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Subscription Enquiries:

Judith Lawrence, Secretary, 121 Hendon Lane, London, N3 3PR

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BOOK REVIEWS

UNCONSCIOUS PHANTASY AND ARCHETYPE – a suitable case for rapprochement?

Hester McFarland Solomon

> Hearing psycho-analytic controversy I have felt that the same configuration was being described and that the apparent differences were more often accidental than intrinsic; different points of view are believed to be significant of membership of a group, not of a scientific experience.
>
> Bion – *"Attention and Interpretation"*

It is a truism that since the first researches in psychoanalysis, the analytic frontier has been pushed increasingly back in psychological time. In the first wave, Freud focused his interest at around 4-5 years, at the Oedipal level. Along with his own self-analysis which had much to do with the relationship with his (by then) dead father, Freud arrived at his one essential mythologem of the killing of the father/king by the son(s) in order to gain access to the mother, and the ingesting of the king as an act of conciliation and identification. By definition, in working primarily with neurotic adult patients, Freud treated essentially a group of patients who would have already negotiated, more or less successfully, the pre-Oedipal in order to have achieved the Oedipal phase of development. It was totally appropriate that he should have concentrated on a psychological system relevant to that stage.

The second wave, so to speak, that pushed back the investigation through psychological time belongs to two apparently different, and (in some minds) antipathetic groups – the Kleinians and the Jungians. Klein's observations were founded primarily on the clinical observation of the pre-Oedipal child, including observations of her own children, and this constituted the basis of her theory building. Jung based his observations primarily on psychotic patients, and this became the area of his major investigations, which he further elaborated through his own self-analysis, exploring psychotic aspects of his psyche. My thesis is that the Kleinian construct of unconscious phantasy, and the Jungian construct of the archetypes of the collective unconscious relate to equivalent areas of the psyche.

Klein in her work with the pre-Oedipal child and Jung in his work with psychotic adults, were investigating essentially the same area of the psyche – that which had not yet reached the Oedipal stage of development. Furthermore, they arrived at essentially similar findings, albeit couched

in different terminology. Both theoreticians proposed the existence of innate psychological structures which directly link up to, and serve as vehicles for the expression of, the earliest biological and instinctual experiences of the infant. The experience of these innate structures are mediated by real experiences with the real environment. It follows that a conceptual rapprochement between certain areas of work within each group is possible.

Both Klein and Jung took as given the absolute reality of the inner world, first and foremost. Melanie Klein wrote:

> My hypothesis is that the infant has an innate unconscious awareness of the existence of the mother. We know that young animals at once turn to the mother and find their food from her. The human animal is not different in that respect, and this instinctual knowledge is the basis for the infant's primal relation to the mother. (Klein, 1959)

This exemplifies Klein's ideas of the internal object which pre-exists the experience of the real mother, but which will be mediated by the experience of the real mother.

For Klein and Jung, the quality of the experience of the contents of this inner world would depend on actual experiences of external reality as they filtered through and interacted with the innate structures that were already there. Moreover, for both, these innate structures were intimately linked to the instincts.

Susan Isaacs, a follower of Klein, made a useful distinction between phantasy written with a ph or an f (Isaacs, 1948). Fantasy is a daydream available to consciousness. Phantasy however is an unconscious process. "Phantasy may be considered the psychoanalytic representative or the mental correlate, the mental expression of instincts." (Ibid.) Hannah Segal has written:

> The "ideas" representing the instincts will be the original primitive phantasies. The operation of an instinct is expressed and represented in mental life by the phantasy of the satisfaction of that instinct by an appropriate object. Since instincts operate from birth, some crude phantasy life can be assumed as existing from birth. The first hunger and the instinctual stirring to satisfy that hunger are accompanied by the phantasy of an object capable of satisfying that hunger. As phantasies derive directly from instincts on the borderline between the somatic and psychical activity, these original phantasies are experienced as somatic as well as mental phenomena. (Segal, 1964a)

All this is very familiar to analytical psychologists. Just as the Kleinian pre-Oedipal unconscious exists as a container full of the contents of unconscious phantasies, so Jung's concept of the collective unconscious,

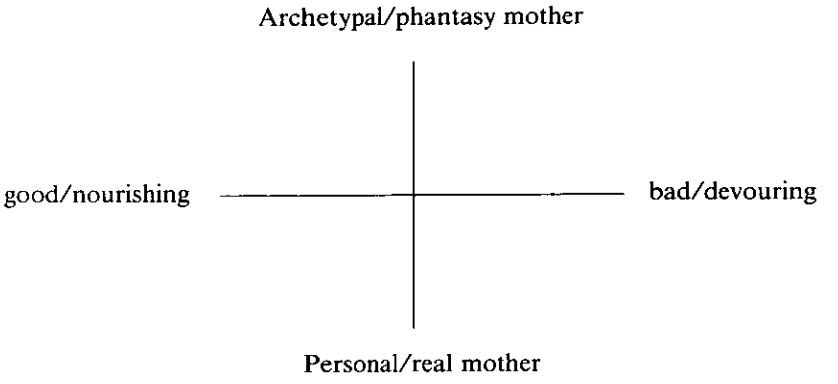
pre-dating the personal unconscious, is a container for the archetypal images that are the psychological representations of the instinctual urges. Archetypes are pre-personal, but just like the internal objects that populate the infant's unconscious phantasies, they are mediated by personal experience. Archetypes are inherited structures which get fleshed out with personal imagery, ideas, motifs, subject to early environmental and, later, to cultural influences. Jung wrote (1936):

> The instincts form very close analogues to the archetypes – so close, in fact, that there is good reason for supposing that the archetypes are the unconscious images of the instincts themselves; in other words they are patterns of instinctive behaviour. The hypothesis of the collective unconscious is, therefore, no more daring than to assume that there are instincts.

Both concepts – archetypes and unconscious phantasy – can be related to concepts developed by ethologists concerning the ordering of the animal's inner life by I.R.M.s. – innate releasing mechanisms – that trigger already imprinted responses – chicks emerging from eggs when it is time to be born, birds building nests when it is time to mate, the infant seeking out the breast when it is time to feed. The notion of archetypal structures in the psyche implies a readiness to experience life along broad lines already laid down over ages, the earliest being that of the dependent baby and its mother. Both Bowlby (1969), a psychoanalyst, and Stevens (1982), a writer on analytical psychology, point out that genetically programmed behaviours are taking place in the psychological relationship between mother and baby. The baby's helplessness and dependency, coupled with its immense repertoire of sign stimuli and approach behaviour, trigger appropriate maternal responses. Similarly, the smell, sound and shape of the mother trigger, for instance, a feeding response in the infant. All this is instinctually and biologically sound and has to do with basic survival. Jung called the archetypal image a "self portrait of the instinct" – mind giving mental expression to body, thereby helping body to behave as it is programmed to do. Susan Isaacs wrote "there is no impulse, no instinctive urge or response which is not experienced as unconscious phantasy" (Isaacs, op. cit., p. 83).

The idea of the opposites and of bipolarity pertain both to the notion of the archetypes and to that of unconscious phantasy. Just as Kleinians talk about good and bad breasts as polarizations of the quality of the mothering experience, so Jungians speak of the good (nourishing) mother and the bad (devouring) mother. Similarly, for both there is the experience of the real mother and of the archetypal/phantasied mother. Thus it is possible to construct a matrix for the use of both groups which would have on its horizontal axis the attributes good/nourishing vs bad/devouring and on the vertical axis objects (either part of whole) – the personal/real

mother vs the archetypal/phantasied mother. This would make sense to both Jungians and Kleinians.



Michael Fordham's (1955) elegant construct of the deintegration-reintegration process in the early infantile psyche provides an explanation of the movement between these bipolar experiences.

Furthermore, there is a sense in which we could say that the pivot of the disagreement between Freud and Jung revolved around how literally to take analytical material concerning parental intercourse. It would seem that some of the heat would be taken out of the argument once we take into account the very real differences between Freud's oedipal patients and Jung's pre-oedipal (psychotic) patients. Freud largely insisted on the literalness of the primal scene, and this may to some extent be explained by the fact that ego development of a child of 4-5 years is capable of dealing with whole objects by the time he reaches this stage. Jung however considered that certain primal phantasies of adult patients did not arise from real childhood experiences, but were better conceived of as projected into what are experienced as memories from childhood. The sources of these projected "memories" are the archetypal images of the collective unconscious, images of, for example, the anima and animus in coniunctio. It is interesting to note, in this context, that Freud left scope for developing ideas about adult phantasies of the primal scene. In 1916 he wrote:

> There can be no doubt that the source of the fantasies lie in the instincts ... I believe that primal fantasies ... are a phylogenetic endowment ... that the psychology of the neuroses has stored up in it more of the antiquities of human development than any other source.

In terms of the present discussion, we can place Melanie Klein at the archetypal side of the argument. For Klein, the infant's phantasy is of the parents as being in an almost continuous state of intercourse. In Hannah

Segal's words, "The infant will phantasy his parents as exchanging gratifications, oral, urethral, anal or genital, according to the prevalence of his own impulses ... This gives rise to feelings of the most acute deprivation, jealousy and envy, since the parents are perceived as giving each other precisely those gratifications which the infant wishes for himself." (Segal, 1964b).

The phantasy of the continuously gratifying parental couple – or its opposite, the phantasy of the coupling parents locked in desperate and mutually attacking sadistic embrace – are themselves projections of what is happening at the breast or anus. In other words instinctual body sensations and the phantasies to which they give rise are in turn applied to the unconscious phantasy of the archetype of the coupling parents, the parents in bed. Andrew Samuels points out that in this system, as in the archetypal one, image creates image. I would elaborate this to include the idea that in large part the work of reconstruction is about taking a history of image building. As Samuels points out, in the image of the parents in bed there is room not only for the image of the warring and/or self-gratifying parental coupling, both images leaving only negative affective precipitates of exclusion, terrifying the infant. There is also room for a unifying, containing and mediating image, that of the union of opposites, signalling the potential within the infant for future psychic integration.

It is likely that an explantion of the old truism that Jungians tend to emphasize the positive aspects, and Kleinians the negative aspects of the same experience, lies in the fact that Klein pursued the notion of aggression as a manifestation of the death instinct, whereas Jung and his followers elaborated a model of the archetypes in their various forms based on a teleological notion of the appropriateness of gradual separation and individuation, a development which could be served by anger and aggression without being ultimately destructive of the forward moving aspects.

In this paper, I have tried to show an important way in which the theory building of a psycho-analyst and an analytical psychologist – of different backgrounds and with different types of patients – and apparently different theoretical constructs with which to describe them – may be integrated by a careful examination of the underlying meaning of those constructs. It is as necessary to recognise differences between analytic approaches when they really exist as it is to attempt to dispel apparent differences when these are not truly there. To choose not to do this work serves badly our professional societies and the students towards whom we have major responsibilities.

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DISSOCIATED STATES IN A BORDERLINE PATIENT

Joan Burnett

Referral

I first met Sharon when I was working for an agency. She was then 31 years of age and had been referred by a pregnancy advisory service after a termination because she was depressed. I saw her weekly for eighteen months and in that time the depression receded and the tenor of her daily life became more even. There were, however, deep-rooted problems. I discussed this with her and as a result she began psychotherapy with a man. Almost three years later I received a letter from her, forwarded by the agency for which I was no longer working. She wrote that she had married six months previously and "I now find that I am tearing the relationship to pieces, in more or less the same way as I used to do before coming to see you ... my behaviour is compulsively destructive. In accordance with the old pattern there is a strong possibility that I am now pregnant ... I am very frightened by this business". She asked whether she might see me privately. When we met I learned from her that psychotherapy had ended after two terms: she gave her falling to sleep during the sessions as a reason for this. She started in twice-weekly therapy with me, after one term stepping up to three times a week for a period of just over two years. Then she started a new job and her sessions were reduced to once-weekly and continued for a further year. She was then 38 years old.

Brief History

During her first two and a half years, Sharon lived with her parents in a flat below that of the paternal grandparents. Her care was shared with the paternal grandmother and she is reputed to have been a happy child in those years. However grandmother disapproved of mother, whom she accused of neglecting Sharon. There was talk of Sharon being adopted by an aunt. When her parents moved out of London, Sharon of course lost her daily contact with grandmother. Two years later a brother was born and since Sharon was then 4 years 7 months she would have started school about then. Mother was probably under stress during or after that pregnancy because she ran away from home for a few hours, leaving Sharon in the house with a verbal message for father and a note. This was an occasion when Sharon exhibited the dissociation and denial which were to arise frequently during her therapy. She remembers playing calmly while her mother left the message with her. When father came home she considered his intention to follow mother to the railway station and bring her home

was quite unnecessary. She and father could manage perfectly well without mother. This they had to do when Sharon was 7 years, when mother contracted TB and was hospitalised for eighteen months or more and the children were not allowed to visit her. The paternal grandmother came to look after them. Sharon has no memory of mother going into hospital. Her brother is amazed this should be so; three years old at the time, he remembers the drama clearly. The teenage years were very stormy. The good relation Sharon had with father during childhood was shattered and she seems to have been virtually out of control. There were fights with father who could not cope and once took her to the police station, vowing to have her made a ward of court. There was also a suicide attempt at 13 years – an overdose of aspirin in response to "something which father did": another instance of an unremembered drama. It was father who took her to hospital. By the time she was 18 years she was engaged. When she became pregnant she broke off the engagement. Her parents adopted the son and Sharon took up the college place she had been offered. During her first year she describes herself as having broken down and she stayed in bed all day. She left her college and read for a degree in Physics at a polytechnic. In the following ten years, prior to my first seeing her at the agency, she had a number of relationships with men, one of which lasted six years. During this time, when she was 23 years old, her parents had emigrated, taking her son with them. The parents returned on a visit nine months before she came to see me the second time – for psychotherapy. It was during their visit that she met Bill and was married to him within six weeks.

