if understood only as omnipotence, can lead to a retreat. There are several battles to be fought on the road to taking in something from another. One may be to do with the anxiety that there are no others to lead the way, giving up the omnipotent role leads to a collapse of objects, and as Miss L and I began to understand, no 'other' could understand and care for her like her own caretaker self. Another reason may be that asking for something may open up a cavernous need and hunger and so my patient could not know about her internal world. She described what she left behind as a burnt out field, a field which she said, she had set on fire using a matchbox to set everything alight.

Perhaps this thought about setting it all alight leads to another area and that is one already touched on. In the therapy there are not and cannot for a long time be two people in the room, because to allow that would create the situation of greatest risk, death to one or the other. What I want to convey is that there is no capacity to glimpse the possibility of loss, the idea of two people implies that there may be differences, differences mean separation. My patient could not give up the fields, she had to burn them, not to know where she had been or when, to leave no trace. My patient described her world as one over which she had control, a world without consequences. A world in which time did not exist, there was no sense of the finite, no knowledge of a space. To learn, then, is to know one does not know and to be able to bear that. To learn is give up aspects of the self. Time and again I would need to point out to my patient how she might in a manic way hop from one thought to another, taking me with her at times with horror at her dangerous behaviour, at other times finding myself laughing, being amused and colluding with her wish to avoid the pain. Behind all this was the 'parasitic' transference, the experience that her life depended on me but that coming to life would be too much for us both.

One further impediment to internalization is related to the threat experienced by the patient to their uniqueness, which perhaps I described earlier as authenticity. While the False Self may be one way of keeping out intrusion, there remains the lack of a real barrier, a real boundary between the external and the internal world. The early experiences of invasion, intrusion of being taken over are evoked again and again in the therapy:

> 'Perhaps the original stimulus barrier, a precursor of defence, persists in these individuals against a very early threat of being overwhelmed by the instinctual drives not yet structured by object relationships.' (Ross p. 68)

Conclusions

I have tried in this paper to outline some of the difficulties the patient and therapist might have to face when dealing with the False Self. Winnicott's warning about the dangers of undertaking therapy with such patients is worrying but elusive. The therapy, he indicates, could end in suicide. While suggesting that there need to be the right conditions for the True Self to come into existence, he says little about what these conditions might be.

Much has been written about containment which would be as important with the type of patient described as a False Self as with other patients. Perhaps implicit in the notion of containment is Winnicott's idea of survival, the therapist being able to tolerate the stresses and strains of a therapy, which Stone (1954) describes so well:

> '. . .the decisive factor is the ability to stand the emotional strain of the powerful tormented and tormenting transference and potential counter-transference situations which such cases are liable to present over long periods, without giving up hope. . .' p. 587

In the case of the False Self it is not only this aspect of survival but also the capacity to survive the aggression, aggression that perhaps is a regression to a time when there was a failed bid for life. Survival here is about the meaning given to the aggression. When it reappears in the transference the risk is that it is understood only as an attack on the therapy and the therapist, and not as an expression of the vitality of the True Self, that bid for life which seeks recognition.

References

Balint, Michael (1968) *The Basic Fault* London: Tavistock Publications
Bollas, Christopher (1987) *The Shadow of the Object: Psychoanalysis of the Unthought Known* London: Free Association Books

—— (1989) *Forces of Destiny* London: Free Association Books
Carpy, Dennis (1989) 'Tolerating the countertransference: A mutative process' *Int J Psychoanal* 70: 287–294
Cassimitis, E.G. (1984) 'The 'False Self': existential and therapeutic issues' *International Review of Psycho-Analysis* 11: 69–77
Chasseguet-Smirgel, Janine (1985) *Creativity and Perversion* London: Free Association Books
Deutsch, Helene (1942) 'Some forms of Emotional Disturbance and their Relationship to Schizophrenia' *Psychoanalytic Quarterly* XI: 300–321
—— (1955) 'The impostor: Contribution to ego psychology of a type of psychopath' (in John D Sutherland & M Masud R Khan (eds) *Neuroses and Character Types* 1965 London: Hogarth Press
Freud, S (1916) 'Those Wrecked by Success' *SE*XIV London: Hogarth Press
—— (1941 [1938]) 'Findings, Ideas, Problems' *SE*XXIII London: Hogarth Press
Gaddini, E (1992) *A Psychoanalytic Theory of Infantile Experience* London: Routledge
Greenacre, Phyllis (1958) 'The impostor' *Psychoanalytic Quarterly* 17: 359–382
Greenson, Ralph R (1954) 'The struggle against identification' *Journal of the American Psychoanalytic Association* 2: 200–217
James, Martin (1960) 'Premature ego development' *Int J Psychoanal* 41: 288–294
Katan, M (1958) 'Contribution to the Panel on Ego-Distortion 'As-If' and 'Pseudo As-If'' *Int J Psychoanal* 39: 265–270
Kaywin, Louis (1968) 'The evocation of a genie: A study of an 'as if' character type' *Psychoanalytic Study of the Child* 37: 22–41
Kernberg, Otto (1985) *Borderline Conditions and Pathological Narcissism* New Jersey & London: Jason Aronson, Inc.
Khan, Masud R (1971) 'Infantile neurosis as a false-self organization' *Psychoanalytic Quarterly* 40: 245–263
McDougall, Joyce (1986) *Theatres of the Mind* London: Free Association Books
Ogden, Thomas H (1992) *Projective Identification and Psychotherapeutic Technique* London: Karnac Books
Reich, Annie (1953) 'Narcissistic object choice in women' *Journal of the American Psychoanalytic Association* 1: 22–44
Riesenberg-Malcolm, Ruth (1990) 'As if: the phenomenon of not learning' *Int J Psychoanal* 71: 385–392
Ross, Nathaniel (1967) 'The 'As-If' concept' *Journal of the American Psychoanalytic Association* 15: 59–83
Schacht, Lore (1988) 'Winnicott's position in regard to the self with special reference to childhood' *Int J Psychoanal* 15: 515–529
Stone, Leo (1954) 'The widening scope of indications for psychoanalysis' *Journal of the American Psychoanalytic Association* 11: 567–594
Weiss, Joseph (1966) 'Clinical and theoretical aspects of 'As If' characters' *Journal of the American Psychoanalytic Association* 14: 569–591
Winnicott D.W. (1949) 'Birth memories, birth trauma and anxiety' in *Collected Papers: Through Paediatrics to Psycho-Analysis* London: Tavistock Publications (Reprinted by Hogarth Press and the Institute of Psycho-Analysis, 1975)
—— (1949) 'Mind and its relation to the psyche-soma' in *Collected Papers: Through Paediatrics to Psycho-Analysis* London: Tavistock Publications (Reprinted by Hogarth Press and the Institute of Psycho-Analysis 1975)
—— (1950's) 'Ideas and definitions' in C Winnicott, M Davies, R Shepherd (Eds) *Psycho-Analytic Explorations* (1990) London: Karnac Books
—— (1950) 'Aggression in relation to emotional development' in *Collected Papers: Through Paediatrics to Psycho-Analysis* London: Tavistock Publications (Reprinted by Hogarth Press and the Institute of Psycho-Analysis, 1975)
—— (1960) 'Ego distortion in terms of true and false self' in *The Maturational Processes*

and the Facilitating Environment (1965) London: The Hogarth Press and the Institute of Psychoanalysis

—— (1962) 'Ego integration in child development' in *The Maturational Processes and the Facilitating Environment* London: The Hogarth Press and the Institute of Psychoanalysis 1965

—— (1968) 'Thinking and symbol-formation' in C Winnicott, M Davies and R Shepherd (eds) *Psycho-Analytic Explorations* (1990) London: Karnac Books

THE PROVISION OF A CONTAINING STRUCTURE FOR AN ACTING OUT PATIENT*

BERNARD SHAPLEY

Introduction

This paper describes the first eighteen months of therapy with a thirty year old woman, in which a major feature of the early stages of treatment has been the patient's acting-out. After giving a history, I will describe the clinical work with Ann, giving particular emphasis to the various ways in which we came to understand the acting-out behaviour. In the discussion, I will suggest that activity and action are used instead of thinking and words to negotiate circumstances where there is overwhelming helplessness and confusion in the face of perceived rejection by her objects.

Freud (1914) spoke of patients acting out what had been forgotten or repressed, instead of remembering past events and considered it to be a way of remembering. He also considered acting out to be a measure of resistance to the therapy. 'The greater the resistance, the more extensively will acting out (repetition) replace remembering. . . .' (p. 151)

In this latter sense, it is a phenomenon felt by some to be undesirable and the term has become used outside psycho-analytic treatment as a rather pejorative term for impulsive and irrational behaviours.

However, Sandler, Dare and Holder (1973) comment that '. . .acting out as a clinical phenomenon has undergone a similar change to that which earlier occurred in the case of transference and counter-transference, both of which were originally regarded as obstacles to treatment, but which were later seen as valuable sources of information.' (p. 101) In the work, I have tried to keep in mind the concept of acting out as a preliminary communication, though one that the patient or myself may not be able to understand or put into words until we have both repeatedly experienced the action. The therapist's task is to remain engaged with thinking about the communication,

*Reading-in paper for Associate Membership of the BAP. Awarded Lady Balogh prize in 1994.

through the counter-transference, by containing and processing the affects involved.

I considered it particularly important to avoid premature interpretations, made in angry retaliation or in a desire for some potent force to counteract experiences of helplessness in both patient and therapist. An interpretation may eventually be framed around the conception produced as a result of the thinking (Bion 1967), that can be offered to the patient. The experience of being with a therapist who transforms into thoughts the patient's actions, then offering them back in a tolerable form, provides the patient with an opportunity to begin to think about the meaning of her behaviour. This process nurtures the patient's embryonic capacity for thought and containment, as opposed to action and expulsion of thought.

History

Ann was in her late twenties when she first applied for psychotherapy through the Reduced Fee Scheme. She was single, coming to the end of a professional training and hoping to begin her career. She is the eldest of three children, and has two younger brothers.

Ann's parents were recently married and in their early twenties when she was born. Breastfeeding was abandoned by mother after a few days and a rather cold untactile relationship is often conveyed. Her mother's relationship with her own mother is described in similar terms, as if women can only ever be rivals and the real warmth is reserved for the men. An early memory is of being given a life-size doll before her elder brother was born. He was successfully breastfed and Ann has been told how she tried to remain on mother's lap at the same time. She also remembers bringing in other children to watch mother feeding her new brother. There is an early sexual memory, at about three, of playing alone in the garden and having some sexual contact with a mentally handicapped adolescent who lived nearby. She thinks this involved some sexual touching of his penis and of a goat that ate the boy's cigarette. Afterwards she felt very guilty when her father called her, imagining he must know about what had happened.

The birth of the two brothers also seems to have led to a relative loss of her father, as he became immersed in his enthusiasm for sport, something he could share with the boys but not with her. Ann became mother's silent companion, while waiting for father to return from

long drinking sessions. She remembers being filled with jealous fantasies about father's affairs with other women while he was absent, while mother is described as having a rather stoical attitude at most times.

The power of the absent object is also the theme of a traumatic family incident when Ann was about ten. Her elder brother injured a child by throwing a stone, and then ran away from home for a few days to escape punishment. Great anxiety and a sustained search ensued and his safe return was greeted with relief and presents of chocolate. This confirmed for Ann that the absent one gets more attention than those present and that anger could be manipulated into relief if one went missing after an aggressive act. I shall describe how this emerged in the acting out.

Educationally, Ann had some learning difficulties at school (dyslexia), and would regularly disrupt classes in order to avoid her spelling difficulties being noticed and she also felt she was given little encouragement because she was a girl. She left school at the earliest opportunity and began an apprenticeship at a nearby town. She seems to have withdrawn from family life at this point, both physically and emotionally. She reports having begun drinking, using drugs (mainly cannabis), engaging in promiscuous sexuality and over-eating.

Ann came to London at about twenty, continuing a 'bed-sit' life while working until she became interested in reading, encouraged by a student boyfriend. This led her to begin a 'fresh-start' course and she then obtained a place at polytechnic on a degree/professional training, as a mature student. She was most surprised that she could undertake academic work, was not stupid and that the polytechnic took her dyslexia seriously.

In the final year of her degree, she began living with David, a boyfriend who had children by a previous relationship. Shortly afterwards, Ann became pregnant and decided to have a termination because if she had the baby she would not be able to complete her degree for some time. The termination took place some months before we began therapy.

The Referral and Initial Interview

Ann referred herself to the Reduced Fee Scheme, being aware of it through friends and fellow students who were also in therapy. Her quite detailed letter requesting therapy mentioned concern about being

'. . .iratinaly jelouse. . .' and anxious about the effects this could have on her relationships. She also mentioned a defensiveness in the face of any criticism and confusion about her past and her relationship with her parents. The crisis of the pregnancy and termination had led her to seek once a week counselling, but she now felt she needed more than this. There was some rather insightful acknowledgement of resistance in her admission of a wish to continue to see the problems as 'everyone else', and in the way she ends her letter, 'I hope this letter makes sense as I do not intend to redraft it for fear of it never being done.' It seemed hopeful that she wanted to communicate with someone whom she hoped would be interested in the content of her letter rather than the shortcomings of her spelling.

The assessment interview covered similar concerns, but also communicated a rather chaotic state of mind, in which past and present, internal objects and external reality can become very confused.

Ann arrived for her initial interview early and looked rather anxious. She began our interview by describing her overpowering jealousy towards the children of her boyfriend's marriage, or of any contacts he had with other women. She felt that this had something to do with her past. She described her family background but tellingly said little about her mother. Her father was described in rather disparaging terms, either absent or soppy when drunk. She became angry when she spoke of her parents' lack of expectation of her at school, because she was a girl, and how demeaned she had felt by their praise of her abilities in art.

She was tearful as she said she thought men got everything, though also acknowledged that her mother had in fact given her considerable financial support during her degree.

Three elements of the interview now seem, with hindsight, most significant. The first is a point quite early on when she suddenly checked herself after having spoken very freely about her jealousies. In response to my enquiry about what had happened at that moment, she expressed discomfort that I was a man and wondered if she would be able to speak to a man about all she had to say? In fact, at first she thought the BAP had made a mistake when a male therapist was offered. If Ann's psychopathology is seen in terms of occupying a boundary between pre-oedipal and oedipal relations, I was being offered as the available father (at that stage) which she initially accepts, but then remembers that *she* has made a mistake, that what is wanted at a pre-oedipal level is a regressive two-person relationship with mother. This wish certainly reappeared at the beginning of therapy

proper. A little while later, her anxiety about a claustrophobic merger emerged. A comment of mine about her ambivalence about beginning therapy was responded to by telling me of her fear of her parents taking her life over if they came to visit her flat. She was also afraid of a maternal closeness, of being taken over and made helpless by me, when I make the comment about ambivalence that deepened our rapport.

The second important element was the illustration of a key defence, in the light of the subsequent acting out. I was told that David and a friend of hers were also in therapy under the Reduced Fee Scheme, with women therapists. Ann had made a point of telling David I was male, imagining that this would engender his jealousy, in spite of her own doubts. Her own sense of jealousy and exclusion from their therapies had been reversed by her actions and projected, so that she gains the good object and they have the now devalued woman. Her jealousy of others was, in my view, an important motivation for her seeking therapy in the first place and this will be considered further in the next section.

The third element was my counter-transference, which involved me experiencing an affect that I came to recognise was, in part, my own reactions and in part, the patient's reaction that had been expelled into me. I felt very surprised when Ann expressed relief when I agreed to take her on as a patient. Given her previous comments, I had felt like the one likely to be rejected by her, but she had imagined I wouldn't want her as a patient! She could tell me this in words once I said I did want to work with her, but prior to this I was experiencing her anxiety on her behalf. It required some subsequent thinking and processing to understand that I had experienced a projection of her anxieties about rejection that needed to be disentangled from my own anxieties as a beginning therapist and my wish for a suitable training patient.

Acting out as a preliminary communication

The task of creating and maintaining a secure therapeutic space, in which to think about and understand Ann's life, was made immediately difficult because of the pattern of acting out behaviour. The verbal and symbolic realm could not be fully utilised immediately and highly charged mental representations had to be discharged through action rather than thought. I tried to remain as a non-retaliatory containing

object, trying to understand and put into words the various meanings I could glean from the communications through action. It seemed particularly important to process and contain my own feelings, as I felt invited to become an acting-out object as well. There seemed to be a wish for me to respond in a way that confirmed the expectations of that part of her mentioned in the initial letter, which blamed others for the state of her life. We could then fight, she could then leave and the projective defences would be maintained unaltered. At times it did seem as though words and interpretations were hardly a very significant force for a patient who believed in action and probably only noticed my actions in maintaining our boundaries. Limentani (1966) points out that '. . .analysts are apt to forget that interpretations are meagre satisfactions to our patients who long for action from them'. (p. 279)

The therapy began with a crisis, a dissertation uncompleted, from which the consequences would be no qualification or prospect of employment in Ann's chosen field. Her non-completion of the task seemed to be a condensation of a number of anxieties and wishes. First of all, as with many students, it undoubtedly involved developmental *rites de passage*, fears of the move to the adult world of professional qualification and employment, of being unprepared. The dissertation also represented the 'baby' she had chosen instead of the aborted baby. The guilt and sadness at the lost baby needed words rather than self-punishing actions and interpretations to this effect did help her engage with her work.