Patient's Circumstances before and during Therapy

Sharon started sessions with me at the beginning of a summer term. At that time she was a lecturer and owned the flat in which she and her husband lived. He was a skilled tradesman and had formerly lived in digs. Sharon was in process of selling her flat and buying a house. She planned to give up her job and spend two years in full-time study for another degree. Although she had some financial resources to underpin this plan, she would be dependent also on her husband being in work. In the event she barely started the course. By the autumn she was in too poorly a state to study and it was to be a further two years before she was capable of taking a full-time job again. During those autumn months the marriage was stormy and violent. There were brawls, a suicide gesture on her part and calls on the police to mediate. Just before Christmas Sharon obtained an injunction forbidding her husband to enter the house. Despite this Sharon was not psychologically able to separate from Bill and invited him to return after Christmas. It was to be a further twelve months before she could

leave Bill. Six months later she had repossessed her house and obtained a divorce. She started a new full time job the other side of London and a part-time course of study. I could not offer new session times to fit her timetable and money had become a problem after two years out of work and since now there was only one income on which to live and pay off debts on the house. She cut down to once a week for a year and then, when her timetable changed once again, the therapy ended.

Sharon's history and the course of events in the time she was in therapy with me give a graphic picture of a state in which, as I shall illustrate, her rational functioning was severely weakened by the primitive defence mechanisms of wholesale identification, projection, projective identification, splitting, dissociation, idealisation and denial. Consequently the patient's significant relationships were disrupted by the intrusion of dissociated memories, fantasies and introjections. Her perception of external reality was seriously distorted, her life lacked direction and ordinary hopeful planning was absent.

Her pregnancies, one ending in adoption, others in abortions, follow both the history and the characteristics of the mother who did not like babies. In her early years it had been suggested that Sharon be adopted by an aunt who would care for her more satisfactorily than mother. Sharon had a baby for whom she could not care as a student and which was adopted by her parents. Mother had pregnancies after the birth of her brother which were aborted – babies being a nuisance, interfering with working life. Similarly, Sharon several times allowed herself to become pregnant and arranged abortions in order that she could continue to work. She never became pregnant in her marriage with Bill, but arguments about the idea came up in sessions, with complains that the care of children in unfairly left to the woman. Sharon refused to embark on motherhood unless she had a cast-iron certainty that her husband would do 50 per cent of the work. Once Sharon visited a friend whose children left their orange-peel on the table instead of throwing it away. This incident led to thoughts about children encroaching upon the life space and time of the mother to an intolerable degree. Sharon was speaking as mother, who had so often complained that Sharon had never been anything but a nuisance and a drag on them.

The neglect or abuse of small or helpless things was enacted at intervals in Sharon's life. Her childhood memories included ones of pets neglected by her, left to starve for lack of food and warmth. A vivid memory was of taking her cat to be put down. "She" (mother was usually referred to as "She") made her do so because the cat was a nuisance. However, we came to doubt the simplicity of this tale. Mother very likely grumbled about the cat and threatened to have it put down, but she did not compel

Sharon to do so. Sharon projected on to mother her own aggressive feelings and her own neglect of the cat. She then acted in identification with mother and carried the cat to the vet in a dissociated, almost hypnoid state, wondering why she was doing this thing. She did something similar during her sessions with me at the agency. She visited her GP about her depression and was referred by him for a psychiatric consultation. She did not tell me about this. The psychiatrist concerned knew me and perceived her virtual self-referral as 'acting out within the therapy' and referred her back. When I took up the matter with her she said "It's funny, as I was walking up the hospital drive I said to myself "Sharon, just what do you think you are doing?" I underestood of course that I was being complained about to a third person as an unsatisfactory mother and aid invoked.

Since Sharon had not developed the ego capacity to cope with her own aggressive and violent impulses, she habitually attributed these to others. Only fleetingly was she able to acknowledge them as her own. It was at one such frightened time that she wrote asking to come into therapy with me. In the relationship with Bill it seemed that her projective identifications induced hm to behave in such a way that real and fantasy-embroidered historial incidents were re-enacted with him, but with Sharon also in a dissociated state with accompanying amnesia it was impossible to gain a clear picture of the origin and course of the dramatic and dangerous brawls in the marriage.* A small incident will more simply and quickly illustrate the process at work. Sharon telephoned: there was something she must tell me before she forgot it. Beside her sink was one of those tea-towel hooks with a rubber suction pad. Also on the draining-board was a fly. Sharon thought to herself "Bill is just the sort of person who trap that fly under the suction pad – 'wouldn't hurt a fly' – ho, ho, ho!" Some time later she had picked up the pad and found the dead fly under it. She was very shocked that she had done something she could not remember. We also see that she was so fragmented that she could not cope even with the amount of aggression needed to kill a fly. Sharon was right ... by the time of the next session the significance of the incident to her had disappeared and was mentioned in the end by myself. This eradication of events by her conscious mind was something she had to admit to herself, since two trusted women friends had expressed surprise that she could not remember actions which they had observed her perform. She related that her previous therapist had raised with her that they had encountered each

*Footnote: "... it is psychical reality which is the decisive kind" (Freud 1917). The psychotherapeutic task was to seek to enter Sharon's inner world and understand how she felt and perceived these happenings. My own anxiety about the physical dangers this ill woman (and her husband) might be running nevertheless prompted me to try and assess the reality and consequently to suggest certain practical steps to my patient.

other in the street when he was pushing a toddler in a chair. They had come face-to-face. She had no recall of the incident and of course certainly not of any emotion aroused even when he recounted it, though she believed that if he had said it happened then it had. The existence of her brother, with which she was daily confronted, could not be extinguished by such a denial, but instead there was a close identification with him. So close that Sharon believed she always knew what he was thinking – suggesting that the identification verged on a merging which softened the edges of his separate existence. This defence by identification-cum-merger-cum-omnipotent control of brother did not significantly forward Sharon's mastery of three-person relationships which could always threaten her with disintegration, especially if she was unexpectedly presented with them. When Bill returned home one day, accompanied unusually by a male workmate, Sharon became disorientated and ran into the street in a panic, mumbling nursery rhymes to herself. She went into the corner shop to buy cigarettes, thinking to herself that the assistant there knew her and her name and would recognise her. This worked and she recovered some sense of her identity. We may also suppose the cigarettes were important too – giving the sensation of nipple-in-mouth around which the fragmented self could be drawn together. I think Sharon's intercourse with Bill (and previously with other men) was important to her for a similar reason. Sharon was angry that Bill was often impotent. The unpredictability of his erection was disturbing to her: She felt deprived and disorientated when it failed. The sensation of penis in vagina gave the same feeling of security and being held together as did smoking a cigarette.

It will be remembered that before she came into therapy Sharon met and married Bill within six weeks, at a time her parents were visiting from abroad. This precipitate marriage was another dramatic example of acting in identification with mother, reproducing her parents' marriage in the present. To ward off painful affects of exclusion and loss, the pathogenic identifications with her parents were reinforced. A major life choice was made, quite uninfluenced by considerations which a reasonably functioning ego would have brought in. Bill fitted in with her family and its pre-history. He was a working man like her father: he came from a disturbed, chaotic, aggressive and heavy-drinking family – as did her mother. Sharon repeated with her husband the physical fights she had with father, including calls on the police to intervene and a suicide gesture by overdose. In both cases the primal scene fantasies being expressed had woven into them mother's stories about her own father's drunken violent behaviour, culminating, so went the story, in his throwing Sharon's grandmother down the stairs. It was said she later died from her injuries.

In the marriage, Sharon was also undoubtedly striving to enjoy and establish a warm intimate relationship upon which she could depend, but she did not have enough ego strength to maintain a separate sense of self within it. In this sense the marriage was a major precipitating factor in her breakdown. I have already referred to the projection and projective identification which was so muddling to her and to the observer. Additionally, Sharon idealised Bill (as she had done her father in pre-adolescence) as a dear, warm, loving man. This idealisation further diminished Sharon's self-esteem and sense of self and of course muddied her judgment – and mine too. It was befuddling to hear from the couch about Bill's violent behaviour, his deviousness, drinking and neglect of her and at the end of the session to observe him meeting her with a kiss and their walking off together arm in arm. Despite the co-existing hatred, this idealisation and the reality factor that Sharon could not manage at this particular period without a supplementary ego, however flawed it might be, were among the factors which prompted Sharon to allow Bill back into the house after obtaining an injunction against him and to continue in the relationship for a further twelve months. Bill was both the idealised father and the bad father.

Throughout, Sharon was struggling to control Bill and not only by inducing him to behave in certain ways which fitted in with her view of her past relationships and with the self and object representations in her inner world. This struggle to control was very tiring. It involved constant second-guessing and a fair amount of actual sleuthing – ringing his bank, family, employers and going through his pockets and then making deductions. All this to counter the threat of Bill's separateness, awareness of which made her feel utterly small, weak and helpless and open to exploitation. It also softened the pain of separation, helping her to feel in touch with Bill. When he was physically absent she at least had the reassurance of keeping tabs on him. There were times when to find his pullover was not where she expected it to be provoked extreme panic in her.

Phases in the Transference

How was I experienced in the sessions? There were three transference phases in Sharon's time with me. We have to remember that a major transference relationship with which Sharon sought help was already established outside the therapy before she came into therapy. It was within this relationship that the major psychopathology was enacted. It was not contained in the sessions. I very much wonder whether had it not been for the pre-existing pathological relationship with Bill, the transference would have been manageable. The two terms with the other therapist which took place before

the marriage to Bill suggests it might not have been. As it was, I was preserved in this preliminary first stage as the good grandmother-cum-aunt who should have adopted her, while Bill carried the other half of the split in the mother/combined parental object – a split between grandmother/aunt on the one side and mother on the other side. This split was later continued between father and mother, for during infancy and latency years father was much loved by Sharon, whereas mother was denigrated.

Also in this preliminary phase, I was used as a transitional object. In part of a dream which Sharon brought, one year into therapy, the scene was a party in a big house. It was Sharon's party but not her house and the food and drink were not provided by her. She and Bill were in bed and it was only after a couple of male friends had called and chatted that Sharon remembered that she had invited people to a party. In the kitchen was a tiny woman who was much older than she looked. The house had large high rooms with mouldings. The little woman had a prestigious title. Sharon picked up up and introduced her to Bill.

Sharon's immediate comment was that some of the people at the party were her. It is her party but it is my house from the description, and my food and drink. It seems I am a prestigious personage but that fact, my ownership of the house and being provider of the necessities, does not make Sharon feel inferior or small. She can handle me at will and I seem obliging. I can be picked up and put down. I am a condensation of myself and an transitional object and I think the grandmother who doted on Sharon – for the description of a woman who was older than she looked, while maybe a fair or reasonable opinion of me, can certainly also refer to an aspect of me that is grandmother. My countertransference feelings through much of the therapy were indeed those of a concerned grandmother.

A month later we were talking about the summer holidays. Sharon said "I look upon you as somewhere I can leave things until I come back to them. I have a considerable respect for you – you can't be fooled easily – you are flexible and adaptable and if I leave things with you, you won't tamper with them while I'm away. I trust you." Those sentences are surely a very good description of the functions and attributes of a transitional object. The reference to my not being easily fooled I took as the reverse, but without dismay – for it indicated that I had avoided being too active and had enough of the time phrased and timed my interventions sufficiently carefully to avoid frightening her – with a resultant disastrous withdrawal and termination of therapy.

In another second transference phase, soon after a summer break, I became a resented parental figure. I was accused of chivvying her along, demanding that she accomplish all her unfinished jobs. "You have become

rather a dragon and it's not a comfortable feeling. I expect you to be critical – to have expectations I am not going to meet. I strongly resent my own expectations of myself ... I have always had a mood in which I let things drift." When I suggested that she was seeing in me her own internal critical parental figure and its expectations and thus avoiding conflict with the drifting-along part of herself, Sharon confirmed this by referring to her accusations of others – that when they did not want to express feelings for themselves they 'made' others do it for them. I came to understand more about Sharon's drifting-along mood on those occasions when she became aware of my maternal failures – as when the central heating broke down and she had to use my blanket. In the same sessions she said "I feel paralysed; I can't do things until other things happen". I remarked that she could not do things until she felt looked after by me. As she commonly did, Sharon replied "I am not aware I feel like that", adding "and now I feel very sleepy". Her denials notwithstanding, in the following session she made the accusation "you neither feed nor warm me".

Later still in the therapy her predicament with Bill became clearer to her. She drew apart from him and finally left him. She felt angry about the time and energy invested in what she came to regard as a thoroughly negative experience and considered I should have prevented these nasty things happening to her.

The third phase was dominated by an uncomfortable awareness of me as a separate person whose very separateness was a threat to her sense of identity and way of looking at things. In earlier stages of the therapy this took the form of reaction to my impingements upon her. During a session in which she expressed irritation with my interpretations, she asserted "You won't allow me to be me because of what you are". Towards the end of the therapy, as she became more of a separate person she spoke on more than one occasion of her need for space to develop herself and her interests.

Thoughts on Reconstruction and Aetiology

I was writing this paper at the time of the Hungerford massacre and read this passage in **The Independent**, Friday 21 August 1987:

> (Mrs Rose) recalled the first words Hannah spoke to her. "She said 'We are coming to find you'. They just put out their hands and held my hands. The little girl said 'A man in black shot my mummy and he has taken the car keys so James and me can't drive the car without the car keys, so we are going home' ... The children did not seem really dazed. They told me they had been tired and had had a little sleep in the car." Hannah was 4, James 2. They did not cry.

This account put me in mind immediately of Sharon's description of her mother running away. There is the dissociation from the enormity of the event, the denial of the helpless situation in which the subject finds herself as a consequence. Hannah speaks as though she could have driven home; Sharon imagines she could take the place of the absent mother and manage with father. Also there is the 'little sleep' with which the traumatic event is blotted out. Sharon did not sleep in sessions when some dangerous thought or feeling threatened to break through (though she reports having done so in her previous therapy); instead she would say "now my mind has gone all wooden".

Masud Khan (1963) conceptualises a type of partial breakdown of the protective shield of the caretaking mother over the whole course of the child's development from infancy to adolescence, which he designates as cumulative trauma. This militates against developmentally arriving at a differentiated separate 'coherent ego' and self, and becomes clinically observable in ego-pathology and schizoid character-formation. He points out that "one treacherous aspect of cumulative trauma is that it operates and builds up silently"; it is difficult to detect clinically in childhood.

Sharon seems to have been a happy enough little girl up to the age of 3 years but factors in the environment which did not facilitate development and integration of the ego can be traced. Mother was impatient of the care of babies; their dependency was something with which she could not cope; they were a nuisance; they interfered with her work; they encroached upon her. The paternal grandmother lived close at hand, with Aunt B. Gran'ma took a large share of the early care of Sharon and came again into the picture when mother had to spend eighteen months in hospital with TB. Gran'ma disapproved of mother and competed with her, thus undermining whatever confidence mother had. Sharon has two good early memories of mother. She was sitting on a table shelling peas with mother; on the radio 'Listen with Mother'. She was happy. Father came in and remonstrated that Sharon should not be involved in domestic chores. He was echoing Gran'ma's words? This sort of thing, repeated, was an added difficulty in the way of Sharon making a good, reasonably unconflicted identification with mother. The other good memory is of mother making her pretty dresses. But Gran'ma, with no consultation, took Sharon to the hairdresser and had her hair cut short. Sharon was assured everyone would admire the result and was deeply dismayed by the uproar which ensued. In Sharon's mind it was after this incident that mother stopped making her dresses and mother's pleasurable interest in her little girl lapsed. Sharon, fond as she was of Gran'ma, has remarked "It would have been better if Gran'ma had not interfered." Nevertheless, there were serious deficiencies in maternal care – of such a degree that Sharon's primary

dependency needs shifted from mother to grandmother when she lived nearby in the first two and a half years, and to father until things went wrong in adolescence. Then Sharon was really on her own: there was no path back to mother.

Sharon often complained that her parents habitually spoke to her as though she was someone else – a person they had constructed, not herself. The development of a cohesive sense of identity was much impeded by the parents projecting parts of themselves on to Sharon and then addressing these. Sharon was on to something when she said "Where would my family be without me? They put all their bad feelings into me." I came to understand that this denial of Sharon's spontaneity and of the existence of her emerging self had resulted in the organisation of her psychic life on the basis of 'raw' introjects clinically seen as multiple identifications. Sharon was very sensitive to interpretations in the later part of her time with me, as though I were trying with them to make her into what I wanted her to be and pushing parts of myself into her – a process which I have shown she used in reverse. A dual fear of domination by me and of merging with me must have been relieved by the termination of the therapy. The practical reasons for the termination were undoubtedly real ones, but it was also a psychic relief to Sharon at that particular juncture. Typically, she denied any feeling about our parting. Come the final session, she did not appear. She rang me later in the day to say she had forgotten, and asked if I could still see her. I fitted her in – resentfully, for my holiday had already begun – and angrily because I was bearing all the feelings about the ending, to which she appeared indifferent. When she came she sat up. There was an enormous gulf between us and no emotional contact. I felt overwhelmed after her departure – tearful, disappointed, frustrated and very sad. In terminating her therapy Sharon dropped me in the way she had experienced mother dropping her at the age of three years, when grandmother had Sharon's hair cut. I experienced some of the pain which Sharon herself must have felt. However, I do not regard Sharon leaving as purely defensive in reaction to a merger threat: there was a positive element. It was an opportunity for her to experience leaving the nurturing environment and to consolidate her gains in separation and individuation. She had, as she said, other things to do and wished to get on with her own life.*

Postscript

Two years later, Sharon wrote me a warm letter. She wished to express

*Footnote: Zetzel (1966) comments on the symptomatic recovery of the Rat Man after a relatively brief psycho-analysis. "Freud's willingness, however, to let him try his wings once his serious symptoms had disappeared is relevant to the recurrent problem as to the indications for interruption or termination of psycho-analysis".

her appreciation for the help I had given over the years and in some very difficult periods of her life. She had been promoted and was happy in her work. Nowadays she could recognise some of her feelings and her self-esteem had increased. Under pressure she still split off (as she put it) and the part of herself she dubbed "Militant Hannah" came into her own. Sharon now though of this as a survival mechanism and not a bad device in a catastrophe, though what Hannah saw as a crisis was not always that serious. Her relationship with mother had changed a lot: she now felt affection and compassion, though history had not changed. She felt more detached from mother and at the same time could be more involved – as with her work. She felt therapy had helped her move forward. Though at the time she had not been aware of changes taking place, over the past year she had looked back with more and more appreciation. Now she thought it was time to go into therapy again, but this time it must be with a man and she thought she had found just the person. I later realised this was probably the leader of a group she had joined. Two years later again, as a consequence of watching a series of TV programmes on psychoanalysis she telephoned me for an appointment. When I met her again there was a very different feel to her. She could no longer be considered a borderline patient and this was evidence of the progress and change she achieved in her first phase of therapy.

Discussion

During the years of therapy on which I have drawn in this paper, I observed a vivid picture of a split internal world containing various self-other objects and fantasies involving them which were re-enacted in relationships with significant persons in Sharon's life, to her confusion and bewilderment. These striking phenomena can be variously conceptualised, according to one's view of the development of the internal world. Object relations theory regards internalisations as taking the form of representations of events and people in the external world in relationships. The earliest internalisations are of confused self/other objects and a little later of primitive wholesale introjections of objects, part objects and objects in relationship. Sharon seemed to have become stuck with these earliest forms of internalisation and the more mature development of object relationships and the resolution of later oedipal conflicts consequently suffered. The confused self/other type of internalisation was very apparent in Sharon's relationship with her husband. In her confusion she did not know how to think of Bill. She was not sufficiently separate to develop a consistent view of him and so was unable to carry through a plan to leave him. Her awareness of the threat of a confused self-other relationship developing with me was explicit in her statement "You won't allow me to be me because of what you

are." After she had managed to separate from Bill, was recovering from her breakdown and getting back to work, this threat of a merger was expressed in her growing distance from me.

The coexistence of unassimilated images of objects in her internal world was demonstrated by Sharon's increasing awareness that she could be different people at different times. She could even note the click in her mind as she switched from one to another. As I got to know her and her story I could trace which identification was taking over. The organising, no-sentimental-nonsense, tough-as-nails 'Militant Hannah' as she came to be called, was a version of mother which was powerful and able to relate to the world. So I observed Sharon sometimes well able to cope with a crisis and at other times helpless as a baby. We could both see Gran'ma when Sharon comforted herself with a 'little treat' such as tomato soup fried bread, though at other times she would for twelve hours or more neglect to eat. Her marriage to Bill was in identification with the parental couple as well as, inter alia, in defence against their impending loss through their return abroad.

When acting in accordance with one or other of her 'selves', Sharon could be described as dissociated from other parts of herself. This state could also be observed in those incidents when she reacted with over-excitement to traumatic memories or traumatic fantasies, which, once triggered, were re-enacted in a dissociated or hypnoid state. The brawls with her husband (and probably in adolescence with her father) seem to have been in response to primal scene traumas or fantasies of them. In their grip she became hyper-alert in protection of herself; her conceptualisation regressed to primary process organisation and she ran amok. The trauma occasioned when her husband returned home unexpectedly with a workmate may have been embodied in a fantasy containing aggressive and sexual elements, but perhaps the major traumatising factor in this incident was Sharon being suddenly confronted with the fact inherent in the primal scene, that she was not in control of the object. Bill could be with someone else. She was faced with the loss of him and of that part of herself contained in him. Depersonalisation, extreme anxiety and fragmentation of the ego resulted. Her reaction was of wild flight accompanied by a breakdown into primary process incoherent speech, the equivalent of babbling.

This last mentioned incident raises the question of whether Sharon was there in a state of dissociation or disintegration. In a letter to Masud Khan (1961) Winnicott (my abbreviation) writes:

> ... the word integration describes the developmental tendency and the achievement in the healthy individual ... The state prior to integration I call unintegration. In psychopathology there is disintegration, which is a defence, a fragmentation of the

> personality produced and maintained in avoidance of the destructiveness inherent in object relationship after fusion (of erotic and destructive elements). Then also there is dissociation, which is a rather sophisticated kind of splitting in which the total personality does not split ... Dissociation (like disintegration and splitting) seems to be a defence organisation.

Following the distinctions Winnicott makes, Sharon's state in the incident under discussion was disintegrated rather than dissociated. However, her typical defence mechanism was dissociation, and Winnicott terming this as a more sophisticated form of defence than disintegration has helped me to understand how it might be that Sharon made such relatively speedy progress towards healthier psychic functioning compared with other borderline patients I have treated.

A third phenomenon, which might also be considered as falling within the term 'dissociation', is that of Sharon's amnesias. Her inability to recall the train of events in certain incidents – particularly the brawls – can to some extent be accounted for by the activation of a confused self-object state in which projections also played a large part. There were, however, other incidents which were deleted in their entirety from Sharon's consciousness. Some were obviously incidents which, if acknowledged, would have registered facts and aroused feelings about which Sharon did not wish to know. This was not on the face of it always so, and then I could only speculate that they put Sharon in mind of a matter of which she preferred to remain oblivious or that she was at the time they occurred entirely taken up by a conscious or unconscious fantasy.

Sharon was one of that group of patients who not only repeat the forgotten past in action and act upon their impulses outside therapy, but also express their fantasy life in action. Acting out is not the subject of this paper but it is difficult to conclude without acknowledging this feature of her psychopathology and linking it with Rosenfeld's (1964) opinion that excessive acting out is always linked with an extremely aggressive turning away from the earliest object and Limentani's (1966) that it is found in individuals with a schizoid personality and a severe tendency towards splitting processes, denial and unreality feelings, plus a history of trauma in infancy.

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HOMOSEXUALITY IN THE EIGHTIES

Berenice Krikler

Introduction

In 1967 Legislation was implemented following the recommendations of the Wolfenden report of 1964. Thereafter sexual acts between consenting adult men in private were no longer criminal offences. Nevertheless homosexuals remained fearful of persecution both at a personal level and in terms of employment. Over the last decade opinion has moved in favour of positive discrimination towards all minority groups. In the U.S.A. the pendulum had swung even further and the American Psychiatric Association's DSM 111 excluded homosexuality from the category of emotional disorders. In Britain currently, not only in lay circles but in the eyes of many professionals, homosexuality is no longer regarded as a sexual perversion. The opposing view, that homosexuality clearly falls into the range of disorders called perversion with a demonstrable psychopathology that underpins all perversions, is regarded as intolerant, narrow minded and prejudiced.

The advent of Auto Immune Deficiency Syndrome, AIDS, with the intense fear it generates, has begun to swing the pendulum the other way fuelling homophobic attitudes. Homosexuals are now placed in positions of intense anxiety, ostracised by many, treated like pariahs, more vulnerable in terms of employment and bad risks for insurance and mortgages. In my view if we fail to understand that homosexuality is a perversion which means no more than it is a recognisable syndrome, we fail to face the full consequence of a devastating illness on the male homosexual population who remain a major "at risk" group, in terms of AIDS. Homosexuality is a system developed by individuals to organise experiences and expressions of conflicting and painful feelings, and the system serves as a containment of deep anxieties. It offers for the individual a modus vivendi. The system is not just an object choice, but a long standing way of relating, is part of a person's character development and far more complex than the notion of it being an alternative object choice.

While it is understandable because of homophobic attitudes that the problems of homosexuality have entered the political arena, the consequences of this have had negative effects upon the homosexual population in general. This is clear from the American experience in the last decade.

It was in 1981 that victims of AIDS in the homosexual community in the United States were first reported (Centres for Disease Control (CDC) 1981). An account covering the progress of this illness, the political and public health ineptitude in the United States is carefully documented in "And the Band Played On" (Shilts 1988).

A double tragedy emerged. On the one hand for years the Administration paid scant attention to the growing pleas from the scientific community for funding for research into the strange new frightening illness. It was an essentially homosexual illness and in the eyes of many no more than homosexuals deserved. On the other hand the homosexual community itself played a part in the failure to curb the disease.

A powerful homosexual lobby proclaiming homosexual activity as an alternative form of sexuality built up in the 1980's. With it came the proliferation of bath houses where homosexual activity in its most bizarre aspects took place. The excitement in the misuse of sexuality to escape depression, the total misnomer of the word "gay" to replace homosexual, is tragically exemplified in the bath houses and "gay" clubs. Here indiscriminate exchange of partners takes place, body parts rather than intimacy is the focus. Physically damaging activities such as "fisting" (thrusting fist and forearm into the anus) in a manic upheaval barely covering despair, are common. "Poppers" (amyl nitrate) are used to heighten erotic awareness. The use of the latter is so common in homosexual activity that in the early days of the scientific exploration of AIDS, it was suggested as a causative factor. Bath houses have not been part of the homosexual scene in Britain, but clubs where amyl nitrate, exchange of partners in Stygian gloom occurs in a continuous chain of despair, have existed and still do. Similar clubs and brothels, for heterosexuals would equally fall into the category of sexual perversion.