However, the way in which the crisis was presented to me, in our first session, also involved a phantasy of therapy as a place of regression to passivity with mother. She expected that I, or other helpers she was successful in manipulating to do some of the work on her behalf, would take over and rescue her.

Beginning therapy involved a regressive desire for fusional oneness with me as an all providing mother who would instantly meet her needs and expect nothing in return. She was often late for sessions and did in fact have a quite complicated journey by public transport. However, she also acted upon a belief that 'mother' trains would appear immediately she arrived at the station, to get her to therapy on time and it could hardly be her responsibility if she were late. A therapeutic timetable involving clear boundaries to sessions and payment were very important in helping Ann feel safe enough from her fear of the regressive desires and she became able to think a little. For example, in response to a bill, I was told about a letter once written to her by her mother, in which all the money given to Ann to support

her through her degree was mentioned. She had noticed that I was counting sessions as well, not acting as the all providing mother of her regressive fantasy.

Zetzel (1968), in her paper on 'The so-called good hysteric', describes a group of patients that she calls the potential good hysterics, in terms of analysability. She describes them typically as having failed to achieve stable ego-syntonic obsessional defences, having greater open ambivalence in their relationships and being afraid of their dependent wishes, which are near the surface. She goes on to suggest that the major problem in the analysis of this group is in the first phase of analysis, that is to establish a stable analytic situation in which an analysable transference neurosis may emerge. Patients often respond to the beginning of analysis by a flight into health or '. . .the emergence of a regressive transference neurosis before the establishment of a therapeutic alliance.' (p. 238)

This description of Zetzel's seems to encapsulate events at the beginning of Ann's therapy very well and perhaps helps in understanding one important and consistent aspect of my counter-transference during the first few months. This was of my having begun the therapy some months after Ann, of always trying to 'catch up' in some way, of only ever beginning to understand events well after they had happened.

Ann was persistently late, missed many sessions, paid bills late and in doing so I was left to feel ignored, discarded, of no value to her, anxious about her whereabouts and then overwhelmed by a stream of words when she did attend. Gradually it appeared that a reversal was taking place, an identification with the aggressor, in which I was expected to *experience* what she had experienced, rather than have it revealed to me as memories. For instance, she would not attend and not contact me, so I would become anxious about her whereabouts, just as she, we later found, had worried about where her father was, when waiting with her mother at home. Words had been used by her parents to beat her with, she could never get a word in to have a dialogue and now I was being beaten by all her words. I could wait for her to pay/feed me, just as she had had to wait for the 'powerful' parents to give to the dependent child. She was leaving sessions and going to the pub around the corner, just as her father had left her. It is now easier to understand much of this behaviour because I now have a more complete history; but in the early months of the therapy, there was very little comment on, or memory of, the emotional flavour of childhood experiences. In fact she said she could remember virtually nothing before the age of ten. Instead, all experience was contained

in the acting out and used in part as a communication, by placing me in the position of her as a child. Patrick Casement (1985) describes this process as communication through defensive behaviour, a way of telling the therapist about the patient's unbearable experience. In the Dora case, Freud (1905) is deserted by Dora as she believes she has been deserted by Herr K. There is repetition in action that is linked with that part of the patient that wishes to maintain the status quo in her psychic life.

The therapeutic task is to think and feed understanding back to that part of the patient that is thinking insightfully and desires change, glimmers of which could be seen in Ann's initial letter of application for treatment.

At this point I was not in a position to offer interpretations that linked present and past and offered insight. Instead, I attempted to offer a holding environment (Winnicott 1960), a calm secure and non-retaliatory setting in which her communications could be thought about. Some holding of the counter-transference to the acting-out in myself, that could then be thought about and eventually interpreted, then enhances the patient's sense of a secure environment.

Another aspect of the counter-transference was a maternal desire to care for someone in real distress that enabled me to feel it was appropriate to bide my time with interpretations about her attacking behaviour, until it was possible for her to hear these. Giovacchini (1987), following Winnicott, suggests that the therapeutic setting has two components, which he calls the foreground and the background. In the foreground are interpretations in the classical sense, the food of the therapy designed to foster insight. The background is the holding environment from which the patient obtains support, in a harmonious and held setting that is mainly communicated at a non-verbal level. Both are required for effective therapy but it seems to me that at this point background activity prevailed before any of the foreground could be heard and understood.

The dynamic constellation that dominated the manifest material in this early phase was exclusion, at both oedipal and pre-oedipal levels. With her partner's children, she could feel like one of the children, the oldest of three, repeating the family dynamic. She would either feel excluded and jealous while they received his attention or, if with him, would become anxious about the idea that they had now been excluded. Ann could readily feel excluded from the life of a couple, which precipitated intense levels of jealousy and florid sexual fantasies about the couple.

She once reported attending a dinner party, in which she and her partner were seated at opposite ends of the table, her partner next to a woman friend. It was as much as Ann could manage to hold inside quite overwhelming fantasies that they wanted to be together, were glad she was at the other end of the table and were perhaps having an affair? On other occasions, the fantasies were acted upon with dramatic accusations, although she always had enough insight subsequently to know that she had over-reacted.

In the transference, any growth in attachment to me would lead to her partner being 'out', in her mind, and vice-versa, especially during breaks and weekends. A stable three-person relationship appeared to be untenable, precipitating massive jealous and rivalrous fantasies. Slowly it emerged that such fantasies had preoccupied her in childhood; she had been convinced that her father had been having affairs when he said he was at the Sports Club. She could hardly believe that her mother had been so naive as to believe him. Seeing him get out of a car after having been given a lift by a woman confirmed all her suspicions.

She recounted two recurrent dreams from childhood, one in which she was looking down from a great height at father and someone else. The other was of being on an island, in which a gulf opens up, separating her from her parents and her brothers, but then they all become separated from each other eventually. The preoccupations were all connected with separation and exclusion.

However, important as the understanding of this sense of exclusion was for the long-term progress of the therapy, its main importance in the first few months of treatment was as fuel for Ann's journey into therapy in the first place. Before she had embarked on it, her partner and a number of friends had all been in therapy, and a good deal of talk about therapy and therapists had seemed to take place.

In Ann's eyes other 'children' had been getting more than her once a week counselling. She wanted more, and there was a hint of oedipal triumph in her reported boast to her partner that she had been allocated a male therapist. However, there is a difficulty with the desire to acquire what others have as a motivation for seeking therapy. What does one do with it once one has obtained it? One of our initial tasks was to help Ann beyond a triumphant 'I've got it now!', to establish a more stable working alliance based upon some shared recognition that there were real needs and difficulties that required attention.

Sandler, Dare and Holder (1979) regard the treatment alliance proper as a function of a relatively stable part of the individual and

'. . .based on the patient's conscious or unconscious wish to co-operate, and his readiness to accept the therapist's aid in overcoming internal difficulties. This is not the same as attending treatment simply on the basis of getting pleasure or some other form of gratification. In the treatment alliance there is an *acceptance* of the need to deal with internal problems, and to do analytic work in the face of internal or (particularly with children) external (eg. family) resistance.' (p. 30)

Through all the missed sessions, an important family dynamic emerged. Absence was felt by Ann to have greater impact in the minds of those left behind than presence. Ann had spent a good deal of time with her mother waiting for her father's return and the incident when her brother ran away from home also conveyed an impression upon her that attention is directed to the absent one.

In the transference, it was as though she felt missing a session would have greater impact on my mind than her attendance and thoughts. It revealed a lack of a sense of worth in her presence, as someone who was of value. She was unable to complete application forms for permanent jobs and was full of doubt about her judgement in her temporary post.

She was testing our boundaries to find out how much I was interested in her presence rather than her absence.

This was brought home to me, when on one occasion I made an error in the face of another destructive, testing attack on me as a consistent, non-retaliatory object. Ann phoned at the very beginning of her session time, to say that she would not have time to travel from where she presently was, to get to therapy with much time remaining. I accepted this as a cancellation and, practically speaking, she was probably right that the journey would not have been possible in 50 minutes. Normally, I simply say that I will be available until the end of the session time.

In the next session, she immediately brought material about people at work who had abandoned her carefully prepared 'care plans'. I said that she felt I had let her down by too readily agreeing to abandon our 'care plan' for the previous session. I had, in her eyes, allied myself with her destructiveness in a way that disappointed her, as she needed me to stand for presence, not absence. Dreams are quite sparse, but she brought one to the following session, in which she was driving a car with her partner next to her, and someone in the back tried to stab her. Her immediate associations were to the abortion which allowed us access to speak about her ambivalence and destructiveness towards the therapy, without so much persecutory anxiety. Her

response was to become quieter and she spoke of a growing intimacy with her father, which I commented on in terms of how much she also wanted a close and understanding relationship with me. Containment and interpretation brought confirmation through Ann's thinking as, in the next session, the dream was again mentioned and now she remembered that it was a woman who had attacked her. I commented on how she seemed to stab the opportunities for intimacy with me in the back, trying to keep away from a closer involvement that she both desires and fears. She responded by telling me of an incident in which her mother had broken up some non-sexualised intimacy with her father.

The overwhelming anxieties about the couple being together could be avoided by absence and separation, reducing conflict with the internal mother who spoilt and disrupted the opportunities for intimacy in the therapy.

I have described this sequence in some detail because it represents a movement in the therapy away from offering a holding background, towards a foreground in which verbal interpretations made some impact, where there could be thinking and understanding and some presence and inter-relatedness could emerge. I could now speak about and Ann could hear and think about the destructive part of herself that wanted to abort our care plan, that attacked another part of her that did want to be psychologically held and understood. We began to leave the dominance in the therapy of absence and disconnection. Limentani (1966) considers that, from a technical point of view '. . .it would seem that there is every indication for tolerating acting out in the course of analysis and for allowing its gradual decrease'. (p. 281)

Missed sessions, numerous as they still were, were now more connected with what I too had experienced, in a deepening transference relationship. In terms of my initial counter-transference, of trying to catch up, at least I now had her in sight sometimes! There was a sado-masochistic element to the transference, as she tried to regulate and control the deepening relation to me as a maternal object. She continued to come late for sessions, to miss sessions and sometimes did not telephone, leaving me in a state of uncertainty and annoyance. I understood this as a continued reversal of what she felt it like to be in therapy. I was felt to be the sadistic figure, who controls when we meet and then discards her. By not turning up, she became the one in control of when and if therapy would take place and I could be the sufferer.

At times I did feel quite helpless, unable to comment on her

destructiveness, yet increasingly convinced that what was now required were some clear interpretations about her behaviour. Repeatedly, my interpretation was essentially 'You are doing to me what you feel I do to you between sessions and at weekends'. She was able to contain and think about her guilt more easily, now that she had some view of me as a relatively benign, non-retaliatory object who was interested in her presence. As a result, when we came towards a holiday break she was taking before my holiday, arranged during the time when sadistic retaliations dominated, it was approached with a more depressive anxiety.

She became for the first time concerned about the effects of her absences on herself and the therapy. She recognised that she had a real need to attend and there was a wish to preserve some life in the therapy over the break. This was symbolised by her buying plants from a shop near my consulting room, to take to her garden and then arrange to have them watered during her absence.

Acting Out as a Signifier of New Material

A sequence of clinical material from early in the second year of therapy illustrates a new way in which acting out began typically to be used, that is, as a preliminary communication to me of new material.

The following sequence became a familiar one:

Acting out
↓
Containment through a transference interpretation
↓
Remembering and early links

Below is an illustration of one of the earlier instances of this sequence.

In a Monday session, she was faced with the realisation that I saw other patients. For the next two sessions, the remainder of that week she was ill with a 'viral' illness, as if the whole week had been infected. A dream was brought to the next Monday session, in which she had to eat a lump of meat, that was cooked on top but raw underneath. Her thoughts before telling me that dream had been about people being with others, especially at weekends. Her associations afterwards were about how much she wanted to sort herself out, but became so irritated when proper boundary arrangements were made for her. I said she was feeling raw inside about our boundaries, weekends

especially, and who I was with when she was excluded. She took this to mean other patients (the 'virus' that could now be spoken about) and felt her rawness was more caused by knowledge about the one before than the one she supposed came after her. I wondered if this referred to father, always wanted by mother more than her, or her experience of the birth of her brothers, when in mother's eyes their needs came before hers. Similarly, she imagined that I must still be preoccupied with the one who comes first.

In the next session, more of the dream was remembered following a further interpretation about her raw feelings about me and others. In the dream there had been a woman, someone she knew from college, whom she had heard some months previously was pregnant.

In the dream the woman was beautifully dressed, fully pregnant and radiant, madonna-like. Ann's partner was also in the dream, eating some fully cooked meat while she was peeling back layers of her meat, revealing it to be more and more raw. All her associations were to do with others having something she didn't have, including me and psychotherapy training (she is fully aware I was a trainee and was quite informed about psychotherapy training). She had heard, after having the dream, that the woman was about to give birth and David was coming to the end of his psychotherapy (cooked meat!)

Her dream shows that unconsciously she had been observing the growth of the baby in the woman, and the growth of a capacity to understand her in me, who appears in her eyes as radiant, full of beauty and having everything that she is excluded from. There is not only rivalry with the sibling but envy of those who appear complete. The 'virus' is her envy of and exclusion from the process of fully becoming a woman through having a child, that she is overwhelmed by when as a little girl she observed her mother's pregnancy and the birth of her brother. Envy of mother's creativity now became a theme of major importance to the therapy and had emerged out of the acting out.

However, it was the emergence of such material that could also lead to fresh impetus for acting out behaviour, this time connected with resistance to the uncovering work of the therapy. Ann was openly becoming concerned about herself and would complain about this. In her sexual life, she was taking back the projection that it was her partner who had been troubled. Instead of an attitude towards her sexuality that had appeared happy-go-lucky, unthinking and somewhat promiscuous, there were emerging great anxieties about control, penetration and a knife-like penis that would mess up her insides. The

abortion seemed to be a concrete enactment of a long-standing internal phantasy.

Ann's sense of herself as a woman was damaged and she imagined that she could never become pregnant. The earlier pregnancy had brought some relief but she now toyed with the idea of pregnancy as 'cure' for the damage because this avoided the emotional pain of therapy. The holiday mentioned earlier had been promised before therapy began as 'cure' for the termination. Greenacre's (1950) view of acting out being related to a largely unconscious belief in the magic of action seems most appropriate here.

It is a belief in the omnipotence of action in the face of emotional and literal impotence (or a fantasy of impotence).

Ann, with increasing insight, would describe how she would provoke fights with her partner in order to force him to reject her. These typically occurred at weekends and I repeatedly interpreted in terms of transference leakage, a deflection and splitting of the transference onto her partner (Greenson 1967, Klein 1952), in order to enact and gain mastery over the helpless feelings associated with the weekend break and my rejection of her.

Limentani (1966) considers that the omnipotence of action, in the face of helplessness on the part of the patient, may be paralleled by a similar phenomena in the therapist, in the need for 'therapeutic omnipotence' (p. 280).

I certainly often felt that I 'should' be offering 'the' interpretation that would halt all the missed sessions and lateness. However, most of all I was experiencing the helplessness and impotence that was being reversed and communicated through the acting-out. There were times when the chaotic atmosphere prevented me from thinking, as if my mind became part of a split-up state and I omitted to make fairly obvious links with the past and the transference, in interpretations. I regard this as what Racker (1968) describes as counter-resistance, in which my state mirrored Ann's resistance to think about and link her experience together, which I could unconsciously collude with for a time. The chaos generated by activity is chosen instead of thinking and linking, to deal with the anxiety and confusion about herself that was becoming increasingly clear.

I've been thinking...

These words began to appear (and be greeted by me with much inner relief) after a year or so in therapy, heralded by the Summer break

mentioned earlier. The therapeutic setting was offering an alternative to action and activity as a solution to psychic distress, and Ann was developing her capacity to hold and tolerate her affects. Externally, there was a change of workplace, preceded by a successful application and interview for a permanent job, that enabled Ann to have a considerably easier journey to her therapy. The holding environment had been tested sufficiently by her aggressive attacks on the structure, the setting and my capacity to think, for her to apply to join her therapy on a more permanent basis. She noted that her new workplace was quite different from the old one. That had been an atmosphere of open plan chaos, where nothing could be expected of her, where there were so many distractions. Now she was in a studious and contained atmosphere, which she tried to enviously denigrate as 'boring', but also acknowledged that it raised her anxieties about the expectations involved in a more serious commitment. She remembered that, as a child, she had often been disruptive in class in order to avoid writing and exposing her dyslexia. This also represents the split in her attitude to the therapy, a part of her wanting to be in a studious and thoughtful atmosphere where she would try to take responsibility for herself, as opposed to another part that sought action and projection.

Greater confidence in the containment offered by the therapy and a growing capacity to bear the guilt about her aggression, led to a reduced use of splitting and projection in order to maintain psychic equilibrium. She could more easily acknowledge her own violence and aggression, rather than have to place it all in a partner provoked by her. There was also a reduced splitting of the object, particularly between her partner and myself and he became less often attacked for lack of attention at weekends, while she faced loneliness and depression far more fully than she had ever done in her adult life.