All the excitement, an abandonment of true self and of intimacy, in the name of sexual freedom, is part of the homosexual psychopathology. If one fails to understand this compulsive need, no amount of moral admonitions regarding continence and condoms are going to help in curbing the spread of AIDS.

In the United States the powerful homosexual lobby was blind. Many of the leaders "played politics with the disease, putting political dogma ahead of the preservation of human life." (Shilts 1988) The bath houses remained open too. Vested commercial interests took precedence. There were leaders in the homosexual community and public health officials as well as doctors, nurses, scientists who fought to address the real issues involved. It took time and with time more and more people became infected. It took time before the transmission of the HIV virus was understood. (Barre-Sinoussi, Cherman, Rey et al 1983) (Gallo, Salahuddin, Popovic et al 1984). It's impact on haemophiliacs, drug abusers, prostitutes, others in the heterosexual community who were found to be at risk, also took time. It was only when the population as a whole appeared to be at risk, that the community as a whole began to sit up and take notice. It seems ludicrous that through the fear of offending the homosexual community

and the fear of fuelling homophobic attitudes further, there was a failure, in the Western World, to see AIDS as a major public health risk for male homosexuals. Without proper understanding of homosexuality as a perversion, we will fail to help those so tragically affected by the virus.

The transmission among drug addicts can be curbed by using clean syringes, whatever the problems in health education may be for this particular "at risk" group. This group is the main group from which transmission of AIDS into the heterosexual population occurs. It is not bisexuals who have contributed in a major way to the spread of AIDS into the heterosexual community. The AIDS risk to haemophiliacs and others in need of blood transfusion can be halted by treating blood samples effectively. The transmission for homosexuals lies in their sexuality and the significance of this for all male homosexuals is that it cannot be addressed by using condoms or by containment of sexuality alone.

A high number of homosexuals are promiscuous. Their promiscuity is a feature of the psychopathology that underpins homosexuality. The necessity for continence has consequences upon their psychic integrity. If this is ignored it is likely to face them with greater pain than they presently endure. We are likely to see as a result of enforced continence an increasing number of homosexuals in need of treatment for depression and intolerable levels of anxiety. The promiscuity is a way of acting out, to defend against the very anxieties that are a part of homosexual psychopathology.

It is important to recognise that there are different kinds of homosexuality, and varying levels of psychological disturbance between different groups. Limentani (Limentani 1977) has differentiated homosexuality into three sub-groups. These do of course overlap, and do not form totally discrete sub-groups. They do, however, enable one to think more clearly about treatment aims, the consequences of enforced continence and management with respect to treatment.

One Sub-group he describes as true homosexuality. Here the individual has sustained early and profound narcissistic blows. He is very much caught up with primitive anxieties concerned with psychic survival. (This will be discussed at greater length later in the paper, in the section on the Roots of Psychopathology in Homosexuality). He defends himself against possible psychotic breakdown. He is unlikely ever to have been drawn sexually to women in phantasy or reality. He may suffer powerful feelings of depression and his ideation contains a paranoid flavour. The persecutory annihilatory anxiety engendered from his superego is readily projected. Any mild or implied criticism is experienced as sharp and wounding, and easily elaborated into a paranoid phantasy. His relationships are qualitatively remote, distant. Developmentally, conflict and anxiety concerned with oedipal issues are of far less consequence to him. His main conflicts are rooted around his

very early relationship with his mother. The individual who is a habitue of public lavatories or "cottages" for sexual contacts is likely to fall into this category.

The latent heterosexual is a second group Limentani (Limentani 1977) discusses. While the true homosexual lives in his inner world essentially in a dyad, the third force, the father, being only a shadowy figure in any meaningful sense in his inner world, the latent heterosexual has approached closer to the oedipal struggles. Early infantile fears remain unresolved but do not occupy such an entrenched position as they do for the true homosexual. The latent heterosexual has cathected the father, the third force, to some extent. A fair proportion of his anxieties are occupied by fears of castration. Sexual engagement with a woman is a source of terror not only because of fear of engulfment from the female, but contains fear of the father in relation to incestuous interests directed towards the mother (and subsequently to women in general). He defends against his intense castration anxiety via his homosexuality. Breakdown is more likely to produce neurotic as opposed to psychotic illness.

The third group Limentani (Limentani 1977) discusses are bisexual. He considers this group as deeply disturbed, showing bizarre feminine identification and chaotic personalities. They can be with neither gender without longing for the other. When with a woman, they long for a man and vice versa. In action they run from one to the other to insure against psychic disintegration.

In my view not all bisexual activity is of this dimension. The bisexuality most commonly seen is more characteristic of latent heterosexuals who cannot successfully traverse the anxieties of castration and earlier fears of annihilation, sufficiently to remain with a woman.

I would like to make clear that many homosexuals do find a modus vivendi, and do not demonstrate levels of psychopathology that give rise to intense experienced anxieties, nor behaviour that puts them into the severe "at risk" category in terms of AIDS. My intention in this paper, however, is to confine my discussion to the more severely disturbed adult male homosexuals; those more likely in Limentani's differentiation to be classified into the category of true homosexuality. This will serve to illustrate the underlying psychopathology more vividly and economically. If we can understand underlying psychopathology, treatment and management issues become clearer. This is of particular importance in the 1980's with the impact of AIDS on the male homosexual population.

Roots of the Psychopathology of Homosexuality

Glasser (Glasser 1986) has identified what he refers to as the "core complex". This is a common denominator in all perversions including homosexuality.

The central pivot for this is a powerful wish for union with the object, a fusion of self with the other. This longing is common to us all and is achieved in its fullest intimacy in sexual intercourse provided each partner is secure in their own boundaries of self. The homosexual, in common with people suffering from other perversions, is fundamentally terrified of intimacy. He experiences it as engulfing, overwhelming, or deeply intrusive, an annihilation of his separate being. The reason for his difficulty arises in the setting of his early relationship with his mother.

Mothers of homosexuals in their relationship to their sons tend to be engulfing, overwhelming, intrusive. This is experienced as annihilatory.

The response to the threat of annihilation from the object is commonly fight or flight (Glasser 1986). Thus aggression and narcissism are intricately woven into the core complex. If the response is fight, the aggression that has been mobilised to defend the self from annihilation is directed at the longed for but threatening object. It is aimed at attacking or destroying the object. This level of aggression is itself dangerous to survival. It is thus deflected by sexualization into sadism.

The sadism serves to hurt and control the object, thereby keeping it at a safe distance but not letting go of it nor destroying it. Sexualization becomes a marked characterological feature.

If the response is flight, there is a withdrawal from the object. This narcissistic withdrawal brings in its wake feelings of desperate isolation and abandonment. The aggression that has been mobilised by the threat of annihilation by the object, is redirected to the self. It is deflected from the self by sexualization into masochism. There are accompanying feelings of worthlessness. This prompts the longings for a return to complete union, fusion, and so the infant moves in great intensity in his internal world between the two poles, one of closeness that elicits annihilatory fear, the other of isolation with fear of nothing to hold the infant together, no way to contain him from falling apart. The only way of maintaining a relationship with the object is via sado-masochistic mechanisms which by their nature negate true intimacy.

The early object relationships of homosexuals are characterised by mothers who either engulf or deprive or alternate in these modes with their infant sons. They are seductive emotionally and sexually, at an unconscious sometimes even conscious level, towards their infants. Work with the mother of a homosexual illustrates this (Patient A).

The son, an aspiring and potentially successful artist, was in treatment with a colleague. He was twenty years old, still very attached to his mother, in a bond characterised by intense sado-masochistic exchanges. I saw the mother to facilitate separation.

She told me her marriage had served as an escape from her own parents.

Her husband was financially successful and generous but there was no involvement by him with her or the children. When she became pregnant, she was certain she was carrying a boy. She dreamed of him as a child of great beauty, golden-haired, gifted. She breast fed him for over a year and described this as idyllic, far superior to sexual intercourse. At the age of two and a half she began toilet training and her anger with her son surfaced. On one occasion he defaecated on the floor. She felt uncontrollable rage, and she dragged him again and again through his excrement. Between intermittent bouts of angry confrontation with him for the next few years, were moments of blissful engagement. She would lie on his bed next to him to settle him to sleep. She would stroke his golden hair, his back, his buttocks, conscious he was masturbating. His childhood was characterised by violent tantrums that frightened her. She feared he would grow up to be a criminal. When he went to school, she suffered intense anxiety particularly en route to fetch him. She would phantasise he might have been abducted. When they met they would rush into each other's arms like lovers. Then they would fight and argue in the car en route home. She was relieved in his adolescence that his violent eruptions disappeared and she valued his dreamy preoccupation with his painting.

The sado-masochistic mechanisms are obvious with their intensity surfacing in the anal developmental phase. The son as a narcissistic object for his mother is also revealed.

In all homosexuals, the most potent force in their lives is their mothers. The mothers are commonly narcissistic, lacking in sensitivity to their infants' needs. Fathers are remote, actually or in spirit. They may be harsh, and if not harsh, expeienced as unreachable. They do not assist their sons in the necessary effort to separate from their mothers. Indeed as a result of their own difficulties in their relationships with their wives, they collude with the perverse mother-son attachment, as Sharon Stekelman of the Portman Clinic Staff has pointed out (Personal communication). It takes the heat out of their own uncertain engagment with their wives/partners. They fail to provide the reality of a triangular relationship. This leaves the son vulnerable to the mother and impedes development at all levels and in particular at the oedipal level. Men are dismissed in the minds of mothers who produce homosexual sons. There is no viable third force. Those women who rear male children on their own who are not homosexual, convey the existence and importance of men to their sons through their own successful internalization of a male object representation. One of the significant features of anal intercurse among homosexuals, is an attempt at regaining some representation of the father in a concrete, bodily manner by the introduction of the partner's penis into the anus. (Glasser 1986).

In phantasies and actions the search for partners acquires a compulsive flavour. The search may take place in such alienated places as public lavatories or may be in more reasonable settings such as bars or clubs, or selected places on common ground such as the Heath. The search is not for companionship. It is for a sexual, usually brief encounter that momentarily shores up feelings of isolation and anxiety, without the commitment of a more intimate engagement. It is predicated by the need for sexual contact without the idea of first discovering overall possibilities of compatability in terms of temperament or interest that might promote a wish for more intimate involvement. For some homosexuals a very particular type of person is the focus of interest, for example, rough, tough looking men, known as "rough trade". In phantasy this may represent a wish to incorporate a powerful male object representation, together with sado-masochistic phantasies of debasement and violence. For others very beautiful young men are objects of desire fulfilling narcissistic phantasies. The isolation is intense, the longing for human contact powerful but fraught with the terror of annihilation. By chosing a man, the terror of the engulfing castrating woman is by-passed.

Difficulties in close relationships leads to splitting sexual and loving feelings. In the majority of long-term homosexual partnerships sexual activity between the partners ceases within the first two years. Some may act out sexually with other partners in brief encounters, or may repress their sexuality totally. In the latter case they frequently develop psychosomatic symptoms, episodes of acute anxiety and depression.

The problem of closeness and distance is beautifully illustrated in Victoria Glendinning's biography of Vita Sackville West (Glendinning 1984). Vita, a gifted woman, had numerous homosexual affairs during her enduring marriage to Harold Nicholson, himself a homosexual. Their relationship was maintained chiefly by correspondence. Their letter were filled with mutual endearments, but they housed together only for limited periods. To quote: (Glendinning 1984)

> "In their letters each addressed the essential other and lived their marriage at its closest. They verbalised their affection and need. People with a sexual bond do not have to say so much. The marriage of their correspondence was their platonic ideal, in which they both believed. If this was an instinctual psychological device to contain the looseness of their union, it was a successful one – so successful it took on a life of its own. The more effectively they could meet on the page, the more separate they could be in everyday life. What began as a unifying process legitimised their separateness."

Persistence of Infantile Sexuality

The core complex colours every phase of development. Oral and anal development are imbued with sado-masochistic mechanisms to control the object. At the oral level intensified oral needs are accompanied by sadistic unconcious phantasies, biting and spitting out of the object. Dependency upon the object is increased and separation and individuation delayed and distorted. Catastrophic reactions later in life to the break up in homosexual relationships is commonly the point at which referral for psychotherapy arises.

A patient referred in just such a situation (Patient B) described patterns of his earlier life when he first actively engaged in homosexuality. His main interest sexually was fellatio. He would be drawn to rather effeminate, dependent men and preferred to actively suck their penises rather than be sucked although he enjoyed this too. Anal activity held no interest. The relationship would last a few weeks. He would find it unbearable, claustrophobic and would hate his partner for the partner's dependency. He would break off the relationship in a cruel manner, heaping verbal abuse. As he was extremely fluent, to the point of verbal diarrhoea, this would devastate his partner.

The activities in which the more disturbed group of homosexuals engage illustrates their fixation at oral and anal developmental levels. These include anal intercourse, "water sports" (urinating upon each other and into each other's mouths), "rimming" (licking around the anus), "fisting" (the insertion of fist and forearm into the partner's rectum). These activities put homosexuals into the extreme risk category in terms of AIDS. For example the structure of the anus as opposed to the vagina is more vulnerable to rupture and bleeding and hence the ready transmission of HIV virus.

The messy object is part of the anal world. The frequent use of "cottages" (public lavatories) as a meeting point for homosexuals is not simply because there are so few places to meet, particularly int he 1980's. It is linked with developmental problems arising in the anal period. Battles around this arena feature in the psychopathology of many neuroses. For the homosexual the particular nature of his core complex anxieties and the particular sado-masochistic mechanisms entrenched in his oral relationship to his object make this period of development intensely difficult. The infant already subjected to intrusive, enveloping mothering has heightened levels of aggression deflected by sexualization into sadism and masochism. He reacts to toilet training as a threatening intrusion by his mother, a taking over of his body. Such mothers are more likely in any event, to be intrusive in their management of toilet training. This generates further aggression aimed at negating the threatened intrusion, which to prevent object loss is further deflected into the sadism and masochism of anality.

The sado-masochistic defence, which is built up in the pregenital stages of development, is powerful and colours all future relationships. Whenever any genuine contact is made in a relationship, it is almost as a reflex followed by a sado-masochistic exchange aimed at distancing and controlling the external object.

The use of sado-masochistic mechanisms in therapy to invite engagement and when it occurs, to distort real engagement into collusion is illustrated in the material of a patient (Patient C).

The patient was highly intelligent, articulate, charming in manner, camp in demeanour and appearance. Early on in treatment he talked at some length about his sad childhood and narcissistic and elusive mother. This engaged my concern and compassion and it was as if for a moment real understanding was shared. He then began to illustrate her personality more clearly. He mimicked her strong Irish accent (his accent was BBC English), her gestures, her mannerisms, and her verbal wit. I felt mesmerized as if in a theatre. He watched me carefully. I felt uneasy, then quite out of touch with the earlier sadness he had conveyed. I did not laugh, I felt very distanced, indeed a bit disgusted, and realised his sadism to his mother-therapist was distancing me. If I had fallen for his seductive charm I would have betrayed him. He would have, by my laughing and engaging with his witty vignette of his mother, have succeeded in deceiving, controlling and temporarily corrupting me. Our search for the truth and the pain of his internal world would have been obscured. This manner of relating to me remained a recurrent theme throughout his treatment.

The struggles in terms of the core complex at successive preoedipal levels of development have their impact upon separation and individuation, impeding this process. There is a wish to obliterate all differences. This has been clearly addressed by Chasseguet-Smirgel (Chasseguet-Smirgel 1983). She points out that the very core of reality is created by differences between the sexes and differences between generations. The "perverse temptation" as she puts it, is to equate the desires and satisfactions that apply in the early pregenital development of infants not only as equal but indeed superior to the genital desires and satisfactions of adults. She draws attention to the anal universe as exemplified in the works of the Marquis de Sade. Here interchangeable couplings of genders, generations, blood relations takes place. All differences are obliterated.

Internal Object Relations

I propose to concentrate here only upon problems of identification and super ego formation.

At the preoedipal development stages, problems in identification arise. Patient C, referred to earlier, illustrates this. He was feminine looking in

an almost offensive way. The mocking vignette of his mother was mirrored in his own appearance.

To quote Glasser (Glasser 1986) "Identification is the process in which the subject modifies his self representation in such a way as to be the same as one or more representations of the object".

One shapes one's self representation by incorporating object representations. For the homosexual such identification is problematic. He would experience such incorporation as annihilatory, being taken over by the object, without modification into the self representation. In Glasser's terms the act of unconsciously modelling his behaviour on that of the object without structural change of the self, leads to a pseudo-identification, which he calls simulation. Character structure is then built up on simulation.

The afore mentioned unattractive aspect of my patient's (Patient C) appearance and manner, based as it seemed on simulation, contained a mockery of women within his pseudo-identification.

This mockery had an added dimension. His pseudo-identification contained envy. In his treatment this was readily apparent. He came to treatment with some familiarity with the psychoanalytic literature. His initial engagement with me, included fawning admiration and our "shared" knowledge of psychoanalysis. It felt phoney. As this began to break down through interpretive work, he began to comment on my clothes, and began to dress himself increasingly flamboyantly. This in turn elicited comments from his colleagues and he would complain of their intolerant abuse of homosexuals.

The continuous basic core complex difficulties affecting identification have their impact upon the super ego development of homosexuals. The super ego is an introject rather than becoming part of the self representation (Glasser 1986). It is an introject filled with the possibilities of unleashing annihilating punishment. To comply with it is to be annihilated. To disobey is to survive but in a climate of intense unconscious guilt and feelings of worthlessness. It is fuelled with the rage of oral and anal conflicts. Evasion, denial of guilt, deviousness, manic defences and projection become a way of life.

The super ego acquires a harsh punitive and omnipotent character in the setting of an introject as opposed to becoming part of the self representation.

Consequences of Disillusion with Parents

Disillusion with the parents plays a significant albeit painful part in the normal child's detection of and adjustment to the realistic object world. With a growing loss of belief in his own omnipotence, the child participates in the omnipotence of his parents. In the phallic stage with growing

independence, the belief in parental omnipotence and participation in it, is slowly given up. At the oedipal stage omnipotent competition is relinquished in favour of identification with the father, and postponement of immediate gratification. If the infant meets with decisive disappointment at a time when the infantile ego has established itself to some extent, disillusion with the parents results in a realistic evaluation of the parents, the object world and the self.

The homosexual beset by core complex anxieties bereft of the third force, the father, does not achieve such resolution. He cannot profit from disillusion for the development of his ego.

Early disappointment repeated in the setting of the core complex intensifies narcissistic hurt. Oral and anal impulses fuse in a reaction of devaluation. The mother passes through the grind of devaluating criticism. Intense unconscious guilt is generated. Splitting mechanisms are enhanced. The disappointing object appears as empty, destroyed, castrated. This prompts in Chasseguet-Smirgel's terms a "nostalgia for a lost paradise" (Chasseguet-Smirgel 1985). The lost paradise was the ideal object, the self fused with the ideal. The longing for an unattainable ideal is intensified, the split between ideal and denigrated object increased. The level of disappointment is such that instead of acquiring a realistic picture of the object world, the homosexual will swing from an extreme optimistic or idealized illusion to a pessimistic denigrated illusion which distorts reality. A part object may carry the focus of idealization filled with magic omnipotence. For example the penis can be endowed with the worshipping phallic attitude that is so common in homosexuality. One patient (Patient D) who had married for "cover" plastered his bedroom walls with "art" photographs of men caressing their penises. Above the marital bed was a painting of the patient naked, penis very much in focus, representing St. Sebastian. The opposite attitude representing denigration, and again focused on a part object, the penis, is found in severely depressed isolated homosexuals. The penis is perceived as bad, damaging, and physical contact with a woman thus impossible.

The disillusion which cannot be used in the service of ego development endows the archaic super ego further with omnipotence and the parental introjects with archaic strength and cruelty. This in turn engenders intense guilt and excruciating self criticsim.

The Role of Confusion

Early disappointment, disillusion, reverses the normal process of renunciation of omnipotence. The child's movement towards separation and individuation is delayed. Confusion between self and object remains. At the same time early disillusion has intensified guilt and the manifold

defences against guilt. Perception of otherness brings in its wake the recognition, responsibility and concern for others. Guilt can only exist in perception of self and an other. This is unbearable if one has not got the ego strength to process it. The infant faced too early with an archaic, guilt-engendering primitive super ego is likely to intensify, cling to his unresolved sense of confusion of self and other, his wish to deny separation.

Maintenance of confusion is then used defensively to avoid, deny, the potential acceptance of feelings both of concern as well as anger with the object. Aggression builds up and is yet again deflected into sadism, the concern that may be expressed is of a simulated, histrionic and frequently placatory quality.

The experiences of homosexuals invariably include early disappointment and disillusion. There is identity confusion as well as confusion manifest in the material within the transference in the treatment situation.

The wish earlier referred to in terms of a wish to confuse genders in the service of core complex anxieties is further elaborated by the need to maintain internal confusion in order to avoid guilt from a peculiarly cruel super ego introject.

The compulsive need for sexual contact with the same sex partner has as one of its dimensions, an effort to reassure against difference. It maintains confusion, temporarily reduces guilt, bypasses real concern. If you are confused you avoid being accused.

Confusion, guilt, apparent concern plus an elusive quality is a common experience in working in depth with homosexual patients.

A homosexual man (Patient E) who came into treatment because of feelings of depression for which he could find no reason, described persecuting guilt in a wide range of situations that mystified him. He appeared very attractive, charming, articulate and immediately elicited feelings of sympathy in me plus a strong wish to help, rescue him. I distrusted completely my feelings of wish to rescue, and indeed this was wise. As the transference unfolded he registered confusion at the rather simple connections I was making. It made me feel I needed to work harder and with this I understood something about his passive wish to make me wholly responsible, an invitation to take over to which he was likely to retaliate with either sadism or withdrawal. I had early on succumbed to this and given what I believed to be correct interpretations, and too many attempts made to rephrase them, so that he would understand. His response to this was an escalation in symptoms outside the session and an apparent acceptance in the session of the interpretations. He thereby placated me, distanced me and attacked me by the escalation of symptoms outside the therapy. His confusion continued and with it he took no responsibility for himself in the treatment nor any responsibility for what was happening outside the treatment.

His history was almost too classical. He was the only son of a very beautiful mother and handsome father. Father spent most of his childhood years on business trips, was generally rather a reserved unemotional man. The extent of father's lack of involvement culminated in his total disappearance when my patient was 19 years old. He disappeared, my patient told me, when he learned his wife had had an affair, and when my patient had crossed the Atlantic to see his father to tell his father about his homosexuality. Mother had bouts of idealizing the patient and bouts of denigrating him, especially in front of friends. She would accuse him of neglecting her, among other charges. She demanded constant attention and by the time my patient came to see me in his later thirties he was still telephoning her twice weekly and taking her out to expensive dinners weekly.

He told me he had no women friends, was afraid of women. The fear was they would lead him on and then reject and humiliate him. Aside from a brief passion for a boy at school, he did not fully realise he was homosexual until the age of 17, at the point in time when his parents' marriage began to disintegrate. Guilt was a feeling he had had since his schooldays. It was amorphous, he felt likely to be charged with a crime. It made signing cheques in public a problem. It occurred when he went to the theatre and felt on entry everyone would look at him and know he was a criminal. He was an extremely successful business man and he had never committed a crime nor been prone to sharp practice in business. He was well liked but praise or business success did not build self esteem, it made him feel a fraud.

He had been in a steady relationship with a man several years younger than himself for 10 years. Prior to this he had been fairly promiscous and felt the need to fill his diary with arrangements for every night of the week to shore up his self esteem. The relationship with his partner he described as the envy of his particular circle of friends. The sexual relationship was non existent and has ceased some 18 months after they met. He accepted this as the norm in homosexual society. He had remained faithful and thus felt no guilt about his partner who felt estranged by no physical contact of any kind at all. The emergence of his rather phobic symptoms took place during the course of the relationship and extended to fear of flying, travel in general. There was no guilt experienced at any personal level at all.

The confusion remained a central issue in the first two years of treatment and we came to understand it in varying dimensions. It seemed to avoid guilt at a personal level. If he was confused he could not be accused. He was just a simple practical man and behaved impeccably he felt. The confusion was a way of distancing from me used particularly forcibly when any interpretation was emotionally felt. He could not share it with me.

The confusion invited me to intrude and if I did he could experience me as the sadist. When he began to allow some bridging, some moments of genuine engagement, the confusion declined. He began to face the sadistic controlling nature of his relationship to his partner which outwardly appeared so kind. He lavished money on his partner in terms of gifts, expensive holidays, grand restaurants. He berated him if he spent money in ways my patient considered irresponsible. He began slowly to accept some responsibility for his own sadistic impulses and with this there was a marked decline in the amorphous guilt feelings. There were of course other features and material relevant to these problems which I have not focused upon here as I wish mainly to pinpoint the confusion-guilt-core complex phenomena.

A major breakthrough in treatment came when he arrived at his session in a high state of anxiety. He told me he had torn up some documents in his office pertaining to a business deal just before leaving for his session. He could hardly wait through the session to retrieve them as he was afraid his cleaning lady would put the material together and discover something unpleasant about him. He was able to finally take on board his extreme fear of his therapist who was allowed to be his cleaning lady but not allowed to put things together in search of the truth. One part of the truth was his sadism, his deviousness and wish to confuse in order to evade genuine guilt and responsibility. This understanding brought in its wake an intense depression that lasted several weeks, but could be contained without anti-depressant medication.

Implications for Treatment and Management

I have spent some time elaborating the psychopatholgy of homosexuals because this is relevant to approaching in a constructive and rational manner, the problems homosexuals and the community they live in, face. Many management issues that require careful thought have been intensified with the advent of AIDS. The sexuality of homosexuals provides a containment of profound anxieties that have arisen in infancy and which continue to exercise their hold upon homosexuals in adult life. To forego the stabilising effect of certain activities without providing an alternative containment, is going to have serious repercussions on both the individual and on the community.

Alternative containment of these anxieties is offered by professional help. This help has to bear in mind the pitfalls in treatment itself that can breach the homosexual defence system too abruptly and precipitate the eruption of anxiety that might escalate either acting out or uncontainable anxiety that can lead to breakdown in psychic equilibrium.

Some of the consequences of mismanaged treatment through misunderstanding can lead to levels of disturbance that may require hospitalization for the patient. Uncontainable anxieties can interfere with effective job performance, can result in job dismissal. Other symptoms may manifest themselves, for example psychosomatic illness such as ulcerative colitis. An individual can be pushed towards alcohol or drug abuse in order to meet frustrated dependency needs, and at the same time offer immediate relief from pain. Aggresion can be mobilised in response to frustration. This is commonly deflected via sexualization into sado-masochism. If the escalated sado-masochistic mechanisms fail to hold intense aggression, arising from acute internal stress, acts of violence can replace sexual activity, or the violence can be turned against the self in suicide attempts.