A clearer picture of Ann's internal world appeared, particularly as it manifested itself in the maternal and paternal transferences, now that they could develop more deeply in our less chaotic atmosphere. The relation to her mother emerged as the most complicated and disturbed.

Mother was experienced by Ann as an 'arms-length' figure, unable or unwilling to give her the tactile love she craved. Both I and her partner began to be complained of in similar terms, as if physical cuddling was the only real comfort for her.

An important family dynamic emerged, in which Ann's relation with her mother mirrored her mother's relation with her own mother. There could not be close ties between the women, which led to thoughts

about homosexual desires and anxieties and became a major theme in later material. Instead, women's roles were to wait for the men, as Ann waited passively with mother for father, who provided babies and some positive sense of being a woman. By contrast, the men and boys seemed to be able to emerge from the cold maternal bind, because they had full access to the external world, that contained excitement and close comradeship. There is envy of what she perceives as men's close relationships with each other, that she is excluded from, as she was by her father and brothers over sport and in relation to her partner's male friends. To be excluded from such relationships became more tolerable when she acknowledged that she wanted a similar closeness to a woman. The men have been able to separate, while she was offered identification with someone waiting for a man. It is not an identification with a woman who feels whole and complete in her own right. Wholeness is given through pregnancy and babies, so there is a powerful positive identification with the pregnant maternal figure. However, as the material about the woman in the raw meat dream indicated, mother is also a deeply envied figure for her capacity to produce babies (especially male babies that would please father). The deep desire for babies that became clear allowed us to more fully work through the pain of the abortion, whose second anniversary we were now approaching.

The oedipal struggle for the girl involves resolving the little girl's hatred and envy of mother for having father and the penis, with her desire to be like mother, to have babies as well. In Freud's view (1924), the little girl turns away from mother because of her grievance about the lack of a penis, after she becomes aware of sexual difference, and turns towards father in rivalrous relation to mother. However, Klein (1928), in her paper on the early stages of the oedipus complex, points to an earlier and more important grievance with mother. The little girl is envious of mother's bountifulness, she has the breast and can make babies.

The child does turn to father because mother has disappointed her, is envied and is a rival for father. But again, he does not give her what she wants, the penis and above all babies. So, the original basis of the disappointment has been suffered at the hands of the mother. In rivalry with mother, the little girl has only her unsatisfied desire for motherhood to sustain her, an uncertain state, while the little boy does actually have a penis. In a later paper, Klein (1956) describes the effects of envy on the development of internal objects.

When envy is excessive, the infant cannot sufficiently build up a good

object, and therefore cannot preserve it internally. Hence, somewhat later he is unable to establish firmly other good objects in his internal world. (p. 215)

The material now recalled in Ann's therapy, about events around the time of the birth and infancy of her brother when she was two, point to a struggle to establish a good maternal object against great enviousness of her mother. Ann wanted to be mother to her baby brother; she once attempted to change him with very messy results. Other children were brought into the home to view mother and the new baby breastfeeding, though she also found out that her own breastfeeding had ceased after a few days. She had tried to remain on her mother's lap while her brother was breastfed, as if trying to cling closely to mother as a good object.

A life-size doll had been bought for Ann at the late stages of her mother's pregnancy, presumably in an attempt to help her with all the changes to take place in the family. It appears to me that there is some defensive idealisation of mother and baby (not a genuine maternal identification) that hides the painful reality that Ann was a little girl, not able to have babies like mother, nor was she still mother's only baby, able to have mother and father to herself. Another doll was recalled, a 'Tiny Tears' doll, who had her eyes poked out. In condensation, it represents a desire to harm the new baby and a desire to damage the eyes through which she now had to see a mother and baby together, each having all that she wants. In terms of movement in the therapy, it also represents a desire from the active, destructive her to damage a new 'seeing' Ann, emerging from the therapy.

Envy began to emerge a little in the transference, with me being disparagingly described as a 'calm' therapist in the face of her anger, while she clearly felt anything but calm, as if I too were some madonna-like figure. The struggle to escape the bind to the envied internal mother appeared very vividly in a dream, in which it was Ann's wedding day and mother had brought the dress. However, it was a child's dress that she was forced to put on. My interpretation focussed on her fear of mother's revenge for her envious desire to be an adult woman, that mother would keep her as a child. Similarly in the transference, I forced her into the 'child' patient clothes in retaliation for any envious thoughts about me. Ann recalled how, in childhood, her mother undertook a good deal of dressmaking for her and remembered great anxiety when standing to have clothes altered. Was there a fear that mother was trying to destroy her beauty, though consciously there was a desire to enhance the 'pretty' girl she was always described

as? In other words, Ann's relation to her mother, containing both love and envious attack was projected onto mother and she then anxiously awaits the retaliatory response. The 'arms length' nature of their relationship may well have been Ann's only way of dealing with what was felt to be a mutually envious hostility.

I now turn to the relation to the father who, in the classical oedipal constellation, is available to become the new love object in place of mother and who helps confirm for the little girl her sense of feminine identity, by satisfying her passive wish to be wanted and loved (Freud 1931). However, father was the desirable but unavailable object, whose attentions she could not attract because she was not a man, nor a woman who could give him babies. It seems as though Ann tried to attract her father's attention through her artistic productions (sublimated babies), and devoting much attention to her clothes and appearance. On leaving home at seventeen, her efforts towards maintaining her appearance collapsed for a while, into overeating and a lack of self-care, as she entered a depressed state, defeated in her attempts to gain father's attention. A sad picture emerged of a young girl going to the Sports Club to look for and be with her father, barely able to understand that this was not the place where she could really belong. Earlier in the therapy, she had re-experienced similar feelings (hidden behind the triumph of *being* father) in her use of the pub near my consulting room, where she would sit apart, the only woman amongst the men talking to each other. The two boys could go with father, could share his love of sport, but she was excluded.

In her current life, she perceives her partner as much more interested in his male friends than in her. The weekends became particular wounds to this sense of being excluded from the male world. It was at weekends when her father's absence was most noticeable. Our Friday sessions are full of material about the impending weekend, how she will be left on Friday night, she imagines I am itching to be rid of her and off. She once saw me in my car, shortly after a session and concluded that I must be rushing off to watch Arsenal play football. Much worse was the sense of exclusion when she realised that she didn't know where I was going or who I was with. This more accurately parallels her childhood experience of waiting for her father, full of fantasies and dreams of him being with someone else, as described earlier.

Her raw anger at her father began to emerge; she had wanted to tear him to pieces and found herself close to physically hitting him on one occasion when they were about to part, as if her anger at separation

overwhelms all sadness and sorrow. Her violence often gets displaced into the relationship with her partner. We appear to be getting closer to Ann being able to express her angry and violent feelings towards me, about the way I exclude her, without her having to act them out, by reversing the process and excluding me. An envious relation to mother is therefore overlaid by a jealous relation to father, who wants to be with someone else, be it male or female. As described earlier, I also consider that Ann has carried, by projective identification, some of the anger and jealousy that her mother felt about father's absences. Ann dealt with my imagined trip to Arsenal in exactly the same way as her mother had dealt with father's absence – at least we know where he is! The depth of jealous fantasy about the absent man is not only a function of her personal oedipal issues, but exacerbated by a projective identification with her mother.

Discussion

This paper describes the process involved in establishing a containing structure with this patient. The containment involves two elements, firstly the boundaries of the therapeutic relationship itself, that help the patient experience the sense of being held by a reliable and consistent other. Secondly, containment is offered to an acting-out patient, through the therapist's efforts to understand rather than react to the counter-transference, and then to offer that understanding to the patient at an appropriate point. The interpretation speaks to the patient's capacity to think and so, as well as an internalisation of the therapist, innate capacities in the patient are mobilised.

Out of the containment, the elements of Ann's psychic structure that have slowly emerged involve the transition from two-person to three-person relationships. This is difficult when there is an insecure internal maternal object, damaged by excessive envy. A relatively absent father, unable to provide an alternative love-object has compounded the difficulties. Throughout the material there runs a theme, the desire to move from a passive to an active stance, in order to gain mastery over unbearable feelings. As an example, I want to consider in more detail the meanings behind the provision of a doll before her brother was born. The doll is of course provided to encourage mastery through play as the little girl identifies with and imagines herself to be a mother. But activity and action are being used as a defence against thinking, in this case about accepting the loss of her exclusive

place with mother and the narcissistic wound that she is in fact the 'little' girl. It marks the beginnings of a defence that becomes very common in Ann's life and in the progress of the therapy.

The belief in omnipotence of action, rather than the value of words or the capacity to work at a more symbolic level may relate to a point in child development where Ann's ego became overwhelmed and she had no other alternative way to manage unbearable affects. Stern (1985) describes how a child moves from what he calls an episodic memory, a pre-verbal world of lived experiences, towards a semantic memory, where verbal representations become more important. In acting out, it appears to me that the episodic memory predominates, events have to be experienced, or reversed and experienced by others rather than be thought about and put into words.

For Ann, the doll did recognise some need in her, but is also a misattunement, a regressive response with action and a substitute experience, rather than the acknowledgement of her feelings with words and understanding.

The offer of a doll on its own may confuse and shut off the world of verbal representations before they have fully formed, at a time when she needed to be helped towards a state where words could function in place of action. The first year of the therapy has involved precisely this activity, the negotiation of a move away from action towards a greater recognition and appreciation of words and thinking. I wonder now if my initial counter-transference, of something happening that I could not quite understand or catch up with, did contain an important communication about what Ann felt in being presented with a doll, and a new baby, confused and unable to find for herself or be helped to find verbal representations of these events. At the same time, the doll was an invitation to move on to a symbolic and sublimated solution to her desire for a baby, not something she was ready or able to manage at that time. Her dyslexia may then be a protest against a later situation where she is expected to function at a symbolic level using a shared written language, while she wishes to maintain the personal and idiosyncratic meaning of *her* language.

Dore (1985) quoted in Stern (1985) considers that a mother has to re-orientate her child at a critical point, from a personal order with her, towards a social order. Previous interactions have all been about 'being together', now mother begins to require the child to organise his/her actions for practical and social purposes, and the personal order of infancy is lost. It appears that for Ann, this was a very abrupt loss and father was not fully available to bring her into the social

order and the oedipal world. The therapy aims to assist in the re-finding of a mother and father available to her, that orientate her towards the use of words and thinking to deal with psychic pain, as opposed to action. After nearly two years of struggle, Ann has reached a point where she has developed sufficient understanding to begin to contain her urge to act-out and can use the therapeutic relationship as an opportunity to experience and think about her internal world.

References

Bion W. (1967) *Second Thoughts*. London: Maresfield

Casement P. (1985) *On Learning from the Patient*. London: Tavistock

Freud S. (1905) 'Fragment of an analysis of a case of hysteria.' *SE*VII 1–122. London: Hogarth Press

—— (1914) 'Remembering, repeating and working through.' *SE*XII 147–156. London: Hogarth Press

—— (1924) 'The dissolution of the oedipus complex.' *SE*XIX 171–9. London: Hogarth Press

—— (1931) 'Female sexuality.' *SE*XXI 221–43. London: Hogarth Press

Giovacchini P. (1987) *A Narrative Textbook of Psychoanalysis*. New Jersey: Jason Aronson

Greenacre P. (1950) 'General problems of acting out.' Psychoanal. Quart. 19. 455–67

Greenson R. (1967) *The Technique and Practice of Psychoanalysis*. London: Hogarth Press

Klein M. (1928) 'Early stages of the oedipus conflict.' in *Vol. 1. The Writings of Melanie Klein*. London: Hogarth Press

—— (1952) 'The origins of the transference.' in *Vol. 3. The Writings of Melanie Klein*. London: Hogarth Press

—— (1956) 'A study of envy and gratitude' in *The Selected Melanie Klein*. Ed. J. Mitchell. London: Penguin

Limentani A. (1966) 'A re-evaluation of acting out in relation to working through'. *Int. J. Psycho-Anal.* 47. 274–282

Racker H. (1968) *Transference and Countertransference*. London: Maresfield

Sandler J., Dare C. and Holder A. (1979) *The Patient and the Analyst*. London: Maresfield

Stern D. (1985) *The Interpersonal World of the Infant*. New York: Basic Books

Winnicott D. (1960) 'The theory of the parent-infant relationship' in *The Maturational Process and the Facilitating Environment*. London: Hogarth Press

Zetzel E. (1968) 'The so-called good hysteric' in *The Capacity for Emotional Growth*. London: Maresfield

OF COURSE I SHAN'T GO

BRITTA LLOYD

Introduction: *'A heap of broken images'* Eliot, T.S. *The Wasteland*

The story of K. has, in a sense, no beginning and therefore there is no middle, although there is always an end. I could describe him as being like a seed which has not been planted. The story that unfolds is mostly mine, a story of hard-won flashes of progress and hope, evolving slowly into a sad recognition of how limited my influence was. The awakening was mine rather than his.

Beginning: *'only there is shadow under this red rock'*

K. arrived on time for our first meeting. He was slight, very casually but neatly dressed, young, fair. Although he spoke only in response to my questions or prompts, the session seemed quite full. There was a mildness about him which matched his boyish looks. I warmed to him. However, the literary turn of phrase which I had noted on his form: 'I shunned the company of Family and Friends', 'I was consumed with unhappiness', had a robotic quality when spoken: 'My childhood was a deprived childhood'. I began to feel that he was repeating phrases he had heard, probably in the Mental Health Centre where he had some group therapy. The words seemed to come from the outside rather than from the inside. I recalled the hesitation in the voice of the assessor when she told me about K. She spoke of a schizophrenic mother who had committed suicide when K. was eight years old, and of an alcoholic father who beat him and his older sister. She gave information about many job changes, short term relationships and the current use of antidepressants. She had been cautious about his potential as a psychotherapy patient. But something vulnerable and not yet formed in him touched me, and we agreed to begin working together.

Early work: *'I was neither living nor dead and I knew nothing'*

The sessions appeared to be a struggle for K. He spoke only in response to questions or comments from me. With difficulty I began

to gather fragments of information about his childhood. He seemed to have had no experience of mirroring, acceptance, response. Instead K. described a confused woman who asked for a light as she held an apple, and who put her head into a lit oven in front of her children, burning off her hair. She was taken regularly to a mental hospital. K. remembered his mother sitting in a chair much of the time. She used to ask for assurance of his love, he told me, but he saw no reason to love her. A picture emerged of a neglectful father who haphazardly beat K. for infringement of unclear rules, and again when K. cried. Food was sporadically provided, clothing ignored. K. described himself as dressed in rags and often bullied at school.

What dialogue there was, I initiated. It felt as though I was rescuing him from a paralysing blankness. He spent much of his sessions with his head leaning back and his eyes closed. In between these withdrawals, he would study and pick at his nails, tap his foot or stare fixedly out of the window. When he strode out of our first interview, I was struck by his seeming older than his 28 years. Within a few sessions, I thought of him as a *puer*, unsure and underdeveloped. My perception of his age dropped session by session. Soon I found myself watching his shut-eyed face and feeling protective. He had become a baby.

K. seemed incapable of symbolic thought or even imagination. Asked to describe his sister, he eventually came out with, 'She was a schoolgirl'. Similarly, about his grandmother, who had the children each weekend and gave them their only proper meals, he said, 'We didn't have much in common.' There was no substance to people in his life, and no curiosity about anyone, including me. I struggled through the sessions, working hard to try to find some way to reach him, to encourage some spontaneity, or even to find out something about him. Coming up against the wall of his concrete responses, I asked questions, I told him what he might be feeling, I led, I encouraged, I spoon fed him.

K's gross early deprivation had left him with dominant schizoid characteristics. I knew he would resist dependence on a relationship which would mean both his and my access to the vulnerable, infantile part of his personality. I understood him as preferring an inner silence and emptiness to the torments of hatred or the risks of caring. Frances Tustin (1986) describes the autistic encapsulation which develops to encase and immobilise the damaged part of the personality concerned with understanding. She writes about over-concretised thinking, the restriction of reflective thought, and a sensation-dominated world

under the patient's control. Psychic function is frozen. Efforts to keep going and maintain an appearance of normality are very hard work. She refers to minimal contact with people, and a lack of motivation to communicate. All of this applied very closely to my patient. However, the concepts of 'encapsulated' and 'immobilised' held out hope to me. In due course I felt I would be able to reach the protected and frail part of K. I would serve as an auxiliary ego, and be the caretaker of his links and his reflectiveness until he could bridge the frightening chasm between ego and affect. I had as an ally, Jung's concept of the archetypal will to heal and develop, and I felt that even if my spoken thoughts could not be heard, our unconscious interrelating would have an eventual effect.

I saw my primary role as being a container for K, steadily, empathically, thoughtfully available, in Winnicott's mothering sense. I imagined that K's trauma had begun in his first hours of life, or pre-natally, so that he had been deprived of the symbiotic stage of infancy where basic trust and a core sense of self is developed. The unspoken aspects of the therapeutic relationship, familiarity, voice, atmosphere, would be of particular importance to him. At the same time I felt it important to help him to know about things. In a very fundamental way, K. did not 'know', either emotionally or practically.