All the above reactions are likely to arise if sexual continence is forced upon the individual without the sustaining features of a treatment situation. But it is vital to be aware that mismanaged treatment can provoke any of these reactions and make matters worse rather than better.

Let us look at some of the management issues in more detail.

We begin by acknowledging that in core complex terms the homosexual patient lives in a constant fear of either abandonment or annihilating intrusion and engulfment. Careful diagnosis of the degree of psychological disturbance is vital before commencing treatment. Any intrusive form of treatment such as aversion therapy could precipitate breakdown either in terms of increased acting out, or the development of severe stress symptoms, at times leading to suicidal attempts. Analytical psychotherapy if aimed towards an extensive internal change can also be experienced as too intrusive and precipitate breakdown. Limentani's paper (Limentani 1977) offers a framework for diagnostic considerations in general terms, as a guideline.

Once treatment commences, attention to core anxieties need to be borne in mind. For example holiday breaks, cancellation of appointment exacerbate fear of abandonment. If not managed by careful preparation, one can predict the possibility of intense acting out before, during or immediately after the holiday break. The compulsive frequenter of public lavatories, who may have been held by the treatment might escalate his forays into "cottages", or he may withdraw and fail appointments and become debilitated by depression.

If one is not alert to anxieties created by intrusion one may not time one's interpretations, comments, clarificatory or otherwise sensitively enough, and they may while accurate be experienced as intrusive. Particular care needs to be taken regarding interventions at a late stage in each session so that the patient is not left with the uncontainable affects that prompt acting out or feelings of such intense isolation that treatment is seriously disrupted with the patient feeling isolated and depleted.

The consistent sado-masochistic way of relating that is a feature of homosexual psychopathology also requires constant alertness. A moment of genuine contact in a session through understanding, is likely to be experienced as intrusive. This will lead to some form of sadistic response from the patient, often heavily disguised in order to control and distance the therapist. The therapist if unaware of this can be seduced into collusion. This breaks the essential boundaries the treatment situation offeres as a means towards increasing the patient's ability to separate in a healthy direction towards individuation of the self. Or the therapist, under attack can masochistically lose his power to think, can appear weakened. The momentary triumph the patient gains promotes further acting out. If the therapist counter attacks, this threatens the patient's sense of self, again provoking acting out. The conflicts in terms of intrusion and engulfment, exacerbated by failures in management of the sado-masochistic engagement which the homosexual patient offers, may provoke breaking off treatment, or precipitate disintegrative anxiety.

Consideration of super ego issues are always at the forefront in treatment. Knowledge that the super ego of the homosexual patient is particularly cruel and annihilating is of the utmost importance. He engages in many activities to defy and subvert his super ego. Within the transference relationship, the professional helper inevitably features as the super ego. Therefore directives or prohibitions by the professional worker prompt a reactive negativism.

A negative response may not only be expressed in an intensification of acting out in a contrary direction, but can promote acute depressive anxieties, feelings of disintegration, powerlessness, in meeting the demands of the therapist-super ego.

Risk taking features quite powerfully in homosexual psychopathology. Risk taking serves to provide an illusion of omnipotence with which to challenge the omnipotence of the super ego. The professional helper will in any event be endowed with omnipotence. When such omnipotence is invested with super ego projections, the very treatment is under threat. The offer of help, containment, is perceived as annihilating and is undermined, subverted, to the point of breaking off treatment. There will be subtle challenges to the therapist, the patient will take risks with his treatment, as he takes risks with his body, to try and maintain an illusion of omnipotence to challenge the omnipotence of the therapist-super ego.

The risk the therapist takes if his treatment is directed towards certain changes he believes to be in his patient's interests, can be exemplified in the management of bisexuals. Here, considerations not only addressed to super ego issues are relevant.

The bisexual may with a part of himself wish to move towards

heterosexuality. The professional helper may endorse this wish. It would please the patient in part and please the professional helper. At this moment in time it might please the community, who fear further incursion of AIDS via transmission to women from bisexual men. The professional helper featuring as the super ego and representative of the community too, is likely to be challenged. An escalation of sadistic acting out in relation to women is possible in terms of reactive negativism. The problem for the compulsive bisexual, as opposed to the latent heterosexual who sometimes attempts a relationship with the opposite sex, are of extreme importance in management terms. For the compulsive bisexual, his psychological equilibrium is maintained by contact with both sexes (Limentani 1977). If this is not understood and the said individual is pushed towards either exclusive heterosexuality or homosexuality, he is at risk of breakdown in functioning.

Risk taking is strikingly evident in the behaviour of the compulsive "cottager". He is always at risk of arrest, and he knows this. His compulsion reflects an attempt at a momentary challenge to his excruciatingly severe super ego. It also reflects the need for sexual contact to reassure against feelings of isolation. This brings us to consider the heightening of anxieties and problems for homosexuals faced in these times by a decimating illness, AIDS.

The majority of homosexuals who may require or wish for professional help do not find their way to such channels. In any event treatment facilities are so limited as a result of lack of funds, that even if required there is inadequate provision. This is an even more serious problem with the advent of AIDS.

At the extreme end of the spectrum of homosexuality are those homosexuals who are so isolated that contact via their sexuality may be the only form of human engagement available to them. For such a person, offered no alternative containment via professional help, to advise sexual continence spells total isolation for him. In addition, to suggest the use of condoms to him is to deny to him the skin contact that has such significance for him. It is the only way he is physically touched. It is the only medium of closeness he knows physically and emotionaly. Generally he seeks his contacts in public lavatories where the risk taking affords him momentary relief from severe super ego onslaughts. If he does not obtain the only relief he knows, he is liable to psychological breakdown. If he continues to compulsively frequent public lavatories he is very much at risk of AIDS.

The "cottager" as has been mentioned previously, not only seeks public lavatories because of his difficulties in relationships in general, he seeks them because of his anal preoccupations. While he may be at the extreme end of the spectrum of homosexuals, all homosexuals have anal

preoccupations. There is much difficulty in advocating the use of condoms to a group of people where sexual interest is so fixated at an anal level. Condoms are particularly antipathetic to the anal preoccupations of homosexuals, as well as denying them their particular need of skin contact.

AIDS lends credibility for homosexuals to the nightmare emanating from fears of annihilation at a psychic level. An appalling uncontrollable plague is actually annihilating their lives, commensurate with the psychic annihilation they have anticipated all their lives from their mothers, and severe super ego introjects. It increases their belief in the omnipotent power of mother. It also conceives of AIDS as a retribution. If those in whose care the sufferer from AIDS or the HIV positive person, rests, do not understand the significance of this and related psychological mechanisms, anxieties and consequent acting out will not be diminished.

For example, a small number of homosexuals, in response to the enormous anxiety generated by AIDS, become increasingly sado-masochistic. They deliberately attempt to infect partners should they learn they are HIV positive or indeed even simply fear this. It is essential if people do submit themselves to tests for HIV to offer informed counselling support that acknowledges the significance of sexual activity for homosexuals in terms of their total personality. It is essential in terms of the individual's personal suffering and in terms of public health risks.

Many homosexuals are understandably afraid to find out if they are HIV positive. Clinics that offer diagnosis and treatment for sexually transmitted diseases are in a conflict about offering or informing clients about HIV testing. Few have adequately trained counsellors in attendance.

Counselling services are mushrooming for HIV positive suffers and for those with AIDS. These services offer care and compassion to a population in desperate need. A number of counsellors, however, deny the importance of homosexuality as such in relation to the illness, and fail to understand the underlying anxieties and thereby are not able to contain them.

For those few homosexuals who are in a treatment which reflects an understanding of their inner turmoil therapy can mediate acting out, by bridging the divide between intense affects and action, with thought, promoted by empathy, in the context of a professional relationship.

One cannot leave out of account the number of homosexuals whose capacity for care and concern abound, and whose example is sadly not seen to be emulated by many professionals. They make strenuous efforts to help partners and friends who become ill. Their care of the terminally ill is poignant. There can be no homosexual who has been minimally active in the past decade, who is not consciously living in fear of being HIV positive. Every cold is regarded with trepidation. These fears need expression,

understanding and acceptance. Even in the most stable homosexual this is a haunting anxiety that cannot be ignored.

Sadly there are few facilities, no funding takes account of these problems.

Evidence from the U.S.A. suggests that there has been a levelling out in notified AIDS cases which is attributed to homosexuals becoming more sexually continent. (Personal Communication Ann Coxon, Consultant Physician, Portman Clinic). In terms of this paper, increased continence without alternative containment via professional help will escalate psychological disturbance among homosexuals. There appears to have been absolutely no monitoring in the Public Health Sector of any change in the incidence of such disturbance among homosexuals in the U.S.A. I am sceptical anyway of the maintenance of continence via "safe" sex. "Safe" sex aside from the use of condoms, suggests the minimum of body contact. The parlours in San Francisco now replacing bath houses, consist of chairs arranged in a circle, each individual masturbating himself on his own, looking at the penises, bodies, faces of one another in a dehumanising situation. Its effectiveness as a containment is highly debatable.

Whether or not such a trend of levelling out of AIDS follows in Britain, there is certainly no existing format currently for monitoring incidence of psychological disturbance among homosexuals to my knowledge.

The funding for medical scientific research is inadequate in itself, but it is obviously a top priority in the search for prevention and cure of AIDS. There is no funding at all directed towards the psychological problems of homosexuals who may not be AIDS victims nor HIV positive. If this is not addressed by the Public Health Sector I do not believe the spread of AIDS can be effectively managed. I also believe an increasing number of homosexuals are likely to become emotional casualties.

Conclusion

This paper has considered some of the basic anxieties that form the core of the system of homosexuality as a defensive mode of engagement. It has focused upon the more disturbed homosexuals in the spectrum of homosexuality for reasons of economy. It is of particular importance to understand what homosexuality means to the individual in the 1980's with the advent of AIDS.

The lesson learned at great cost in the U.S.A. in the slow acceptance of what was happening physically (Shilts 1988) appears to be at risk of repeating itself in terms of failure to recognise the impact of AIDS on the psychological equilibrium of homosexuals presently.

I have confined myself to some of the problems of AIDS and homosexuality in the Western World. The particular nature of AIDS in the Third World has not been addressed.

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The Editor regrets that the Article on Pages 43 - 53 has had to be withdrawn.

THE PROVISION OF A FACILITATING ENVIRONMENT IN THE TREATMENT OF A BORDERLINE PATIENT

Sue Johnson

In this paper I will be drawing on D.W. Winnicott's concept of the 'facilitating environment' in infant care in my recording of the treatment of a 'false self' (1960) borderline patient.

Winnicott (1974) wrote extensively about this 'facilitating environment' and described it as 'holding, developing into handling, to which is added object-presenting'. After giving some background information on my patient and her initial interview, I will describe the three phases of her treatment in terms of these stages.

Background

Ruth is thirty-four, has straight, blonde hair and is of medium height. She dresses in jeans or cords and brightly coloured tee shirts, jumpers and socks. At times she looks tense, distant and matronly and at others casual, attractive and youthful. She lives on social security and spends her time babysitting and doing voluntary work with handicapped people.

Ruth's mother died six years ago and her father re-married shortly after. She has one sibling – a brother who is two years her senior and who was diagnosed braindamaged. Her parents did not accept this diagnosis and moved home in order to avoid sending him to an ESN school. He eventually obtained a law degree. He had a breakdown after the death of their mother and broke off contact with Ruth and her father. He had just resumed contact when Ruth began treatment with me.

Ruth was referred to B.A.P. by her G.P. for her low-level depression. The referral letter stated that there had been several incidents of wrist-slashing in Ruth's teens which led to her spending time at a therapeutic community. She had been seeing another therapist more recently who had broken down several months after her treatment began.

Initial Interview

My initial interview with Ruth was a prelude of the mess and chaos that was to be the central theme in her therapy for months to come.

Ruth arrived fifteen minutes late for her interview in quite an anxious state. She related her very chaotic trip to me – she had set off with the

Shortened version of a qualifying paper for Associate Membership of The British Association of Psychotherapists, awarded Lady Balogh Prize 1986.

intention of cycling, had got lost several times and eventually abandoned her bike at an underground station. She was anxious she had messed up the relationship with me already.

Ruth was unable to give me any history of herself other than to tell me about her experience with the previous therapist. Understandably she was feeling very anxious and guilty about this and I could only acknowledge her anxiety about beginning treatment with me. At the time I did not know that this was also a prelude of the lack of history I was to be given.

Had I known then that my countertransference would be my most valuable tool for some months to come I might have been able to interpret Ruth's fear of rejection in that initial session. I felt quite strongly that she would not want to be in treatment with me because of the distance and the difficult journey involved; I was relieved when the arrangements to begin had been made. I later understood these feelings (besides being my own feelings as a beginning therapist) as a reflection of Ruth's fear of rejection at the time.

Ruth's chaotic trip and resultant lateness provided a useful focus for her anxiety and served as a defence in two respects. It defended her against the anxiety of being dependent on another unreliable therapist who would be unable to provide the ego support she badly needed. In addition it defended her against the painful anxiety of being rejected, as she could tell herself she had brought it about by messing up the interview, thereby keeping the rejection within the area of her omnipotent control.

My understanding of this piece of behaviour comes from Winnicott's concept of 'disintegration' (1962). He uses the term to describe 'a defence that is an active production of chaos in defence against unintegration in the absence of maternal ego-support ... The chaos of disintegration may be as 'bad' as the unreliability of the environment, but it has the advantage of being produced by the baby and therefore of being non-environmental. It is within the area of the baby's omnipotence.'