Linking and unlinking: *'This music crept by me upon the waters'*

He was passive and gentle, seemingly waiting for me to 'do it'. I felt no transference aggression. Whatever I said, he would reply compliantly, 'I guess so', or 'You're probably right', without feeling. My words seemed neutralised by him, emotional impact gone. Any sense of what he might be feeling came from my counter-transference and my imagination. I could think about his messages, spoken and unspoken, and try to understand them, but I was unable to return them to him for use. I felt he was not taking much in, but came to the sessions because those were the rules. It was when I spoke of his childhood that he listened intently, as if I were telling him an important story. He was receptive to my creating a history for him, so I discussed, filled out possibilities, and speculated out loud. Even though the facts I had to go on were very limited, this ongoing monologue seemed the only way through to him. Apart from these stories, with their fleeting moments of seeming contact with K., the sessions felt lifeless and aimless.

K. told me the one dream he remembered of two planes, each filled with half the world's population, on a collision course. K. was watching. I thought of the rigid encapsulation of autistic children where feelings seem frozen, and of the dread of falling forever if the capsule is cracked. As part of his depersonalised state, there was a pervasive lack of concern for others. The dream showed his alienation from himself and from the whole world. He was truly alone.

Linked with the schizoid defence of splitting off mental images (the doomed plane) from feelings (there were people inside) was an underdeveloped super-ego function. K. did respond to some interpretations from me. For instance, he did sometimes telephone when he missed a session, after I addressed the one-sided keeping-in-mind that his silence entailed. He stopped wearing his Walkman into the room after I interpreted his keeping me away until the last moment. When my words resulted in silence, he might say, 'It's rude, isn't it, not to answer a question, isn't it?' However, the occasional amending of his behaviour was based not on a sense of how it might feel for me, but on a kind of collective consciousness, whereby he did not want to do things wrong. His response was based on shame rather than guilt which would have required a sense of relatedness to me. The wish to do it right also took a poignant practical form, based on another aspect of his 'not knowing'. He asked my advice about what to wear to his college interview: he was not sure whether shorts were appropriate. When he eventually decided to answer a wedding invitation, he asked me where to buy an RSVP card, a gap in his knowledge symbolic of his inability to communicate. These kinds of questions I answered in a straightforward way before addressing their emotional surroundings. Sometimes I talked about practical things, such as options in his college, as a parent might to a child. Having never been spoken to that way, there was much for K. to learn. I recognise that it gave us both a break from the arduous work of analysis.

I felt that anything I said was evacuated, along with any possible meaning. He told me that he never thought of me between sessions. It seemed as if I only existed for him when we were together. He explained that although he sometimes had a thought during the sessions, he didn't bother to tell me. He gave up his anti-depressants in the same off-hand way: he had forgotten to take them for a while, and so stopped. He did not discuss this with me. Nevertheless, I felt unrecognised rather than devalued.

One day K. arrived an hour early, just as I was approaching the front door myself. I told him how early he was, but that I would see

him. He sat in silence. I wondered about his feelings. K. said he didn't like being wrong, and admitted 'fleeting discomfort'. I linked his dislike of making mistakes with the violence he had experienced after 'mistakes' in his youth from his father. After a silence I suggested that my lack of anger had enabled him to put the whole thing aside, after the fleeting discomfort. K. said, 'Your reaction was not untoward. It was just a mistake.' I pointed out that something unusual had happened between us; could he let his mind wander around it? After a silence, I gave him some openings: I had come up behind him; had I startled him? Where had I come from? How would he have felt if I had asked him to return an hour later? He answered, 'I would have had a bite to eat.' I talked about these thoughts giving meaning to what had happened, and spoke of 'colouring in'. He fidgeted, yawned, examined his nails and said, 'One can make mountains out of molehills. It was just an episode. We've exhausted it, really.' K. succeeded in avoiding attaching any thought or emotion to the incident.

The fundamental schizoid defence is splitting, inner from outer, feeling from mind. Betty Joseph (1989) writes about the pull towards life and sanity being split off and projected into the analyst, with the schizoid patient constantly pulling back towards a silent kind of paralysis and near-complete passivity. The life instinct is being split off. The concept of splitting informed my thinking at this stage. Later I felt that the loving, ambivalence and guilt which Joseph describes as being evaded had never been able to develop in K. At the time I kept in mind his undiscovered potential, and Jung's emphasis on transformation. I maintained hope through his very regular attendance.

The sessions continued to be laborious and lifeless. K. gave me the barest minimum: I commented on a loud yawn; he said 'I didn't get much sleep last night,' leaving me tantalised and uninformed. Any effort to think about his relationships with colleagues or acquaintances faded into pat responses. His literary phraseology began to include my phraseology, but used in an imitative rather than thoughtful way. He often arrived late. My relief at seeing less of him was syntonic with his unconscious wish for unrelatedness. I then felt anxious about his commitment to the therapy, an echo of the anxiety his mother's erratic behaviour would have caused him. The lateness usually had a concrete reason, tube delays or oversleeping. Interpretation of oversleeping lead to acquiescence or silence. I would laboriously nudge an idea into place, only to have K. say, 'Perhaps,' and shut his eyes. When he wasn't leaning back with his eyes shut, he was restless, eyes averted

through the sessions. He never broke the silence, bleak and empty rather than painful. I felt he was recreating the isolation in which his mother must have left him. It was not a form of acting out, but rather an expression of his passivity and alienation. It felt as though he cut off entirely, and that I had to give him verbal lifelines which he used but could not recognise. It seemed that without my constant efforts the therapy would simply peter into nothingness. I interpreted along the lines of the classic schizoid dilemma of the simultaneous need and fear of relationships (Guntrip, 1992). I addressed aspects of himself which did want to understand, which led him to make great efforts to come to therapy: for instance, the time he had pushed his bike for half an hour to his session after getting a flat tyre. This aspect, I said, was easily overwhelmed by another part of him which felt hopeless and remote and could not imagine having a relationship with me which could matter or change things. K. leaned back, said, 'You're probably right,' and shut his eyes. He was lacking in the most ordinary insight or self-reflection, and could not in any way elaborate his internal, or even his external, experiences. He was emotionally inarticulate. My protective feelings faded. Instead I felt both frustrated and guilty at not being able to reach him, sadistic as I let the silences lengthen to fifteen minutes, repentant when he took no revenge.

Change: *'If there were water we should stop and drink'*

It became clear that K. could not make use of my words, but I felt that my voice and my steadiness might have value for him. Zinkin (1991) points out that with pre-verbal trauma it is not so much what is said but how things are said that makes the difference. I began to speak more casually and freely, not interpreting much, but expressing my interest in his few activities and his reading. When the silence became heavy I would sometimes, after an initial question from him, talk about items I had in the room, their history, their meaning. I used them to illustrate a point. I used them to introduce symbols in a tangible way, such as the beautifully mended drawing on the wall, the tear all but invisible. I saw this as creating a history between us, in the same way that I had talked to him about his possible childhood history. Meltzer (1986) writes about the therapist's need to perform the alpha function, of which the patient is incapable, in order to introduce meaning and facilitate the move into symbol formation. Helping K. along in the silences with the objects surrounding him

seemed a way to encourage symbolic thought. K. sat more quietly and occasionally volunteered some information. I felt more comfortable, although it was difficult to tell whether he did. Sometimes I would feel that some contact had been made, that some links were tenuously being forged, but K. would undo any fragile bonds with a comment such as, 'We don't have a relationship, do we?' or, 'At the end of the day it doesn't mean a lot to you whether I'm pleased to see my sister.' At the time it felt as if the budding dyad was too much for him and had to be destroyed. Had K. felt helped or understood, this response would equate with the narcissistic defence of enviously destroying anything which felt helpful or good. However, I did not feel that degree of emotional movement from K. I fluctuated between feeling hopeful and irrelevant. Months later, when I referred again to items in the room, K. looked slowly around and said, 'There's nothing here of any interest to me, really.' Looking back, I think that the sense of contact and linking were taking place within me, and never reached K.

K's hoped-for solution to his problems was to gain an education. He applied to a foundation course and told me he wanted to end the therapy. I talked to him about the door to his painful inner world being opened a crack by the therapy, and the ease with which he could shut it, and of the frightened bruised child he wished not to know. He asked for time to think about it, and came back session after session, not having made a decision. Finally, he decided to continue. He explained his decision by saying he didn't want to think about it any more. Despite the let-down of this explanation, I felt it important that he had made a positive decision to continue. The therapy took on a different tone for me. I felt freer, no longer so attacked by K's undoing statements. I no longer felt punitive during the silences, and after interpreting how often he shut me out, K. kept his eyes open for more of the time. A strong resentment of his father began to be expressed, although it was by chance that I would find out that he had seen him. However, the silences continued heavy and empty. I feared that my probing might feel intrusive, but felt I had little choice. The concreteness continued unabated. When returning to one of the few subjects that we could talk about, he would say, 'We've talked about that already. It's been concluded.' During one session I laboured to reach some meaning in his wish for later session times. K, knowing the change was possible, impatiently cut me off with, 'What's the problem?' I interpreted that I might feel authoritarian and laborious, rather than like an ally. He answered, 'I haven't really reached a conclusion as to definitions.' Yawn. 'It's no big deal.' Sometimes his paucity would be

transferred to me and I would escape into my own thoughts during the silences, feeling let off the hook if his eyes were shut. Sometimes I found my voice over-lively, as if trying to get some energy through to him, but then I worried that I was driving him away, being out of step with him. Although at the time I felt more commitment from K. and more ease between us, I now think that I seduced myself, not him, with my eloquent case for his continuing in therapy. I wove a web of words which camouflaged his inability to consider his choices, and in the end he took the course of no-change. Thinking back, it was not so much him, but my own adjustments which had felt like change.

Withdrawal: *'There is not even solitude in the mountains'*

What did change for K. was a wave of depression which pulled him down during my summer holiday. He had restarted anti-depressants during the summer and all the denied anxiety about his access course emerged in body symptoms. He slept badly, couldn't concentrate, and felt exhausted. He insisted that it all had to do with anti-depressants: he never should have stopped taking them. He told me he felt better immediately after my return, but rejected any possibility of my having influenced either his low or his improved state. Strangely enough, the tone of the sessions did not alter, despite his problems. Months later he arrived at a session having spent the previous 24 hours drinking. I was struck again by how that seemed to make no difference to the session. Both tiredness and the after-effects of alcohol seemed to tally with his depersonalised state.

K's college course began and immediately created difficulties for him. The battle between turning towards or away from life, which was to mark every phase of our work, was fought and lost. He had chosen to study humanities. I wondered whether he was trying to learn emotions, and thought of his literary turn of phrase. He could not understand the imagery of the reading. He sat at the back of the class and dreaded people talking to him. He began to cut classes and soon withdrew altogether. I interpreted his humiliation at feeling faulty and weak and at the resulting loss of control, and his anxiety about spoiling something good for himself. K. blamed his downward slide on the combination of alcohol and his anti-depressants after a visit to the pub. It was only later that I discovered that the outing had been with his father. Again, he felt that chemicals, not emotions, created change. Slowly I nudged into place the concept of his feeling towards his father

having an effect. He decided to 'excommunicate' his father, trying to expel concretely the cloudy head he had complained about since the pub visit.

Hope: *'But who is that on the other side of you?'*

I felt that a sense of trust had developed as we discussed K's humiliation over the college failure. With some trepidation, he told me that he was a Marxist. I spoke to him about finding a place for himself within that structure, and sharing his sense of 'not having'. Privately I felt that Marxism allowed him to incorporate an intact thought system which enabled him to avoid conflict. It allowed him to understand personal experience within the impersonal and ordered structure of that political system. I saw this intellectualised route as compensatory, echoing his constant choice of books over people. I eventually decided that rather than showing a sense of trust, it was my being a non-person for K, which enabled him to speak to me about personal matters he would never normally address. Stronger words like 'dreadful' and 'miserable' appeared, and for the first time he referred to the silences as 'intolerable'. He said nothing was happening, but I felt more commitment from him, as he began to volunteer more information. Duty was balanced by anger when his father rang and complained he never came. He began to feel his father had no right to criticise him and I felt a thin pencil outline of his boundaries, containing a nascent sense of self, was being drawn. Although all these thoughts required prompting from me, I felt that slowly K's horizons were expanding.

I sensed a turning point when K. told me about a tree outside his flat which had beautiful coloured leaves which had fallen now. He said he missed the colours. To hear K. speak of beauty and loss was a dramatic move forwards. When he entered my room, he would look me in the eyes and smile, a big change from the downcast eyes of earlier days. I felt more trusted and secure in our relationship.

Then the feel of increased energy and linking disappeared and K. became monosyllabic again. The hint of closeness had to be undone by him as soon as it was felt. My words broke the renewed silence but could not be used. I felt his bleak emptiness. He said, 'These days are terrible, really, when you look at me and speak, and I don't say anything to you. Just look at you. I hear what you say but nothing seems appropriate to answer.' I told him about my image of him

trapped in a room, unable to make more than brief forays into the risky world of relationships. He felt he was marking time. In response to a query about feelings he said, 'I can't remember how I felt. I didn't give it much thought. I don't think I can look deeper in a meaningful way. It might even be harmful at this stage.' He agreed that my words were necessary because he could not find his own. The despairing aspect seemed to be wiping out the subtle progress he had achieved. I told him my own story of a tree, in response to his earlier one, about a little boy who tries to stop the leaves from falling by shielding his tree from the autumn winds, and his despair at failing. In the spring the leaves grow anew and the child realises that the tree has been alive all along. He was like the tree, I suggested. K. listened intently, and then said he would find a book on trees. Books were his tangible ally and his defence, perhaps a way of keeping contact with our shared symbol of the tree, but under his control. K. missed the next session, his internal saboteur keeping him distant after our linking. Nevertheless, the story seemed to mediate K's hopelessness and soon afterwards, as he described someone on the tube, our dialogue turned into somewhat of a game, imagining about the others on that journey. It was an attempt to help him to 'know' about others. I recalled Plaut (1966) linking trust and the capacity to imagine, both of which are severely disturbed by defects in early relationships. At the end of the session I wondered about his imaginings about me, and he immediately withdrew from that intimacy. He said he felt that would be invasive. When I referred to that in the subsequent session, wondering whether it was he who had felt invaded, by my question, he answered, 'I'm sure you couldn't care less, really.' I felt as though he had hurled me away from him. I said he thought of me as doing a job of work (referring to his description of a dentist he had just seen), and that would have nothing to do with relating. He answered, 'Even if you do relate to me, to be honest, it's not very fruitful or productive to come here, so I can't see that relationship in a very good light.' At the time I felt that he had related to me and he needed to withdraw. Our exchange about the trees had felt hopeful and precious, our first small *conjunctio*, but on reflection I think it probable that he spoke of the tree because 'it was just something to say', and the yearning was mine, not his. K's immunity to my efforts to reach him, no matter what path I tried, was becoming hard to bear. I felt very alone and sought for any sign of relationship. Sadly, with hindsight, I think I was relating mostly to myself.

Repeating the cycle: *'Each in his prison, thinking of the key'*

K. received an invitation to the wedding of a cousin. 'Of course, I shan't go', he said. His response typified the turning-away-from response which pervaded and crippled our work. My efforts to modify the bad mass of family into individuals, failed. He wished to have nothing to do with them. 'It won't be a seminal event, or anything. So there is no need to subject myself to the stress.' However, he came up with much new material. His mother had had a poem published, and had once left home for another man. He expressed no curiosity or pity. He couldn't remember the poem and was not sure where it was. His grandmother had often taken him and his sister on outings, once leaving him behind after a pantomime, scaring him badly. I wondered about the possibility of fear being felt as a punishment for childish excitement, curtailing spontaneity. It seemed that his great-grandmother had raised many of the family's children, but K. felt that she had loved them, and had only seen him out of duty. 'She didn't have a relationship with me. After all, I didn't have one with her . . .' In his not knowing about 'the other', K, through projective identification, cannot know about other feelings either. His limitation in differentiating his feelings from others avoids conflict and ambivalence. He told me that although his sister had her meals in their great-grandmother's room, K. was considered disruptive, and ate with an uncle. Again, I wondered about boyish energy being punished by banishment. Was he lively, or was he destructive? K. could not elaborate and the picture remained unclear for me. The most painful image was of K. walking with his father along a narrow passageway. The father was shoving K. from side to side, all the way down. He was told about this by a relative, who had witnessed it. That scene typified, in K's mind, his clear need for help, and the family's lack of response. K's reaction to them now was one of indifference, not of anger.