First Phase – Holding

Ruth's behaviour at the beginning of treatment was of someone who was anxious to please. She appeared to be very motivated in that she cycled part way to her sessions and was prepared to attend two sessions out of three at 7.30 am. She obediently put herself on the couch, but did so so lightly she failed to make an impression, and she hardly moved at all.

This behaviour shifted as Ruth began to experience a number of psychosomatic symptoms – breathlessness, heart palpitations, pains in her chest and a violent shaking attack on the couch which lasted for about twenty minutes and stopped as soon as she got up to go at the end of the session. As Ruth began to settle in she moved about much more and

would sit up, usually with her back to me, when she felt anxious.

A central anxiety was that her brain did not work properly – Ruth told me she had had ECT and feared it had left her braindamaged. She claimed she couldn't think. For weeks she failed to talk in complete sentences or to express complete thoughts – she would start to say something, pause, begin one thought, be silent, and finish on another thought, so that I found it impossible to follow her. She was incomprehensible and unable to 'approximate free association' (Greenson, 1967).

After some months Ruth was able to speak in complete sentences and to remember. She related the following childhood game which she would often get her mother to play with her. Ruth would hide out of sight and her mother would find her and ask her to come home with her and be her little girl. She brought the following dream: she couldn't find me, but was also hiding from me and I couldn't find her and was cross with her. At the time I felt both the game and the dream related to Ruth's wishes and anxieties about being 'found' or known. I held in my mind both of these communications but made no interpretation as I felt they were both Ruth's creations and that to interpret them would be perceived as robbing her of them and making them mine.

Ruth's relationships were based solely on the other person's needs and wishes and she responded to whichever friend was most needy – sometimes double booking engagements with the result that she let someone down and then felt hopeless about herself. She said, 'The only time thoughts come to me is when I'm with a friend and they supply the focus and I then have something to react to'.

This proved to be a real problem in her relationship with me. She complained because I did not ask her questions. My response was to point out that that would be reproducing her way of relating to others which she found so unsatisfactory. My attempts to sit back and let her free associate resulted in her feeling left to 'drift in a sea of nothingness' or that she was 'talking in a vacuum' and I often found myself talking far too much. During silences she imagined I was bored, fed up, or asleep. She sometimes sat up suddenly and turned around in an attempt to see what I was feeling or to make sure I was still in the room. In the transference I was someone whose attention she couldn't get.

Ruth was able to tolerate very little contact with me and her difficulty in talking made it hard for me to know what was going on in her current life or even in a session. My attempt to bring anything into focus was perceived as an attack. For example, during one session Ruth began to tell me about an event she had been to with a friend. Her voice became very soft and I was unable to hear her. I felt anxious that I had not heard her correctly and I repeated what she had said. She became confused and

anxious and said the thought had gone. She perceived my attempt at clarification as an attack and attacked herself for being unable to think and therefore unable to use this type of treatment. I, in turn, felt anxious and hopeless that my attempt to understand the content had been perceived as an attack and had resulted in her confusion.

I could do little interpretative work based on the content of Ruth's material but learned to mirror her feelings of anxiety, confusion and hopelessness based on my countertransference feelings.

Winnicott (1963) discussed this type of work when he talked of modifications of technique. 'In treatment of schizoid persons the analyst needs to know all about the interpretations that might be made on the material presented, but he must be able to refrain from being side-tracked into doing this work that is inappropriate because the main need is for an unclever ego-support, or a holding. This 'holding', like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall for ever.'

As time went on Ruth began to be able to observe herself and to realise she often told me only 'bits' of things. Her anxiety shifted and she complained less of having no thoughts – instead, in her words, 'There are a lot of thoughts in my head and I don't know which one to choose – I wish you could open up the top of my head and see the thoughts rushing through.' At another time she said, 'I don't want to talk about any of the thoughts in my head so I have to rush on to another one.' She could accept my suggestion that she was protecting herself and me from painful thoughts rather than having none.

Ruth said sometimes she liked it if I said something that showed I understood her but then she immediately got panicky and had to make it bad. One way she made it bad was to miss the next session. Perhaps this can best be illustrated with the following clinical vignette.

Ruth began the session with, 'I don't have anything to say – I've said it all.' She sat up and turned around and looked at me. She smiled at me and I smiled back. She lay down again. There was a silence and I sensed she was feeling quite anxious. She said she couldn't think and repeated she'd said it all before. There was a pause; then she said her life was so boring – it just went on – she couldn't bear to go over it again. There was nothing in her mind – her brain didn't work properly. I felt she was needing me to say something but also felt I was empty and had nothing to say. I said perhaps she was frightened she was empty and there was nothing there. She immediately began to talk in detail about a series of arrangements she had made. She said she was dreading all of the arrangements but she might as well see people as she couldn't do anything when she was on her own – she had to feel anxious – it was as though

she was anxious if she wasn't anxious. I commented that feeling anxious was something she knew – perhaps she was frightened of what she might feel if she wasn't anxious. This led to her talking briefly at the very end of the session about her brother and her embarrassment when she was seen with him. It was time to stop just as Ruth had reached this point. Ruth missed the next session and telephoned me at the end saying she had overslept.

Through missing the session, Ruth expressed her anxiety about being understood and her anger with me for having understood her. She tried to undo my understanding by missing the session, in the hope that I would focus on the missed session and forget the material she had presented. In addition she was unconsciously punishing herself for the negative feelings she had experienced toward her brother.

Ruth was unable to get in touch with feelings of anger toward me during her sessions and could only express her anger by staying away. Her perception of me in the transference was either of someone whose attention she couldn't get or of someone whose attention she had but who was critical and rejecting of her. There was no continuity in her relationship with me. Not only each week but in fact each session felt like a new beginning and often she was only just able to begin to talk by the end of the session.

Ruth told me 'bits' about her adolescent breakdown and related the following memories of that time. She had begged her father not to pay any attention to her when the family were at the dinner table. She put this in terms of wanting her father to pay attention to her brother instead of her and it was clear she had been frightened of an Oedipal mother. She also told me her father had come to visit her in hospital and she had begged him to stop the hospital giving her ECT and narcosis treatment (which she described as being like 'sinking into quicksand').

Ruth brought a dream in which she was about to be burned alive and she was taking sleeping tablets. She telephoned her father to ask him to intervene. She knew although he didn't want her to die, he wouldn't intervene. (I will refer to this dream in the third phase of treatment).

It was clear that during Ruth's adolescence she had felt her father had the power to make things better for her. In both memories and in the dream she was desperate for some action on his part but unable to get through to him. Both she and he were pictured as being helpless and impotent. In her sessions she presented this material to me in 'bits' and in a confused manner. It was said almost in passing and with a striking absence of affect – the violent, aggressive feelings which I might have expected to be associated with this period were absent. She related to me in a passive, empty manner and I, in turn, felt impotent and helpless in my attempts to respond to her material in a meaningful way; my words sounded hollow

and meant nothing to her.

In the transference I was either a frightening Oedipal mother to whom Ruth had to deny any interest in and love for her father or I was a distinterested, insensitive, distant father whom she could not reach.

During this time Ruth lost her two part time jobs. In desperation she got a cleaning job but felt degraded by her inability to do even that. She described her panic when she arrived at the house and chaotically went from one chore to the other, unable to organise her work there. Her employer left her notes pointing out things she had either left half done or undone. When it appeared she was about to be fired she gave the job to someone else. Ruth had begun cycling the entire way to her sessions to make ends meet (which meant she had to leave home at 6.30am for her 7.30am sessions) but without even the cleaning job she was unable to manage. She stopped payment, missed sessions and talked of finishing treatment as she could not afford to pay me. She seemed to me to be too disturbed to work and I felt if I was to hold her in treatment I would need to reduce her fee, and we re-negotiated it on the understanding that when she was able we would increase it.

I saw this adaptive concrete gesture as having many aspects.In the transference I was Ruth's mother in her childhood game. I was having to demonstrate in a concrete way (rather than through interpretation which I believed her to be too disturbed for) that I wanted her to be my patient. In addition I was her father during her adolescence whom she begged to intervene – I was having to intervene in her attempt to destroy her therapy.

On the positive side, by the end of this stage of treatment Ruth was speaking coherently, had stopped complaining of physical symptoms and was attending a part time course.

What Ruth required during the initial phase of treatment was 'holding' in terms of the reliability of the setting, times and my availability. In addition she needed holding through my acceptance and containment of her chaos and this took the form of 'mirroring' interventions (Winnicott, 1971) or 'feed-back' (Enid Balint, 1963) rather than interpretation which would have been impingement. The second phase – 'handling' – began with concrete adaptation.

Second Phase – Handling

During the second phase of treatment although Ruth continued to be highly defended and to talk almost every week of finishing the treatment, there was a shift in her behaviour from that of a fragmented borderline patient towards a more neurotic patient with intrapsychic conflicts.

Ruth described her life to me in terms of frantically rushing from one activity to another. Through her descriptions she repeated this in her

sessions in an attempt to distract us from doing any analytic work in much the same way she distracted herself. The other person's needs continued to form the basis of her relationships and she filled her time working with handicapped people and drug addicts and responding to whichever of her friends seemed most needy. She was aware that from early on in her life she had had an overwhelming need to demonstrate caring to others. She vividly related a childhood incident in which she locked a younger child in a cupboard so that 'when he cried I could let him out and comfort him better.' In this situation as in her voluntary work she was in control and therefore able to demonstrate caring.

I began to get a picture of the 'false self' from which Ruth was operating. She defined it in these words, 'Since I can't do anything for myself I might as well do something for someone else.' Winnicott (1955-6) says, 'In the favourable case the false self develops a fixed maternal attitude towards the true self, and is permanently in a state of holding the true self as a mother holds a baby at the very beginning of differentiation and of emergence from primary identification.' Ruth's false self maternal attitude was attempting to hold her true dependent self through the defensive use of projective identification described by Rosenfeld (1955). She projected her own handicapped, dependent self into others and identified with and attempted to care for these aspects of herself in others. However, this attempt at cure also left her depleted as she was deeply aware of a lack of genuine care and concern and felt she was conning everyone. Ruth was conscious of her disturbance and in this respect differed from the 'as if' personality described by Helene Deutsch (1934). She was playing a role as described by Fairbairn (1940) – 'really giving nothing and losing nothing, because, since he is only playing a part, his own personality is not involved. Secretly he disowns the part which he is playing ...'

I could now understand how Ruth presented to others as someone who breezed through life with no needs or problems of her own. Her friends commented on her ability to chat easily at parties or in the pub (I had observed her attractive chatty manner with the women she met outside my house while she was locking up her bike).

Ruth was aware, however, that her behaviour betrayed her inhibitions. She said what friends didn't see was that she found superficial things very easy but was terrified of trying to converse in depth; she anxiously tried to read newspapers or books before spending an evening with a friend as she felt she had no resources within herself to make her good company. She was 'empty of herself' (Enid Balint, 1963).

Besides having some picture of how Ruth presented to others, I also began to get a picture of members of her family.

Ruth was highly critical of her father – she described him as 'miserable

out of cussedness', moody and changeable. She said that she had told him of her course in an attempt to show him she was trying to do something with her life. He had asked what the point was of doing that course – where would it lead – why didn't she do a proper qualification or get a job and live in the real world like everyone else. The picture Ruth painted was of a caricature of a man who had failed to see how ill his daughter was and who was therefore insensitive to the level of her distress and anxiety. Each time Ruth spoke of him it was to say something negative and to deny any interest in him and it was clear that I was an Oedipal mother in the transference of whom she was afraid.

In contrast to this was a highly idealised portrait of her mother, who was described as having a delightful childlike quality that enabled her to turn a bus queue or a doctor's surgery into something magical through her sketching. She never said a cross word or was angry with anyone but was kind and wanted everyone else to be as happy as she was. She couldn't bear unhappiness and Ruth remembered finding her in a room with her fingers in her ears once when her father was shouting. The only hint of anything negative was that Ruth felt her mother had been unable to see the pain she was in when she broke down during adolescence. Ruth had failed to go to school; when she returned home at midday crying, her mother brought in a bowl of cherries and said she'd feel better the next day.

My feelings while listening to these accounts of Ruth's parents were a mixture of bewilderment, desperation and rage, in particular towards this wonderful, idealised mother with whom it seemed taboo to express any anger. I found myself wondering what this girl had to do to get her parents to recognise and take seriously the difficulties she was in. I believed my countertransference reactions to be a reflection of Ruth's earlier feelings that were not available to her at this point in treatment.

I began to be able to make sense of some of Ruth's early identifications. It had been obvious from the beginning that she was identified with her brother in terms of feeling and behaving as though she was braindamaged and handicapped. She was identified with her father in terms of her very negative attitude as well as with her cheerful mother who couldn't bear anyone else to be unhappy, and Ruth had adopted this identification as her 'false self'.

At last I was beginning to get a picture of what was occurring in the transference! Ruth constantly imagined me to be fed up and bored with her and to change from one session to the next, and I put this back to her and linked it with her experience of her father. Initially she responded by turning her aggression upon herself and berating herself for giving me the wrong impression of him – he hadn't been at all like that and anyway

he wasn't like that now so maybe it wasn't true. I immediately felt I had committed a crime for linking anything negative with her father and realised I had interpreted too soon and too enthusiastically (as I did feel very enthusiastic to be able to see some links!). For some weeks I concentrated on mirroring her feelings toward me based on my countertransference – my experience was that there was no relationship between us and no continuity in the treatment, and I was often anxious that Ruth would discontinue the treatment. I was frustrated and fed up with my inability to say anything meaningful. Although I believed these feelings to be related to Ruth's experience of her father, I refrained from interpreting this. After some weeks I could link her experience with me with her experience with her father, particularly in terms of always expecting rejection. Eventually Ruth described a conversation she had had with him which had given her a glimpse of how she had felt as a child. She had telephoned him and it had seemed as though he was angry – as though something had happened between them. She could see that he wasn't really angry with her but that he had been preoccupied with something else when she had phoned him. She said she thought that as a child when he had been moody or preoccupied she had taken his moods personally and had thought she'd done something to make him stop loving her. She could remember trying to think of ways to make him happy and to win back his love – she always felt on the 'edge of losing his love'. During silences in sessions Ruth had always imagined I had changed toward her and that I was feeling rejecting of her. In her words, 'When you're silent I'm like a plant that is expected to grow but is deprived of food, light and water.' At this point she could accept my suggestion that this related to her perception of having lost her father's love.