There was some acting out, which could be thought of as expressions of anger. K. often arrived late for sessions, and at one point, he regularly missed his only morning session. He occasionally sounded annoyed, if I pursued a point beyond his liking. As mentioned above, he appeared at a session after 24 hours of drinking. I wondered about him demanding my attention, and of the possibility of a protesting child emerging, but his only concern the following session was whether he had appeared drunk. I did not want to let such an extreme be emptied of meaning, but he was unable to recognise that emotionally, I had been there too. 'It doesn't really matter how I behaved, because

people under the influence behave differently' 'Well, I did feel awkward then, but it's in the past now.' For him, I was an observer, not a participant. When I addressed this, he said, 'I can't gauge how you participate unless you tell me how you felt.' Through projective identification, his emotionless response blunted my indignation, leaving me resigned and 'understanding'. At other times he projected the aggressive shadow of his passivity into me, where it swirled, fuelling sharp bursts of irritation and resentment in me. The attack which was absolutely regular, was his dismissal of me, the therapy and any effect it might have, through his indifferent turning away. 'I haven't really gained from it at all, over the year.' and, when I enquired about a unique, long-arranged supper cooked for his sister, his typical but still startling response was, 'There's nothing to tell.' In its deadening effect, his passivity was aggressive. K. sometimes felt like an impermeable wall against which my interpretations disintegrated. I recognised by now that K. could not feel my therapy, but nor could we think about it together. He would revert to old patterns and beliefs, seeming completely uninfluenced by what had been addressed by me for months. K. kept himself untouched and obliterated any threat of confusion through the destruction of thinking. Bion (1962) explains the rejection of thought with his model of an overdeveloped apparatus of projective identification, which perceives thoughts as bad objects to be evacuated. The apparatus for thinking is not developed, so thoughts are evacuated rather than modified. In this way K. rejects my 'not-self' thoughts, and projects his blank self back to me. We replay his experience with his mother, with our roles reversed. I try to reach K. as he tried to reach his mother. He cannot respond to me, as his mother failed to respond to him. Bion bases this evacuating defence against pain on intense envy. I wonder whether, in K's case, it would be based on the more primitive emotion of fear.

The work returned to bleak emptiness. My mind wandered in response to his detachment. I felt out of touch with him and succumbed to periods of overwhelming tiredness, echoing his unyielding flatness. He seemed disinterested, giving me only the barest facts about his days. In a silence he volunteered, 'At this time of life I should have loads more things, shouldn't I?' I asked what he had in mind. He said, 'I should be in a settled relationship. I should have a settled lifestyle, a network of friends, a career, a decent home, although my flat's not too bad . . .' I spoke about 'those things you yearn for', and said that his goals were important and fundamental. But he had listed them very calmly. I wondered how the yearning felt. He answered, 'It doesn't

mean anything, really. I just said that for something to say.' We agreed that he knew about these things in his head, like a list, but he didn't know what they meant.

K. was invited to a football game by his cousin. K. missed him at the agreed meeting point and watched people go in. He never saw his cousin, so he went home. I needed to ask a number of questions to get this far. I circled round and round the subject trying to build on this rare outing. Slowly, laboriously, other things emerged: K. called his cousin a swine for having included others in the invitation; he agreed that he felt anxious about being left out of the group, but he immediately followed that with 'What they think will only have a momentary effect on me,' foreclosing on the opportunity of relating. It emerged that he had contemptuous feelings about this cousin, whom he saw as a plodder (he placed no value on the regular invitations from the cousin, his only social outlet apart from his sister); when he waited at the gates he heard the roar of the crowds and felt a moment of regret – it had sounded exciting; he admitted feeling alone on the tube ride home. When I tried to follow this feeling, referring also to my imminent departure for the Easter holiday, K. said, 'Anyway, it was a rubbish match. I saw it on television,' evacuating any meaning from the event.

There was no sense of 'the other' for K. How things felt from the other person's point of view, such as his cousin also looking for him at the football game, could not exist. My efforts to add 'the other' to his sparsely recounted anecdotes continually failed. It was as if K. really could not understand what I was suggesting. He would cut short any such dialogue with phrases such as, 'Well, we've exhausted the subject,' or 'It doesn't feel significant.' I, too, was unable to be the other. I existed for K. as a cipher, not as an archetypal bad mother, but as a puzzling neuter. 'I shouldn't be looking to try and have a relationship with you and try and invent things. It hasn't done me much good, has it?' K. waits passively for change to take place. He is bored and restless in his impoverished internal world, but any possibility of liveliness is deadened by his negative internal objects. His expectation is of no-real-concern, no-real-response (no Mother's lullaby?) and he cannot venture forth against the chorus of hopelessness his internal objects sing.

Theory: *'I can connect nothing with nothing'*

Redfearn (1982) states that the prototype of the relationship between ego and non-ego, between I and non-I, is the early relationship between

baby and mother. It is her warmth and care which humanise the environment and become the 'thou' which is also incorporated into 'myself'. With inadequate mothering, the archetypal experience of unity underlying identification, will not be available, and personalisation, which is a natural function, does not develop. K's defences are so absolute that one must imagine a dramatic failure of mothering, and the infant's primal self being overwhelmed and threatened with disintegration. In an enabling environment, the early deintegrates reintegrate into restfulness and stability. If instead, these early deintegrates meet with a shocking environment, would the infant ego begin and continue in a fragmented state? Could the only escape from being overwhelmed by dread, be the closing down of his capacity to feel, to prevent further disintegration of the ego? The frail ego would have to defend itself from stimulus, to avoid repeated experiences of archetypal expectations being met with an intolerably harsh reality. Instead of rhythmic deintegration and reintegration, the infant's coping response would be to mobilise a schizoid defence, like a protective internal fortress, which would be in constant use. As he could not reflect on these defences, they would remain archetypal in their intensity and their control of his personality. The result would be a fundamental turning away from life, and a severely impaired capacity for psychic development.

Khan's (1974) concept of cumulative trauma, repeated failure of the caretaking environment from infancy to adolescence, is relevant to K. Far from being protected by a maternal shield, he suffered pathological intrusion from his schizophrenic mother, probable extreme physical and emotional neglect by both parents, as well as physical abuse by his alcoholic father. These ongoing traumas required K. to maintain his rigid schizoid defences: depersonalisation, splitting, devaluation of objects and of emotional experiences, intellectualisation and an incapacity to verbalise or even experience emotions. K. has remained cut off interpersonally (there is no I-thou) and intrapsychically (there is no ego-self).

Archetypes are considered to be on a spectrum of polar opposites. In the face of such a hostile infantile environment, could it be that archetypal experiences are divested of their emotional content by being placed in the centre of their spectrum, in order to avoid unbearable persecuting archetypal experiences? This centring defence would effectively result in a neutered archetype, the equivalent of being in the eye of the storm. One could assume that the child archetype, energetic and geared towards development, was never constellated. But there is

ample evidence of a witch-mother and a persecuting father archetype. One could assume that the archetypes had to be divested of their powerful negative force to avoid psychotic fragmentation.

If the mother is experienced as intrusive and/or absent, the normal, gradual differentiation between self and not-self would be distorted and happen prematurely and defensively, a wound unable to heal, because it cannot be thought about or mediated within that hostile environment. Not-self feels dangerous and is hidden from. Relatedness, the core of psychic aliveness, remains unknown. K's mother was reported to have been in a catatonic state after his birth. There would have been no container to enable a psychic skin and then a sense of self to develop.

Meltzer (1975) describes autistic suspension of attention, through letting mental organisation (integrates) fall passively to pieces (disintegrate), avoiding both persecutory anxiety and despair, as no violence is involved. An early, frequently evoked autistic state would affect archetypal embodiment, in which case any potential relationship would be pre-conceived as unexciting and meagre. It is this expectation of meagreness which protects K. from emotional danger, reinforcing archetypal neutrality. There is a strongly neutral feel about K. himself, physical as well as emotional. His slight, fair presence now feels sexless, as if he does not possess either an anima or an animus. He has projected both onto me, granting me warmth and creativity, as well as power and dominance. But in K's depersonalised world, the projected positive is not idealised or envied, nor is the projected negative feared.

Similarly, thoughts are neutered unless they are familiar, concrete and part of K's identity: self objects. Outside thoughts are not considered and rejected, but rather they slip like water off glass. Thoughts are incorporated concretely, in a sensation function way. They cannot be reflected upon. For instance, any challenge to a Marxist concept leaves K. floundering. Along with K's inability to think about or feel, is his inability, at certain times, to remember. He almost never refers to a previous session, and seems unable to internalise an image which has been shifted during a session. He once said, 'Sometimes, when you ask me a question, I forget how to answer.' Most striking were two incidents when we had an unusual, confrontational session. One of these sessions was based on a sudden burst of impatience from me, when K. cut me off with, 'You wouldn't be interested anyway. You don't know him.' First I had to point out to him that I had sounded impatient, and then I held him to this interaction for much of the

session. After the session, I was very concerned about having been too insistent, and damaging the frail relationship we had achieved. When I referred to the exchange during the following session, he had no memory of it. 'We weren't talking about anything, were we?' This neutralisation and evacuation of content is his unconscious deadening response to all emotional stimulus. I had not, after all, become an animus-ridden persecutor. I remained irrelevant.

Kernberg (1984) writes about transference repression and the almost total absence of manifest aggression in such patients. He describes the great difficulty these patients have in listening to the analyst as a stimulus for further self-exploration, and their inability to imagine that any knowledge about themselves could emerge from their unconscious. (In response to my efforts to attach meaning to a delayed cheque for his sessions, found hidden in a book, K. said, 'What if I don't believe in all that stuff?') Kernberg stresses their restricted range of emotions and the resulting serious challenge to the therapist's creativity. In the face of my interpretations being continually unmet by K, I would at times need to regain my faith in my perceptions by thinking about how I would have responded to such an intervention from my analyst, breaking away from K's projection of futility and isolation by touching base with my own relatedness.

Storr (1972) discusses the combination in children of extreme vulnerability and omnipotence, which is modified over time as peer group interaction takes place. In K's case, his profound mistrust of 'the other', prevented this clarifying influence from taking place. He remained an isolated introvert. He only recalls one local child as an acquaintance, whose house he never entered. His child's sense of omnipotence developed into a sense of intellectual superiority which never modified into 'good enough'. It is this aspect of K. which would explain his acting out referred to earlier, and his contempt for his sister, whom he finds ordinary, and for his work colleagues, whom he terms dullards. It also played a part in his taking some satisfaction in thinking he must be my most withdrawn patient. He has asked at various points, 'Do you see anyone else as depressed/silent/withdrawn as me?'

Nathan Field (1991) writes that it is not so much rage or loss or frustration that so distresses the schizoid patient, as the feeling of being utterly alone. He explains that since these patients are in states where they are inaccessible to verbal clarification, it is through projective identification that the patient can be understood. It is through the area of shared unconscious, the alchemical state of *nigredo*, that healing

can begin to happen. Schwartz-Salent (1988) calls this analytic twosome the 'imaginal couple' but states that the couple can combine in either a sado-masochistic way or in a mutually enhancing *coniunctio*. I had gained courage from the hope that finding and changing could take place in our shared 'third area', the space between the two of us where, as imaginal couple, unconscious interaction could have evolved. But our analytic marriage has not been fruitful.

I think a game of bridge might be a suitable metaphor of the work done so far between K. and me. The other two players could be K's mother and father, or perhaps my analyst and my supervisor. I am leading, and K. is dummy. I am not sure whether we are at the beginning, in the middle or at the end of the game. K. has turned away and I wonder whether simply being part of the game might be of some value to him.

Just before my second summer break, a year and a half into our work, I addressed the feelings of hopelessness which had been coming into the sessions. The spectre of no change had been raised by K. He spoke about his reluctance to continue intensive therapy with nothing to show for it. We discussed the options – carrying on, cutting down, finishing, or finding a different kind of therapy for him. I felt his therapy with me was about to end. After a weekend to think about it, K. asked to continue seeing me once a week. I felt surprised, relieved and sorry simultaneously. He put his decision down to indecisiveness, but later he said, 'I probably would miss coming here. I don't know why, though . . . probably . . . I might do . . .'

Afterwards: *'I sat upon the shore fishing, with the arid plain behind me'*

After my return in the autumn, K. confirmed his wish to continue seeing me once a week, and asked for reassurance that I, too, would be willing to continue on that basis. His spirits were low. He wondered whether seeing me once rather than three times a week might have something to do with that, his first acknowledgement of my having an effect on him. Perhaps it was my having despaired and given up on him, as he had done long ago, that allowed some sense of being understood to reach him. Maybe it will be from that shared aloneness, that we can, after all, begin.

Conclusion: *'Speak to me. Why do you never speak.'*

In this paper, I have described the cycle of effort, hope and disappointment, fuelled to a large extent by my own emotions, in the work with K. The expected spiral which leads onwards and upwards had remained flat, a circle from which we seemed unable to escape. As I wrote the final paragraph above, I realised that I was, again, finding a future for K. and myself. Perhaps this time we can spiral upwards. Or perhaps we are, once more, at the beginning of the cycle.

> The great tragedy of life
> is not that men perish
> but that they cease to live.

Freya Stark *Perseus in the Wind*

References

Bion, W.R. (1962) 'A theory of thinking'. *Int J. Psycho.*, 43, 306–310

Eliot, T.S. (1922) *The Wasteland.* New York: Harvest Books (All headings quotes)

Field, N. (1991) 'Projective identification: mechanism or mystery?' *Journal of Analytical Psychology*, 36:1

Guntrip, H. (1992) *Schizoid Phenomena, Object Relations and the Self.* London: Karnac Books

Joseph, B. (1989) *Psychic Equilibrium and Psychic Change.* London: Routledge

Kernberg, O.F. (1984) *Severe Personality Disorders.* New Haven: Yale University Press

Khan, M.R. (1974) *The Privacy of the Self.* London: Hogarth Press

Meltzer, D. (1972) *Explorations in Autism.* Pitlochry: Clunie Press (1986) *Studies in Extended Metapsychology.* Pitlochry: Clunie Press

Plaut, A. (1966) 'Reflections on not being able to imagine' *Analytical Psychology, A Modern Science.* London: Academic Press

Redfearn, J. (1982) 'When things are persons and persons things'. *Journal of Analytical Psychology*, 27, 215–237

Schwartz-Salent, N. (1989) *The Borderline Personality – Vision and Healing.* Illinois: Chiron Publications

Storr, A. (1972) *The Art of Psychotherapy.* London: Heinemann

Tustin, F. (1986) *Autistic Barriers in Autistic Patients.* London: Karnac Books

Zinkin, L. (1991) 'The Klein connection in the London School: the search for origins'. *Journal of Analytical Psychology* 36:1

Notes on Contributors

Dianne Campbell Lefevre MB, ChB, MRCP, FRCPsych	Consultant psychotherapist, Basildon Hospital (until recently Consultant Psychiatrist). Associate member BAP. Member APP. Psychotherapist in private practice.
Juliet Hopkins	Full member BAP Adult and Child Sections. Staff member Tavistock Clinic. Psychotherapist in private practice.
Ruth Berkowitz PhD	Full member, BAP. Psychotherapist in Primary Health Care. Member Institute of Family Therapy. Formerly Supervisor and Tutor, Institute of Family Therapy. Chartered Psychologist AFBPsS. Formerly Associate Research Fellow MRC. Social Psychiatry Unit, Maudsley and Friern Hospitals. Author and co-author of several articles on therapeutic interventions with schizophrenic patients and their families. Psychotherapist in Private Practice.
Bernard Shapley	Associate Member, BAP. Senior College Counsellor, College of North East London. Psychotherapist in Private Practice.
Britta Lloyd	Associate member, BAP. Member International Association for Analytical Psychotherapy. Psychotherapist in Private Practice.

Book Reviews

The New Informants: Betrayal of confidentiality in psychoanalysis and psychotherapy

By Christopher Bollas and David Sundelson, Karnac Books 1995 pp. 215 p/b. £14.99.

It is a rare experience both to read and to be able to recommend a book on psychoanalysis because it is passionate, committed and provocative. These are not descriptions usually applied to psychoanalytic writing and when they are it is a barely concealed disparagement. Moreover on this occasion one of the authors, Christopher Bollas, is also one of the best known and respected writers of the decade whose work sets a standard for both psychoanalytic thought and practice. Amongst other distinctions Professor Bollas is a member of The British Association of Psychotherapists. His co-author, David Sundelson is a lawyer and academic in literature and psychoanalysis.

The book is not for the 'faint hearted'. It is a response to a crisis which 'will have long-standing implications for the right of any person in any country to speak in private about his or her mental life.' (p. xv). This bold and alarming statement sets the tone of a book which describes changes affecting the practice of psychotherapy. The authors are courageous in their proposals that psychotherapists should respond with an amplitude which is in proportion to the threats to the future of psychoanalysis. The authors also criticise the lassitude of the profession and give reasons why psychotherapists are in the main not known for speaking out. In addition they charge that there is a complacent favouring of the 'adaptive ego' as a means of mastery and denial; part of what is called in the book a 'culture of evidentiary desire' (p. 124).

The authors are profoundly critical of a classical analytic position in relation to social and political forces which are undermining patients' rights to privacy. 'To remain calm in stormy waters, whatever the cause, seems to be the best way for such analysts to remain psychoanalytic, assured, confident and quiet.' (p. 129). This impatience is indicated at the outset by a 'call to arms' (p. xiii) and as such a desperate attempt to formulate a response to the threats being posed to psychoanalysis both sides of the Atlantic. Perhaps as a result of the apparent need to hurry in arming ourselves we do not

discover until three quarters of the way through the book that the authors in referring to analysts also include those who are trained to practice psychoanalytic psychotherapy. This could have been clearer at the beginning but for the fact that it might have irritated some readers all the more. Nevertheless Bollas and Sundelson intend that 'analyst' includes 'psychoanalytic psychotherapist' and 'psychoanalytic psychotherapy' includes 'analysis'. This is mentioned in the book because it is a contention between organisations as to which are bona fide psychoanalytic. Under these conditions the echelons of the profession are not noted for the 'generosity of spirit' which the authors exhort us to adopt and which they themselves do not linger over. The question of who possesses the psychoanalytic truth is a constant factor in any discussion and it is a criticism that this is a too brief reference in the book to a minefield of rivalry and paranoia. This is even before we get on to differences within training organisations. These differences are of central importance when arguing for analytic communications to be privileged especially as the arguments about difference have been part of the public domain years before this book was written. The fact of the matter is that privilege can only be sanctioned if society believes that it is in its interests to do so. This is where the problems arise and the authors lead us through the consequences of the public's wider access and exposure to psychoanalytic thinking as well as the galloping extensions of psychoanalytic theory and application.

'Psychoanalysis on trial' suggests the cartoon on the front cover of the book. The first chapter 'Breaching the Confessional' cites the conflict between an individual's right to privacy and the right of the wider community to take action to protect itself. This has risen most clearly where patients have confided their intention to commit or have committed serious breaches of the criminal law. In most of the United States there is a duty on all clinicians to report matters which are in the public interest; although there may be acknowledgement that patient communications need to be protected, the position is qualified. The authors argue firstly, that the profession has failed to communicate to the courts that only one breach of confidentiality is enough to signal that all confidentiality is qualified. Secondly, there must be an understanding that the analyst is concerned with unconscious processes which only become available to consciousness post hoc. The argument is that privilege cannot be dispensed with in these circumstances because neither analyst nor patient will know what they are surrendering. Thirdly psychoanalysis may only be conducted under special conditions where a patient and analyst are both free of actual

persecution for what they think. It follows that the greatest possible reserve has to be exercised in extrapolating psychoanalytic facts from their own domain into another domain where different rules apply.

This is not an extreme point. The authors illustrate clearly how psychotherapists competing for professional priority have made psychoanalysis a part of the commodity market and growing 'cook book culture' (p. 133) of psychological know-how. In fact, one of their most outspoken arguments is against the principle of managed care. In this country we are more likely to think in terms of purchaser/provider arrangements and private health insurance through which psychotherapists have actively sought a commercial partnership. Along with this often goes consideration of cost and benefit, accountability and purpose, all of which may vie with the interests of psychoanalysis. For example Klimovsky *et al.* (1995) illustrate the complexity of different classes of ethical proposition which are a part of psychoanalysis. The argument is a correlation with human duty, that is ethics and psychoanalysis; without that relationship, psychoanalysis would be a 'pure' theory (ie. uncontaminated by subjectivity), of decisions about mental problems and would not make sense. Moreover the lesson from Klimovsky is that care needs to be taken in assessing the intentionality of any statement made within the psychoanalytic framework. Once psychoanalysis is being tested in court this becomes crucial where the intentionality is to adjudicate on guilt and innocence. This particular axis is antithetical to psychotherapeutic treatment as Bollas and Sundelson repeatedly illustrate. Psychoanalysis is a perspective on the human condition and has so much to contribute to the understanding of suffering as a part of human existence. It may provide an amelioration of harsh judgement and modify persecutory forces through intrapsychic change and this is the world of dreams and myths which is not easily demonstrated except in the clinical setting and the experience. 'The **furor iudicandi** – if we may so put it – inspires objections no less serious than those raised in the past by Freud to the **furor curandi**' (Klimovsky 1995). With this point well made, the most disturbing thing that the authors suggest is that there is greater disapproval than ever on both the doing of psychoanalysis and deeper level human experience which is possible.

The lamentation of what has happened to psychotherapists in the United States is relentless. The suggestion is of a process of assimilation of psychotherapists as a result of both their default and active collaboration. Evidence of the astonishing increase of cases of child abuse being reported and the growth in both legislation and bureaucracy to

handle this tidal wave are described. Specific statutes which make reporting compulsory have taken away the responsibility from the clinician as though 'deputised' by the law enforcement agencies. This is when it is questionable whether the evidence that disclosures in these circumstances have led to identification of children at risk. The authors do not suggest for one minute that there is no problem but emphasise how easily psychotherapy has become identified with a punitive reaction towards many aspects of the human condition. This identification is as much the responsibility of the clinicians as it is of the legislators because the former have failed to assert the essential properties of psychoanalytic work and the reasons why the community needs to preserve these. Most serious perhaps is that the special skills of the psychotherapist, of winning trust and confidence, may be used to extract information from a patient in the service of external agencies. These skills are based on knowledge of unconscious processes and human vulnerability. A central ethical question is how may these skills be deployed and by whom?

The authors mourn the passing of psychoanalytic freedom and describe a world which is now legally and fiscally regulated. In so doing they describe the disturbance which they perceive within psychoanalysis which gives Chapter 3 its title '*Loss of Confidence*'. The growing legislative requirements have brought about this all important paradigm shift so that the psychotherapist is unduly influenced by factual and legal truth as opposed to psychic truth. This aspect of the *fin de siécle* climate is summed up in the book as follows, 'The transformation of psychoanalysis from a specialized treatment with unique features in its curative process to a cost-effective unit that must continually report on its progress toward symptom elimination has gravely affected the frames of mind of any analyst or patient still participating in such an environment' (p. 100).

The reading of this book is almost shocking as the authors reveal their ideas on the perilous state of psychoanalysis. They demand that the profession becomes more militant in arguing its case. This could be necessary but there is also some confusion in the argument. An example is made of the British Association of Psychotherapists (1994) advising members to obtain legal advice if asked to give evidence and thereby jeopardise confidentiality. The authors say this is putting the decision making in the hands of others. The fact is, that what is or is not sanctioned is always in the hands of others either formally enshrined in statute or by an unwritten consensus. The advice to psychotherapists to obtain legal representation seems good practice

and apart from reasons of self-defence, it is a channel through which to carry a debate into the community. Perhaps the more important point is that by the time this stage has been reached a breakdown has already occurred in the analytic situation whereby the rules of psychoanalysis no longer apply. This in itself is a strong reason why psychotherapists should be very cautious indeed about the way information obtained in the consulting room is ever used outside (See Klimovsky, 1995 and 'intentionality' above).

One solution offered in the book is that psychotherapists need to be much clearer about the role which is being adopted. This concerns the identification of which therapists are committed to strict boundaries of confidentiality. Those therapists involved in public services, called by the authors 'social therapists' would need to be clear with their patients that they may be accountable to other authorities. This model is of course not new. For instance probation officers who often have a keen interest in therapeutic work with their clients frequently have to manage this delicate boundary and there are many other examples in the helping professions of this process. For psychoanalytic practice and where there is a psychoanalytic contract, conscious identifications with punitive agencies have no place and it is precisely this that is being asserted in the book. In fact the book is an admission that for all the reasons mentioned above, psychoanalysis, in both penetrating and being able to contain aspects of the human condition, is also penetrated by it. It follows from this that countertransference phenomena and the mechanisms of projective identification need to be analysed exhaustively in determining our place in a community.

In relation to this book and the principles in question, it is important to consider other spheres of human endeavour in which there are parallels with the plight of psychoanalysis. The example is of university education which has been marketed and re-created as a commodity compared with a valuation of education and the experience of education for its own sake. These issues were identified years ago by clinicians and indeed Bollas' own work in which he coined the term 'normotic personality' (Bollas, 1987) was often quoted in this context. What was being seen then was the effect of monetarism on student attitudes and university policies (the adaptive ego *par excellence*). The principal feature of this was the erosion of the transitional space within which 'playful creativity' and learning can take place (Hewitt 1989, White 1991). Similarly the book alerts us that the penetration of repressive and deterministic forces have now reached to the very core of psychoanalytic organisations.

The book is not simply a 'call to arms' but also a 'call to order'. The discomfort which it creates is a rebuke for the capriciousness of our reality testing and a wavering allegiance to the minimum requirements of working psychoanalytically. With regard to this the authors also have much to say about confidentiality and publications which are in essence another form of disclosure. The requirement is that psychotherapists should hold on to principles if we are serious about psychoanalytic work and the unconscious. To paraphrase Freud (1915), 'What we cannot obtain from psychoanalysis we should not believe can be obtained elsewhere.'

The trouble is that there are factions within the profession and some might feel that psychoanalysis has been in the hands of a few for too long. On the other side some feel there is too much dialogue with others interested in psychoanalysis. Indeed two perceptions of the position today are that if they cannot join us, they will beat us; or if we do not join them, they will beat us. The result is that the centre of psychoanalysis has changed. At one liberal end of the spectrum where Bollas *et al.* reside, there may well be a 'generosity of spirit' but is this representative? Anyway do psychotherapists have a monopoly when it comes to understanding the unconscious? Has not the world of psychotherapy, all psychotherapies, become a fantastic collection of credos and movements each with its own sense of destiny? Factionalism is iatrogenic to psychoanalysis itself; in the honouring a long process in which the analytic discipline is accepted, the psychotherapist may not forgo his sense of achievement any more than he dare forget it. For instance, the dissident voice of Adam Phillips (1995) suggests the emasculating impact of psychoanalytic institutions fostering fear in analysts in the way they approach their patients. There are groups who regard themselves as an 'under profession' of psychotherapists in relation to the major institutions (Gordon 1995). The view here is that psychoanalysis mirrors the political and social structures of a dysfunctional society. This diversity of views and thought could of course fill volumes but for the present there is no more than a whiff to make the point that there is much work to do to bring about an understanding and 'generosity' towards psychoanalytic work. If the profession is prepared for this we will find ourselves in unlikely places. The last time this happened the British Confederation of Psychotherapists was formed*.

* The British Confederation of Psychotherapists (BCP) was formed in 1993 when it broke away from the United Kingdom Council for Psychotherapy as an attempt to preserve a separate identity for psychoanalytic psychotherapists.

Bollas has the credentials to move between the Old and the New World so he is well qualified to stir this particular 'can of worms' and with Sundelson takes no prisoners. It is very much an Old/New World problem which on this occasion refers to shifts in human values which are inextricably linked to 'advances' in social attitudes, the science and technology of a 'brave new millenium'. This book is concerned with psychoanalysis as we know or knew it and suggests the responsibilities psychotherapists have to wider society. The weakness of the book, virtually admitted by the authors, is that psychoanalysis is a 'chorus of voices'. In such a situation it may be self-defeating for some psychotherapists to be claiming to possess what appears to be a priority position as opposed to a different position in a pluralistic society. The 'generosity of spirit' which Bollas and Sundelson say is required may have some attraction in present circumstances but just how far are we prepared to take this?

References

Bollas C. (1987) *The Shadow of the Object: The Unthought Known.* London: Free Association Books

British Association of Psychotherapists (1994) Newsletter 21:35

Freud S. (1927) 'The future of an illusion' *SE* XXI London: Hogarth Press

Gordon P. (1995) 'Private practice, public life: is a psychoanalytic politics possible?' *Free Associations* Vol 5 Pt 3 No 35

Hewitt P. (1989) Impositions, Surrenders and Sacrifices: A therapists' experience of the unacceptable side of success. Conference paper King's College, London. Published by The British Psychological Society – Psychotherapy Section No 14 December 1993

Klimovsky G., Dupetit S., and Zysman S. (1995) Ethical and unethical conduct in psychoanalysis. Correlations between logic, ethics and science *Int. J. Psychoanal* 76 977–990

Phillips A. (1995) *Terrors and Experts.* London: Faber

White J. (1991) 'Adolescence and education in the 1990's' City University Publications Conference 19th July

PHILIP HEWITT

Wilfred Bion His Life and Works 1897–1979

by Gerard Blèandonu. Translated by Claire Pajaczkowska, Free Association Books Ltd 1994 pp. 303 p/b. £18.95

In this book, Gerard Blèandonu, a French community psychiatrist, offers the reader the opportunity to gain a unified view of the manifold

and complex nature of Bion's ideas. Blèandonu's interest is in gathering Bion's conceptualizations and to identify a comprehensive psycho-philosophical epistemology.

The book does not aim to be a clinical exposé. Instead, it seeks to lay the grounds for a metapsychology of Bion's ideas. Unless the reader is already acquainted with Bion's clinical work, he will find the ideas presented interesting, but will not immediately see the enormous importance they have for the understanding of the transference and the dynamics of change. One would, therefore, recommend that clinicians use the chapters in this book as reference study points.

Blèandonu divides his work into five parts: Part 1, 'The years of Apprenticeship' encompasses Bion's developmental years, from childhood to his psychiatric training. Part 2, 'The Group Period', covers his work on groups from 1943 to 1952, leading to his book: *Experiences in Groups*. Part 3, 'Understanding Psychosis' examines Bion's ideas presented in his seminal papers from 1950 to 1962, subsequently compiled in his book *Second Thoughts*. The fourth section entitled: 'The Epistemological Period: The Ideal of a Scientific Psychoanalysis', focuses on his theories of thinking, which culminated in four books, namely: *Learning from Experience, Elements of Psychoanalysis, Transformations*, and *Attention and Interpretation*. The last chapter, *The Final Period*, deals with his years in California, and extensive lecturing in South America, which culminated in his three volume *Memoir of the Future*, and his two volume autobiography, *The Long Week-end* and *All my Sins Remembered*.

Although the biographical aspects are a bit sketchy, due to the fact that the data stem solely from Bion's own autobiography, it nonetheless is helpful in that it gives the reader an insight into Bion's personality and the motivations behind his search for the truth which led to the extraordinary insights later in his life.

On the evidence of Bion's own autobiography, his childhood was filled with guilt, depression, self depreciation, lack of confidence with a severe superego. He had strong sexual inhibitions, with narcissistic tendencies. After spending many years in boarding schools, feeling lonely and dejected, he developed a very moralistic type of personality, straight laced, very honest, obedient, and righteous. Bion underwent three analyses. The first, during his medical training and work at the Tavistock Clinic, with J. Hatfield, a medical professor and psychotherapist, who gave Bion the basis for his interest in psychodynamics and group work. The second, lasting only two years due to the war interruption, was with J. Rickman, a classical analyst but sympathetic to

Melanie Klein's theories which gave Bion a good basis for his next analysis with Klein, which lasted eight years.

During the war, Bion working as a psychiatrist, introduced group therapeutic techniques to deal with war neuroses at the Northfield Hospital in Birmingham. Bion's paper on the subject, 'The Leaderless Group', is one of the first introductions to what was to become 'the therapeutic community' and a model for workers in the field.

Following the death of his wife Betty, and the end of the war, Bion resumed his analytic training at the Institute of Psychoanalysis in London in 1945 and deepened his understanding of group forces as he began analysis with Melanie Klein and applied the discoveries made by her to the study of group dynamics.

Bion's work on groups gave him insight into the fundamental conflict between psychotic activity and activity that is creative and oriented towards reality, as well as into the compromises that must be attained in order to allay the anxieties accompanying psychotic processes while preventing them from overwhelming realistic processes. In effect, Bion realized that the task of a group, like individual analysis, gets diverted by primitive forces which he terms, 'basic assumptions'. These 'basic assumptions' are operating at a preverbal level and are part-object based.

Bion identified three types of 'basic assumption' activity operating within the life of a group. The 'dependent basic assumption', whereby the group is concretely dependent on an omnipotent magical group leader and is similar to a child fused with his mother. The second is the 'flight-fight basic assumption', where two dimensionality predominates, and things are perceived either as friendly or persecutory, and usually, splitting predominates. The Oedipal drama involves a flight from the oracle's prediction and the killing of Laius to negate any separateness and exclusion. The third is the 'pairing basic assumption', a state where the beginnings of three dimensionality appear. The defences seem to be of denial. In Oedipal terms, the parents are recognized but there is no fruitful intercourse leading to the birth of a third party, namely the baby. The leader in the group is relegated to an 'unborn position'.

Parts three and four of the book encompass Bion's study of psychosis and the development of a theory of thinking, which Blèandonu calls his epistemological period. The author shows how Bion constructed his theory of psychosis by applying and interlinking both Kleinian and Freudian theories. Excessive projective identification

dominates the schizophrenic's personality so that he cannot distinguish internal from external realities. Psychosis, in a sense, is a defence against total disintegration, which is based on the death instinct acting from within.

He goes on to clearly describe Bion's explanation of the psychotic part of the personality. 'The future psychotic has introjected an external breast which refused to introject, harbour and modify emotions' (Blèandonu, p. 139). The origins of the psychotic fear lie in the infant's sense that he is dying which is intensified by envious feelings and fear of psychic pain. His own destructive feelings, which have not been understood and modified by a thoughtful and containing breast-mother, intensify the envious attacks. Thus, the psychotic part attacks linking and prevents the development of verbal thought because the latter necessitates ideographs coming together.

Based on his insights into psychotic thinking, Bion developed a psychodynamic model of the foundations of thought and perception, which is an extension and continuation of the work begun by Klein. Symbols are formed as a result of accepting the union of the primal scene, enabling thought to be developed in the infant. Conversely, any coming together is attacked and therefore no symbols, hence no thought, can be constituted (Melanie Klein, 1930–1931).

Blèandonu explains how Bion set himself the task of attempting to develop a language that was scientific enough to be used to study what he calls the psychoanalytic object, which he equates to the mathematical object. In geometry, there was a need to develop symbolic algebra based concepts to bind and understand multidimensional projections (which were impossible to apprehend and comprehend visually), similarly, with the personality and psychoanalytic elements, the mind has to develop concepts that bind and transcend the visible and tangible to understand the world, both within and without.

Bion developed two basic concepts: the alpha function, (psychic activity which produces alpha elements which serve to transform 'raw' experiences of the senses into psychic experiences of memory and dream thoughts), and he establishes 'the grid', which can be used as a new system to record and note psychic phenomena and, therefore, to reconstitute the psychoanalytic project.

The alpha function emerges as a result of the preconception of the personality being met by a container. In other words, the prototype of all thought development is when the baby, who has an expectation or a preconception of the nipple to be found, experiences its realization

as of objects coming together. This creates the seeds for the creation of symbols, tools for the production of thinking ideographs. Bion thinks that these patterns increase in sophistication as these preconceptions get realized over time. The increase of curiosity and need for discovery remains unsaturated. When this intellectual sequence is disturbed, then the curiosity is undermined and the personality saturates itself prematurely. The thinking apparatus is arrested as a result. The personality, like the psychotic part, is only interested in either knowing and getting rid of any curiosity or in switching off the mind, as for instance, in autism.

The grid is an abstraction of mathematical resemblance, as it is constructed in the form of a matrix, to formulate a schema of how the thinking mechanisms take place to use or misuse the thoughts and discoveries made through alpha function in the sessions. The grid exemplifies that thought can only develop when there is a matching of two minds. The preconception, which Bion maintains is an unconscious search for needs for growth to be met, is composed of a constant known and an unknown (he calls it the unsaturated element), a constant testing of reality allows the mind to grow towards abstraction and meaning.

Because Bion stresses that the analytic task is like a gigantic chess board activity of inquiry, elucidations and obstacles, and under bombardment of emotions which involve what he calls **K** (Knowledge), **L** (Love), **H** (Hate), or their reverse according to the valence being constructive or destructive, (that is, is either player seeking truth or a distortion of it, or an outright reverse of the truth), the sequence of development can be interrupted by either player in the chess board. As a result of this model, from a clinical point of view, it is extremely important for the analyst to enter the analytic experience with as few saturated preconceptions as possible and to be receptive to what Bion calls the selected fact, defined as an intuitive awareness of elements coming together which can lead towards a hypothesis.

Bion became more preoccupied with the method of capturing the states of mind, which he delineated in his grid, between patient and analyst. Departing from the point of view that transformations can only be achieved if real thought emerges to conceive the preconceptions seeking a thinker, he proposes the method of 'intuition', which is neither intellectualizing nor feeling. Blèandonu quotes Bion: 'The fundamental tension is between a patient A, who cannot bear pain, and patient B, who is capable of becoming a psychoanalyst because he is capable of toleration of the tension.' (Blèandonu, pp. 218).

The author explains how the ultimate truth represented by the symbol 'O' by Bion, is that which emerges in the session, when real thinking about what is going on has taken place and the participants in the exchange have become the fruits of their thinking via transformation. Bion distinguishes firmly between knowing and becoming.

Freud's famous advice to blind oneself artificially to focus all the light on one dark spot becomes a *leit motif* of Bion's work. Bion advises the relinquishing of the attachment to desire and memory as a way to be able to allow for the mental desire to emerge. The desire for closeness and knowledge and curiosity are predispositions and preconceptions which are blinded by the sensual gratification. In effect, Bion finds that knowledge develops at the same time as the mental apparatus. Knowledge can only be obtained through transformation. Meaning can only emerge through the tolerance of pain, mourning the loss of the needed.

The fifth and final part of the book covers his years in California, his seminars, lectures, and the writing of his novel, *A Memoir of the Future*, where Bion expresses his theories and ideas in a non-scientific way to reach a greater audience. In a sense this is a quasi-philosophical fictional treatise aiming to show how the mind is curtailed by pain.

The formulations that mature in Bion's mind during this period represent both brilliant insights into the nature of scientific investigation as well as offering psychoanalysis a new path of discovery and change. Negative capability is one such formulation defined as a state of mind reached through reverie. A capacity to stay with the unknown and unfamiliar long enough to permit an intuitive image to emerge, and thus via symbol formation, a conception to be reached. The author concludes that Bion is in search of a mystic truth between analyst and patient. However, it would seem that what Bion teaches us is about the emergence of meaning, which is the result of a three dimensional capacity to think creatively and aesthetically.

The main contribution of Bion's work to clinicians is that it gives them a way to see how the mind functions at different levels of emotional development. Thus the therapist needs to be aware for instance that his own way of thinking, ie, at the normal neurotic level, is not the same as that of a patient who is functioning at a borderline or psychotic level. Understanding and interpretive activity are not enough to give meaning to the analytic encounter. The analyst can help the patient, via the use of projective identification containing

techniques, to name the hitherto unknowable and unthinkable. In order to understand Bion's ideas, it is important to switch one's mind to the very attitude Bion himself advocates as a method of transformation, to detach oneself from memory and desire, and be open to the pursuit of discovery.

The book reads from a seemingly simple account of Bion's life, at times trivial and somewhat unstimulating, to an increasingly dense and difficult exposé of Bion's theories and ideas. Following his personal philosophical interest, Blèandonu elaborates at length on Bion's philosophical development and how he was inspired by the theories of Kant, Wittgenstein, Ernst Mach, Gottlob, and Frege, as well as by mathematicians like Henry Poincaré. Unless the reader is already well acquainted with these other thinkers, he will feel frustrated and obliged to seek elsewhere for clarification. It would have been helpful if Blèandonu had discussed the ideas he introduces prior to using them to make his comparative points.

Blèandonu is careful to convey his wish to limit himself to the role of a biographer and historian, but the book, nevertheless, comes across as if he is trying to do something Bion himself never intended, namely to develop a whole philosophical corpus. Therefore the reader is advised to regard the present volume mainly as a reference guide to Bion's achievements. The lack of clinical data might lead some away from Bion's clinical insights and discoveries. For instance, Bion's quest towards an ultimate reality (which he terms 'O') comes across almost as if it were a religious concept instead of a clinical concept, signifying the transformation of the psyche through the total awareness of the experience.

Despite these shortcomings, the book's strength lies in it's intellectual effort to convey to the reader the importance of the psychological insights reached by Bion and their effect on our understanding of the world around us. Blèandonu makes the point that the main question that unites all great thinkers is how to know and trust what we know is real.

The book is written in a logical way, facilitating the reader's task in terms of being able to chronologically follow the evolution of Bion's discoveries and conceptualizations. It gives a sound overview of Bion's contributions and offers a stimulating introduction to the huge corpus of his work and will certainly inspire practitioners and those interested in the epistemology of the elements of psychoanalysis to read Bion directly.

References

Klein, Melanie (1975) 'A contribution to the theory of intellectual inhibition', *Love Guilt and Reparation and other Works* London: The Hogarth Press, pp. 236–248

—— (1975) 'The importance of symbol formation in the development of the ego', *Love Guilt and Reparation and other Works* London: The Hogarth Press, pp. 219–233

Meltzer, Donald (1978) 'The clinical significance of the work of Bion', *The Kleinian Development Part 3*, Oxford: The Clunie Press

RICARDO STRAMER

Non-compliance in Winnicott's Words: A Companion to the Work of D.W. Winnicott

by Alexander Newman. Free Association Books 1995 pp. 459 p/b £25

My first reaction to this book was one of intense dislike. I love Winnicott's work but it did not seem in any way enhanced by this very personal dictionary and commentary. I disliked the way the book was written, and its content. Does Winnicott need this compendium? He may be obtuse at times, but he was the first psychoanalytic writer I ever came across. I have always found that he spoke directly to me. It is an outrage to this sense of personal contact that I have always felt that I had with him, although I never met him and did not come anywhere near to psychoanalysis until some ten years after his death.

However, when I had begun to work through my personal sense of outrage, both about the content and the writing, I settled down to read the introduction. This is informative about Winnicott's life and work, and also about the author's reasons for writing the book. These were a lifetime's teaching, and sharing his love of these texts, a wish to share his rich familiarity with this important figure in the British Psychoanalytic Society: I was partly appeased, but only partly.

I do not agree with Newman's opening paragraph, which talks of 'Winnicott's portrayal of human emotional development as dangerous' or 'subversive', and I disagree that 'his way of disclosing his emphasis lies in sustained litotes and a continuity of irony'. For me Winnicott's language is simple, his ideas profound as is his humanity and his fundamental respect for another's unique humanity. His emphasis lies for me in his constant use of paradox, which allows for the mystery and 'not knowing' at the heart of the matter.

But there are useful aspects to the book. Its overview of all Winnicott's work, its list of his books with the date of publication

and contents of each, are a useful checklist for anyone doing research; as is the main body of the book, which consists of a dictionary of Winnicott's words with a brief (usually) description of each in Newman's words, and an exhaustive list of references to that term throughout Winnicott's works.

The most annoying aspects are the gratingly bad English, and the intrusion of Newman's personal views and patients. I prefer Winnicott by himself.

JAN HARVIE-CLARK

Self and Spirit in the Therapeutic Relationship

by Kenneth Bragan. Routledge 1996. pp. 121 h/b £30.00. p/b £9.99.

This book is not about religion. It is a humane man's offer to share how he has made sense of his life and work in a world of increasing alienation. He describes a world where the individual can be lost in abusive institutions, where technological revolutions have eroded our capacity for human engagement, for instance in the way constant television news of human disasters dulls our sense of the reality of death, and where urban living has corroded our natural sense of connection with beloved, familiar landscapes, that is, with landscape as part-object. His concern is with the fact that the damage is brought to the consulting room, increasingly in the form of disorders of the Self. For this reason he gives particular attention to the work of Heinz Kohut and Daniel Stern and his book is a useful introduction to their thinking.

Dr Bragan worked as a psychiatrist, first in a Scottish hospital and then for many years in New Zealand where he was Senior Psychiatrist at Ashburn Hall Hospital, Dunedin. Although he gives us his clinical advice, with one or two exceptions he refrains from using his patients' clinical material, possibly to retain anonymity. Instead, he turns to the work of writers or of their biographers where, for example, in addressing Kohut's theory of the bi-polar self he draws on recent biographies of Bernard Shaw and Oscar Wilde to illustrate self-realisation at the idealising and mirroring poles respectively. This is interesting, but it is tantalising for the clinician, because we are denied some of the nuts and bolts of day to day interchange between patient and therapist which does so much to explicate a theory.

However, another reason for Dr Bragan's drawing on the experience of writers is his interest in the relationship between creativity and the Self. He has thought a lot about the New Zealand novelist Janet Frame, who had been misdiagnosed as schizophrenic and spent many years at Ashburn Hall Hospital. He came to New Zealand too late to treat her. However, in describing conditions on the wards at the time of his arrival he says of her, 'this person had experienced the most dehumanizing and destructive social conditions imaginable over long periods of time and not been emotionally and spiritually destroyed by the experience. How could she have survived the ordeal, how was her spirit not destroyed, and how could she subsequently have found the mental strength and generosity of spirit to write so well about her experiences? These were the questions to which there seemed no easy answer and from which my journey started.' (p. 94)

There is a second, implicit question in this context which is salutary. If we are aware in theory, and from experience, of optimal conditions for healthy development, for instance as set out in the observations of Stern and in the reconstructive work of Kohut, there is an equivalence in the provision of treatment and a treatment setting. Equally, treatment can echo all that is most hideous in some primary experiences. Although the intricacies of it may vary, core damage to the Self, in or out of treatment, seems to stem from the illicit exercise of power and failures of empathy and reciprocity. Thus, Janet Frame's experiences, which evoked the question whence Dr Bragan's journey started, seem also to have contributed to his commitment to repairing treatment, and it may be one reason why this book is often moving.

He finds the clues 'to the survival of Janet Frame's mind and spirit' first in the title of one of her autobiographical books, *Envoy From Mirror City*, a metaphor for the inner world of the Self in relation to its self objects. In her case it was a benign inner space which she could preserve as her sanctuary when in hospital. This was created by the richness and security of her early years, initially in the country. Then, he considers her capacity for repair as rooted in her capacity to grieve and to 'confront death unambiguously.' As an adolescent Janet Frame had suffered the death of two sisters by drowning. In wonderful images drawn from her books Dr Bragan expands on his belief in the importance of grief in the growth of the self.

At this point he asks about the relationship between the Self, creativity and spirit and this calls for some attempts at definition. For him, Self carries a sense of agency as a result of good internalised self-object experiences. Spirit has the quality not only of agency but of a

creative engagement with the world, both in the revelation of what is real and with a sense of oneself and everything else being part of the flow of the universe. He thinks it was this creative contact with her surroundings and in her capacity to sustain the tensions between the poles of death and life, which enabled Janet Frame to write about her fellow patients despite the conditions she was living under.

Dr Bragan draws parallels with Wordsworth and with D.H. Lawrence both of whom in childhood had a profound love of and connection with landscape. It could also be said that children, later grown ups, blessed both with secure families and the opportunity to be let loose, naturally experience this sense of connection with their environment. It is active, shared with peers, challenging, dangerous at times, involving all of the senses, known in its dark and light aspects, and known at rest. This landscape is not simply a symbol of the mother, it also has nurtured the child. It is this active Self in reciprocal relationship with others and with environment which fosters a sense of universality. It is what D.H. Lawrence is naming when he says of the vital self, 'I am'.

Increasingly people come to us, not with this certainty, but with terror of their own emptiness, saying, 'There is nothing inside'. Dr Bragan places himself with Kohut and Winnicott in believing that it is the real, empathic presence of the psychotherapist which is the ground of healing. But given his emphasis on the ground of spirit and creativity being also in the wider environment, perhaps there is a covert question. In psychotherapy we can attempt to repair failures at the hands of the family; but in a world where political and environmental damage is on an inhuman scale, where in some cities it is too dangerous for children to walk unaccompanied to school, let alone live wild, where in this world about them, will they find a place to stop and look, see things with utter clarity, discover a sense of connectedness and of agency, find the independence to say, 'I am I'?

JANE BUCKLEY

Narcissistic Wounds: Clinical Perspectives

Edited by Judy Cooper and Nilda Maxwell. Whurr Publishers, London. 163 pp. p/b £14.95

Narcissism is arguably the single most important discovery of psychoanalytic research of the past fifty years. We have progressed in our

understanding from narcissism as a developmental, objectless stage of early infancy to an awareness of narcissism as a crucial and generally pathological feature of all personalities; pathological, because it is fundamentally opposed to an awareness of need and the need for object-relating. It has been described as the most conservative force in the organization of the personality, in that it is opposed to change, and, therefore, to the psychoanalytic work. We now know that if a patient's narcissism has not been analysed, then our work remains superficial, or is undone.

We have also come to recognize that certain patients, in whom narcissism exists both to a marked degree and as an organizing structure to their personality, present a significant technical challenge to us as psychotherapists. In a sense, theory has progressed ahead of technique, and we are still struggling to know how to translate our advances in theoretical understanding into ways of working with our patient's narcissism which is helpful in practice.

This volume, as its title indicates, focuses on the clinical aspects of narcissism. After a short Overview, which summarises the important theoretical and clinical literature, the bulk of the book is divided into two main sections. Narcissism in the Life Cycle contains chapters on infancy, adolescence, couples, childbearing, ageing and bereavement. Clinical Aspects of Narcissism contains clinical papers describing the role of narcissistic modes of relating in the psychoanalytic treatment of schizoid, perverse and addicted patients.

Rather than describe each of the thirteen papers in this volume in turn, I would prefer to single out three contributions which I found especially rich, detailed and helpful. Maria Pozzi describes her work with two child patients in whom the seeds of a likely development along narcissistic lines was evident. In both cases, she argues, the origins of this could be seen within the relationship to mother, and to a *joint* inability to properly achieve separation, often because of mother's own difficulty in facing the ensuing depressive pain. Further compounding the problem is the absence of a true oedipal configuration – that is, a father who can help both mother and child out of a stuck relationship. The child is used narcissistically to cure mother of pain and vulnerability – and often the threat of clinical depression – with the consequence that such a child cannot develop a true sense of self, but rather a grandiose sense of existing *for* mother and being able to eternally possess her. This discussion of the origins of narcissism may not be new to us, but it is certainly refreshing to see it arising out of direct clinical observation.

Stanley Ruszczynski also relates narcissism to the problem of separation and separateness in his chapter on narcissistic relating within the couple. This form of relating, in which the object is seen to exist solely as the recipient of the self's unwanted, split-off, projected parts, is contrasted with more mature modes of relating, in which there is some capacity to allow the other to exist as a separate entity, and to tolerate the conflict, envy and helplessness which this arouses. It is emphasized that both modes of relating are ends of a continuum rather than discretely different states, and can be 'mapped' onto the paranoid schizoid – depressive continuum. A session with a couple is described, which clearly demonstrates the way in which confusion and conflict are projected into the partner, and into the psychotherapist, so as to preserve narcissistic self-reliance and psychic equilibrium. As with an individual's psychic organization, such an equilibrium is fragile at best, and only achieved at the cost of considerable strain on both the object and the relationship.

David Morgan discusses the role of narcissism in the perversions, and argues that the perversions 'are a physical expression of severe pathological narcissism where the aim of the behaviour is to destroy any knowledge of the need for the other'. He emphasizes the importance of aggression, and 'the enormous hostility against any awareness that life and goodness lie outside the self'. Further, what is hated is not only the presence of goodness in the other, but more primarily the need for it in the self. A case of a transexual man is used to illustrate these features of narcissism, as well as the fundamental difficulty of how to make meaningful contact through the provision of understanding, when the patient seems to believe that such understanding is already within his possession. At one point the psychotherapist interprets to the patient (who worked as a counsellor) that 'one way of dealing with his own confusion was somehow to become an expert in helping other people with theirs'. I was struck by this comment, because it captured the projective processes at the heart of narcissistic functioning, as well as the act of possession or take-over of the analytic capacity, and demonstrated one way in which this could be shown to the patient. This chapter reminds us about narcissism *in extremis*, as a version of psychotic functioning.

Another reader of this book would doubtless choose different papers to commend from those which I have described; there is sufficient variety of focus and orientation to interest any reader with a concern for the subject of narcissism. Overall, such a volume is inevitably rather a 'mixed bag', and the contributions vary in quality. Useful

clinical insights exist side by side with unhelpful generalizations and occasional wild assertions (eg 'schizoids never stop complaining'). I would have liked more about the technical difficulties of reaching narcissistic patients with understanding, of the place of narcissism in clinical states such as depression and psychosis, and the important issue of recognizing narcissistic functioning in ourselves as psychotherapists, and how this impedes our work.

Now that we have 'discovered' narcissism, we have an obligation to think about it with a greater degree of scientific precision than we perhaps do at present. How malignant and/or hidden is it? What fundamental anxieties does it serve to keep at bay? *Whose* narcissism is it? How does narcissism differ from related states such as schizoid and borderline personality organizations? This collection of papers is a positive contribution to that necessary quest for greater clarity and precision.

NOEL HESS

Michael Fordham: Innovations in Analytical Psychology

By James Astor, Routledge 1995. pp. 271 h/b £37.50 p/b £13.99

Michael Fordham died on April 14th 1995 in his ninetieth year and shortly before this book was published. It is dedicated to him.

Biographical detail gives the reader insight into Fordham's character, his relationship with Jung, and into his intense interest in the concept of the self. There is a bibliography of Fordham's published works compiled by Roger Hobdell.

The weight of this book lies in James Astor's exposition of Fordham's theoretical and clinical work, including chapters on transference and countertransference, and his discussion of how this work is of significance to analytical psychology.

A section on Jung and Freud, and Chapter 3 *Jung and Fordham*, enable the reader to understand the historical background. Fordham believed Jung's work to be complementary to Freud's rather than in opposition to it and he regarded the results of the estrangement of the two men as 'a disaster'. In Chapter 2 Astor describes *Jung's Psychological Model* and Chapters 4–12 each focus on an aspect of Fordham's work and are constructed to illustrate how his ideas developed out of Jung's formulations. The reader is thus able to follow the

progression of the work, having its origins in mind and able to understand how these ideas are innovations in analytical psychology.

Astor stresses that Jung's way of thinking about the self was unlike other models which have used the term to denote a 'self' feeling, a function of the ego and of consciousness. Jung's use of the term embraced both conscious and unconscious and represented the totality of the person. Astor writes on the various ways in which Jung used the term and concludes: 'it is possible to arrive at a self which is both ultimately mysterious and yet manifests itself in the life of an individual in ways which form the basis of personal identity'. For most of his life Jung had described individuation of the self as a process occurring in the second half of life. His view of the aims and goals of childhood and young adulthood was that they were those of adaptation and strengthening the ego. Fordham, working as a child psychiatrist and deeply interested in the theories of Jung and in the work of psychoanalysts, discovered processes in children which he thought could not be described in terms of ego development alone but which seemed to him to be actions of the self. In chapter 4 *The self in infancy and childhood: Pioneering discoveries*, chapter 5 *Ego development in infancy and childhood: The integration of observational research*, and chapter 6 *Archetypes their biological basis and actions of the self*, Astor describes and discusses the gradual development of Fordham's theory of a primary self. He summarises Fordham's model as 'having two tiers; the first a primary self similar to the DNA model which cannot be experienced but must be inferred, and the second deintegrative and reintegrative activities which bring it into contact with the earliest environment and this initiates a process which leads to the structuring of mind'. Fordham used Bion's language to describe these early processes, thus the first deintegrates may be understood as equivalent to the undigested data of a beta element, and a successful reintegrative experience equivalent to the effect of the maternal reverie and alpha function. Astor writes: 'He thinks of the mind structuring itself through the digesting of experience, at first through the activity of the self, then the archetypes, later through the activity of the ego. Additionally what Fordham proposed is that the baby in its sensuous and physical being has the potential to generate the mental equivalent of physical experiences, rudimentary thoughts which can later be used for thinking as the ego develops.'

Fordham's drive towards investigation is clear throughout this book. Astor describes him as having been 'true to the spirit of Jung' in working empirically and in discarding theories when the clinical or

observational evidence suggested something else. His study of the work of Freud and Klein had convinced Fordham of the value of demonstrating how he arrived at his conclusions. He wrote more directly of his experiences than did Jung, thus there is much clinical detail in these pages. An example of a significant gap in Jung's published works became apparent when in 1946 the Society of Analytical Psychology was started. Fordham and a group of analysts wanted to create a Jungian training in London, which could be independent of the Zurich institute founded by some of Jung's followers. Although Jung had long been interested in transference he had written little that was clinically descriptive and which would enable trainee analysts to develop in this area. Jung's attitude to technique was that it was something which 'did violence to the individual nature of the analytic process' and some of his followers were concerned that revealing what they did would be a 'violation of the patient's individuality'. Fordham wanted to open up what actually happened between analyst and patient in the consulting room. He began his writings on transference in 1957.

In chapter 8 *The discovery of the syntonic transference and the importance of analysing childhood*, chapter 9 *Countertransference, interaction and not knowing beforehand* and chapter 10 *Defences of the self, projective identification and identity*, Astor discusses Fordham's researches into transference and technique. Jung had stressed the 'prospective' nature of the unconscious, partly, Astor suggests to distinguish his approach from Freud's for 'historical reasons'. He used the term 'the actual situation'. Fordham reinterpreted this in a way that psychoanalysts and analytical psychologists understand today, as there being 'still active' historical elements in the present. In practice Fordham discovered Jung's method of active imagination and amplification did not prevent occurrences of delusional transference. As a child psychiatrist he was well aware of the inevitability and archetypal nature of transference, the child projected a parental figure on to the doctor and the child in the adult similarly. His experience of child analysis and of Jung's amplification method brought Fordham to a position which Astor describes as 'similar to Jung's later teleological approach to analysis with adults, but which included the analysis of childhood'. He was deeply influenced by Jung's ideas on the importance of the analyst's total engagement in the analytic process and his capacity to be in touch with his own unconscious. While Jung thought that an interpretation should be created anew from the analyst's unconscious for each patient, Fordham thought rather for each interview. He proposed the term 'syntonic transference/countertransference' for the

experience evoked by patients' projections and he distinguished this from a 'countertransference illusion', which he understood as a situation requiring further understanding by the analyst of himself. Later he was to discard this theory as his understanding of projective mechanisms grew. In 1974 he wrote 'Defences of the self' which Astor describes as 'a springboard for analytical psychologists to study projective identification while remaining true to Jung's individual psychology'. This paper was highly significant because here Fordham was bringing together the analysis of delusional transference in adult patients with his studies of infancy. He illustrated what happened when a deintegrate of the self became split off and distorted. Fordham's understanding was that the patient's delusion contained archetypal forms 'which were aimed at establishing relatedness'. His conclusions about technique in these instances are of immense value to all practitioners. He stressed that the analyst must retain his analytic attitude at all costs, that he must not give in to guilt. He believed that the patient's pain and struggle represented the will to live and his attempt to relate, albeit in a malignant form. This is an important book for analytical psychologists. It places contemporary Jungian thinking in the transference, in the consulting room, and it has something to say to psychoanalysts.

Throughout the book Astor stresses Fordham's loyalty to Jung's ideas but also his openness to the work of and dialogue with psychoanalysts. When Fordham described the effect of the split between Jung and Freud as 'a disaster' he also called it 'in part an illusion'. It seems to me that Astor's book does some essential things. It illustrates how Fordham filled some of the gaps left by Jung. It links Fordham's model of infant development with the ideas of post-Kleinian thinkers, particularly Bion and Meltzer. It shows how Fordham developed his ideas from within Jung's formulations, modifying them when the evidence demanded to make available to analytical psychologists a body of clinically and observationally based work which describes a theory of the self throughout the life of an individual.

PATRICIA ALLEN

Publications received

BRAMLEY, WYN. *The Broad Spectrum Psychotherapist.* 1996 Free Association Books 212pp p/b £15.95

CARTER, ROBERT T. *Race and Racial Identity in Psychotherapy.* 1995 Wiley 312pp h/b £29.95

FURMAN, ERNA (ed) *Preschoolers: Questions and Answers.* 1995 International Universities Press, Inc. 204pp h/b £31.50

JEFFREY, CAROL. *That Why Child: Problems in Psychotherapy and Counselling.* 1996 Free Association Books 127pp p/b £13.95

JONES, PHIL. *Drama as Therapy.* 1995 Routledge 326pp h/b £45 p/b £15.99

KAHR, BRETT. *D. W. Winnicott: A Biographical Portrait.* 1996 Karnac Books 189pp p/b £17.95

LANGS, ROBERT. *The Evolution of the Emotion-Processing Mind* 1996 Karnac Books 223pp p/b £18.95

LUKE, HELEN M. *The Way of Woman.* 1996 Gill & Macmillan 202pp p/b £8.99

MAHRER, ALVIN R. *The Complete Guide to Experiential Psychotherapy.* 1996 Wiley 412pp h/b £45

MULLEN, BOB (ed) *Therapists on Therapy.* 1996 Free Association Books 402pp p/b £15.95

NITSUN, MORRIS. *The Anti-Group.* 1996 Routledge 318pp h/b £50 p/b £16.99

PARK, JAMES. *Sons, Mothers and other Lovers.* 1996 Abacus 239pp p/b £7.99

RUSSELL DAVIS, DEREK. *Scenes of Madness: A Psychiatrist in the Theatre.* 1995 Routledge 204pp p/b £14.99

SANDLER, JOSEPH & DREHER, ANNA URSULA. *What do Psychoanalysts Want?* 1995 Routledge 141pp h/b £37.50 p/b £13.99

SOURKES, BARBARA M. *Armfuls of Time.* 1996 Routledge 187pp h/b £45 p/b £14.99

SUTTON, NINA. *Bruno Bettelheim: The Other Side of Madness.* 1995 Duckworth 524pp p/b £20

SYMINGTON, JOAN & NEVILLE. *The Clinical Thinking of Wilfrid Bion.* 1996 Routledge 197pp h/b £40 p/b £13.99

TROWELL, JUDITH & BOWER, MARION (eds). *The Emotional Needs of Young Children and their Families* 1996 Routledge 299pp p/b £14.99

The Institute of Group Analysis
1 Daleham Gardens London NW3 5BY Tel: 0171 431 2693
(in association with the International Attachment Network)

FROM ATTACHMENT THEORY TO DEVELOPMENTAL PSYCHOPATHOLOGY

A course of Seminars:
12 evening seminars held on Tuesdays from 8.30 pm to 10.15 pm from 24th September to 17th December 1996. Chair: Tirril Harris and Felicity de Zulueta

14 September	Richard Powlby and Mario Marrone: Introduction to attachment theory.
1 October	Juliet Hopkins: The biological basis of attachment theory: infancy, instinct and defense.
8 October	Hans Cohn and Nicola Diamond: The philosophical basis of attachment theory: attachment, intersubjectivism and the nature of Man's being-in-the-world.
15 October	Joan Raphael-Leff: Attachment theory in the context of contemporary psychoanalytic thinking.
22 October	Earl Hopper: Attachment and socio-cultural context.
5 November	Lisa Crandell and Peter Hobson: From attachment theory to developmental psychopathology.
12 November	Tirril Harris: Attachment styles among adults.
19 November	Felicity de Zulueta: Violence when attachment goes wrong.
3 December	Valerie Sinason: Memories of abuse.
10 December	Mario Marrone: Applications of attachment theory to psychoanalytic therapy and group analysis.
17 December	Discussion, integration, conclusions.

Workshop:
A whole-day workshop to be held on Saturday 14th December 1996 from 9.45 am to 1.00 pm and from 2.15 pm to 5.00 pm. This workshop will look at recent developments in the understanding of attachment representations and intergenerational transmission of insecure attachment. The morning session will be conducted by **Peter Fonagy**, **Howard Steele** and **Miriam Steele** and will consist of a theoretical presentation illustrated with videos and slides. The afternoon session will be conducted by **Mario Marrone** and **Felicity de Zulueta** and will have an experiential component. Participants will be encouraged to explore key issues of their attachment histories in a group-analytic setting.

The International Attachment Network is a group of psychoanalysts, group analysts, psychotherapists, psychiatrists and mental health workers from England and Spain, which has been recently formed for the purpose of promoting the study of John Bowlby's work, recent developments in attachment theory and research and their applications to clinical practice and prevention in mental health. The annual membership fee is £25.00. Members meet once a month (on a Wednesday evening) for an informal presentation, often illustrated with video material and followed by discussions. Enquiries should be addressed in writing to Dr Mario Marrone, 75 Minster Mews, Minster Road, London NW2 3SJ.

All seminars and meetings (except the Saturday workshop) will be held at 11 Bedford Square, London WC1 (University of London).

PSYCHOANALYTIC PSYCHOTHERAPY

Journal of the Association for Psychoanalytic Psychotherapy in the National Health Service

A·P·P

The areas covered in original articles include the application of psychoanalytic ideas in institutions, audit and evaluation of services, clinical work with adults and children, theoretical formulations and training matters.

Contributors to the journal include psychoanalytic psychotherapists, psychoanalysts and child psychotherapists, from the UK and from the rest of Europe. Most work in the public sector in Health, Education or Social Services, and some are in full-time psychoanalytic practice. A comprehensive Book Review section complements the wide range of subjects included.

Members and Associate Members of the APP receive the Journal automatically. For other subscribers the rates are as follows: Individuals £24 for three issues; Institutions £30 for three issues; Single issues £9. Cheques should be made payable to **Psychoanalytic Psychotherapy.** Or use your credit-card to telephone your order.

The journal welcomes submissions in the form of original articles, clinical reports and theoretical papers as well as book reviews concerned with psychoanalytic psychotherapy. These should be submitted in quadruplicate, typed in double spacing on one side only and with wide margins. A copy should be retained by the author as submitted copies will not be returned.

All enquiries, subscriptions and manuscripts should be sent to:

Psychoanalytic Psychotherapy
24 Middleton Road
London E8 4BS Tel: 0171-241 3696

NOTES FOR CONTRIBUTORS

Papers, particularly from Members of the Association, are welcomed and should be sent to the Editor, Midge Stumpfl, 21 Cantelowes Road, London NW1 9XR and books for review to Ruth Berkowitz, 18 Kensington Park Road, London W11 3BU.

Manuscripts should be typed in double spacing on one side of the paper only and be submitted in duplicate. The maximum length of any one contribution is normally 7000 words. The Editor reserves the right to edit all contributions.

Each author must confirm in writing to the Editor before a contribution is accepted for publication that:

a. publication does not involve any breach of confidentiality or professional ethics, and

b. publication does not infringe the copyright of any person and

c. he/she indemnifies the BAP in respect of any claim arising from publication of the material, and

d. he/she is submitting the material on the terms set out on the inside front and back covers of the Journal.

REFERENCES

An important responsibility of the author is the preparation of a correct reference list. In order to be certain that the reference is correct it should be re-checked against an original source. Authors should be listed in alphabetical order. References within articles should indicate the surname of the author followed by the date of publication in brackets, *e.g.* (Khan, 1972), References should include authors' names and initials, the date of publication in brackets, the full title of the article, Journal and the volume number or page reference, or for books with the title underlined (italicized) and the place of publication and the name of the publisher given, *e.g.*:

James, H.M. (1960) Premature ego development: some observations upon disturbances in the first three months of life. *Int. J. Psychoanal*, 41: 288–295.
Winnicott, D.W. (1971) *Playing and Reality*. London: Tavistock.

For further details of grammatical, punctuation style and spelling conventions, please consult a member of the editorial board.

Printed by The Charlesworth Group, Huddersfield, UK, 01484 517077

ISSN 0954-0350