The other side of the transference coin was that by not being fed up with her and by not giving up the treatment with her I became her maddeningly optimistic mother who denied her inability to carry on and who thought she'd feel better the next day. My interpreting this led again to her fiercely turning her aggression upon herself for having given me the wrong impression.

Ruth told me of another childhood game which her mother invented to get her out of bad moods while allowing her to save face. There would be an imaginary line on the floor and Ruth and her mother would both jump over the line together and it would magically make Ruth in a good mood. She thought her mother had been really clever to invent the game. It seemed I was a bad, failing, unclever mother in the transference as Ruth was still in a bad mood (as she had been from the beginning of treatment) and still feeling as dreadful as ever.

By this time in her treatment Ruth had developed some healthy narcissism. She had begun another part time course and had used birthday money from her uncle to go on holiday. (In the past her 'holidays' had involved her either as a helper looking after handicapped people or as a childminder with a family). She gave up some of her voluntary work and got two part time jobs and at this point she offered to increase the fee.

In the previous spring Ruth had learned that her stepmother was dying of cancer. At the end of her first session back after the summer break she said she thought she ought to say that her stepmother had died. She 'reported' this without any emotion – as a piece of information I ought to be given. Ruth's stepmother, like many of the other people in her life, had always been a shadowy figure. At this point in her treatment she made no further mention of her stepmother's death and I had no idea of the meaning it had for her.

In November Ruth began to be unhappy about the length of the sessions. She said the sessions were too short for her – she was unable to talk until the last ten minutes – it seemed to take her forty minutes to feel safe. My attempts to explore this with her failed to produce a shift. She talked of leaving therapy to test out what I would do and imagined I would be relieved and just let her go. I felt that again we were engaged in her childhood game of getting her mother to beg her to be her little girl.

During this time Ruth brought her emptiness and chaos into her sessions. She began almost every session with a silence, then said she had nothing to say, her therapy was pointless, there was no point in going on, she couldn't think or feel so obviously couldn't use therapy. I found it difficult just to be with her. She was extremely agitated during the sessions – played with the curtain, kicked the rug around, and assumed different positions – would occasionally lie down but seldom for a complete session, sometimes sat with her back to me and sometimes faced me. I, on the other hand, was expected to sit completely still and Ruth spent much time monitoring my behaviour. Any slight shift in my position caused her to sit up suddenly or to turn around and look at me to ascertain what I was thinking or feeling. Neither of us could relax! I was unable to think. Masud Khan (1983) says of one of his patients, 'She had a way of 'blocking' my thinking. She was too present in my space.' This was certainly my experience with Ruth.

There was a build up of anxiety prior to Christmas. Ruth was ill with flu and became so dehydrated that she almost had to be taken into hospital and put on a drip.

This second phase of treatment – 'handling' – began with concrete adaptation in terms of reducing Ruth's fee and intervention in her attempts

to destroy her therapy. It ended and the next phase began with more intervention and management which I believe also constituted 'handling', but I will describe this in terms of the event that happened at the beginning of the third phase.

Third Phase – Object-presenting

Ruth telephoned me on two occasions during the first week after the Christmas break sounding slurred and confused, having taken sleeping tablets. With her knowledge I rang her G.P. after the first phone call.

During the second phone call Ruth began by saying she wanted me to know, 'it has nothing to do with how I feel about you". She sounded slurred and vague – she said she thought the tranquillizers she had taken made her upset and she was worried in case she threw up in her sleep. While we were talking neighbours from two other flats came in to see if she was all right – her father had telephoned one of them and asked her to see how she was. I, too, was very worried and said I would be ringing her G.P. and would ring her back. I spoke with the locum G.P. who, after speaking with Ruth, rang me to say she would be making a visit. I telephone Ruth again and she was upset that it was a doctor and not me who was going to her flat. She rang me at 1.00 am to let me know she was in hospital. She was admitted to the psychiatric ward and remained there for ten days.

While Ruth was in hospital (a safe place) she was free to attack her father and me (her mother in the transference) by letting everyone know how ill she was and how useless her therapy was as she was in this state. She told the psychiatrist and me that the sessions were too short for her – she was unable to 'get into anything' in fifty minutes – and she didn't know where her therapy was going. I said I understood that she was wanting more time but that I could not afford to offer her more sessions at the current fee.

The following day she had discussed this with her father who said she could use the money from the sale of a flat to pay for her therapy. She had told him of the many extended reverse charge telephone calls she had made to me. Her father responded to this by giving her a letter written to her in which he expressed his appreciation of my efforts to help her and enclosed a cheque made out to me to cover the cost. Ruth was obviously delighted that this had been her father's idea. She was struck (as was I) by his recognition and acceptance of her difficulties and his sensitivity in not wanting to interfere in her relationship with me. Ruth and I re-negotiated the fee and arranged to meet for four sessions, two of which would be extended by twenty-five minutes.

This episode was overdetermined and served several functions: my response to Ruth's confused telephone calls and her wish for more time served symbolically as a recognition and acceptance of her illness and contrasted with her mother's response to her adolescent breakdown when she gave her a bowl of cherries and told her she'd feel better the next day. Ruth had also managed to bring her father and me (her mother) together and had got both of us to intervene concretely in her self destruction as she had wished for in her dream during the first phase of treatment. The safety of the hospital and the distance provided by the telephone enabled me to learn more of Ruth's history and more details of her current life than I had learned in sessions in the previous two years. The result was that I was less starved of information and when Ruth came out of hospital I was able to explore the hospital event with her as a re-enactment of a period of her adolescence which I will now describe.

When Ruth was seventeen her periods stopped and she broke down prior to sitting her examinations. Several months later her mother went into hospital for fibroids. From Ruth's memories and associations I was able to reconstruct with her the fact that her periods stopping and her breakdown coincided with the beginning of her mother's gynaecological problems. We were also able to reconstruct the fact that her first serious wrist-slashing happened within hours of her mother being taken into hospital, sooner than had been expected. Ruth was admitted to the psychiatric ward of the hospital where her mother was, and at this point she had narcosis treatment and ECT – this was the beginning of her periods spent in various psychiatric hospitals, including the therapeutic community.

It was discovered that Ruth's mother had cancer of the womb, and she had a hysterectomy. Ruth was not actually told of her mother's cancer until six years later when her mother developed secondaries.

The recent episode had been sparked off by events in Ruth's life she had been unable to share with me at the time. During the previous autumn Ruth had begun to have worries about her body in general and specifically about her coil – she feared it would cause her to be infertile. She had a brief sexual relationship with a man in the autumn and missed a period, and became anxious her periods would stop again. She had several trips to her G.P. but told me only that she had flu. (It is of interest that Ruth did not appear to have been worried that she might be pregnant – only that she would be infertile.) Her stepmother's illness and subsequent death and Ruth's gynaecological worries and missed period triggered off aspects of her adolescence; Ruth was only able to communicate this to me through acting out and in this way she repeated with me the way she had been kept in the dark about her mother's illness. At the time of her admission to hospital I felt very anxious and confused about what was happening;

I later understood this as a reflection of Ruth's adolescent anxiety and her confusion of her mother's illness and her illness.

Ruth had presented me with a clear example of 'acting out' as Freud (1914a) described it. ' . . . we may say that the patient does not remember anything of what he has forgotten and represented, but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it.'

By keeping me in the dark about her worries about her body, Ruth was unconsciously attempting to separate herself from me as her mother in the transference as she had been unable to do during adolescence. In fantasy her body and her mother's body were fused and therefore both ill. In addition, she was attempting to protect me from illness, as in fantasy for her to be ill meant for me (mother) to be ill.

This coincidence of events during Ruth's adolescence contributed to her failure to successfully negotiate a number of normal adolescent tasks – she could not adapt to normal changes in her own body as her body was not normal – her periods had stopped; her breakdown and withdrawal from school resulted in her failure to establish appropriate relationships with her peers; she was unable to separate herself from her parents, and in particular her mother, as in fantasy she was fused with her; she was unable to 'reality test' her aggression toward her parents, and she turned her aggression upon herself – her breakdown at the time of exams was an expression of her anger toward her father for expecting her to achieve academically and her wrist-slashing an expression of her murderous feelings and resultant guilt toward her mother.

This had been re-enacted in the transference. In Ruth's fantasy her fury with me over the Christmas break had killed me off and through projection I had become her dying mother in the transference. Her guilt over her murderous feelings toward me led to her turning her aggression upon herself and she attacked herself, her father and me by taking tablets as she had attacked both herself and her parents when she slashed her wrists.

Ruth had failed to mourn her mother's death and had coped with it through wholesale identification. Her worries about her body were reminiscent of her mother's symptoms and provided her with a motive for suicide.

Ruth's constant need to monitor my behaviour reflected her vague awareness of a damaged mother and I suggested to her that she was so worried and preoccupied with me that there was no space for her.

While Ruth was in hospital, besides feeling very concerned about her, I also felt positively murderous toward her. I felt as though I had been completely taken over by her and that she was letting the whole world

know how useless I was. I also felt very guilty that I had been unable to contain her. I was able to understand these countertransference feelings as a reflection of Ruth's murderous feelings toward herself and her mother, her feelings of being overwhelmed by her mother's illness, and her guilt over her inability to keep her alive.

My conceptualisation of this event comes from one of Winnicott's (1963) many workings over of 'object relating' in relation to 'object presenting' – specifically the following aspect in his paper on communicating. What he describes as aggression experienced by an infant is, I believe, often re-experienced by adolescents. '. . . this aggression, and the ideas bound up with it, lends itself to the process of placing the object, to placing the object separate from the self, in so far as the self has begun to emerge as an entity. In the area of development that is prior to the achievement of fusion one must allow for the infant's behaviour that is reactive to failures of the facilitating environment, or of the environment-mother, and this may look like aggression; actually it is distress. In health, when the infant achieves fusion, the frustrating aspect of object behaviour has value in educating the infant in respect of the existence of a not-me world. Adaptation failures have value in so far as the infant can hate the object, that is to say, can retain the idea of the object as potentially satisfying while recognising its failure to behave satisfactorily. As I understand it, this is good psychoanalytic theory.'

Winnicott goes on to say, 'There is an intermediate stage in healthy development in which the patient's most important experience in relation to the good or potentially satisfying object is the refusal of it. The refusal of it is part of the process of creating it.' This was certainly true in Ruth's therapy in terms of her use of the couch – her need to refuse it to be able to use it creatively – and in terms of the length of her sessions – her rejection of my limits so she could find her limits.

The incident at Christmas seemed to seal the treatment alliance between Ruth and me and to facilitate her ability to integrate.

For the next few weeks she did much research in an attempt to fill me in on her background. She asked her father to write down a brief history for me, she read her mother's diaries, and brought to me poems she had written during adolescence. When I went to return them to her, saying perhaps we could talk about them, she suggested I hold on to them and I think she was symbolically giving me her adolescent self to hold.

Ruth' relationship with her father had already shifted but it continued to shift dramatically. He had been able to say to her that he felt he had bungled things badly when she was an adolescent and he was very keen not to do this again and was anxious for her to carry on her treatment with me.

Ruth's father's birthday was in February and she brought to a session a book she had bought him as a present and she sat at my feet as she showed it to me. Her father was attending some seminars on psychology and the book was about memory. Ruth read bits of it to me and very excitedly showed me a memory exercise she had been able to do. (Two of her initial worries at the beginning of treatment had been her inability to read and lack of memory.) I believe this piece of behaviour served several functions: Ruth was clearly demonstrating to me that she could read and remember, and through this she was unconsciously expressing her appreciation of me and of her therapy. She brought her true spontaneous self into the session, and my acceptance of this behaviour was an acceptance of her spontaneous self and also of her interest in her father – in the transference she was free of the frightening Oedipal mother.

The shift in Ruth's relationship with her father enabled her to begin to think about the difficulties in her parents' marriage as a step toward de-idealisation of her mother. She was able to see how her father had become a misery and a cripple in relation to her too happy and kind mother. I could understand how my acceptance of the letter and cheque from Ruth's father had symbolically represented me as her mother in the transference accepting that he was a good father.

Some time later Ruth re-told the game her mother invented to get her out of a bad mood. In the re-telling she changed her attitude toward her mother from someone who was happy and kind and clever to invent the game to someone who wouldn't allow her to have a bad mood. In the transference, not only have I (mother) allowed her bad moods – I have survived them!

In the re-telling of the game, Ruth was demonstrating that she knew she had had to match and comply with her mother's good moods – that her mother had not met her gesture but had substituted her own. Her mother had failed at the stage of 'object-presenting'. 'It is not so much a question of giving the baby satisfaction as of letting the baby find and come to terms with the object.' (Winnicott, 1962)

Summary

I have described the treatment of Ruth, my first training patient, in terms of Winnicott's concept of the 'facilitating environment'.

During the first stage Ruth's behaviour was that of a fragmented borderline patient who could not speak or think coherently. She required 'holding' in terms of my reliability and 'mirroring' interventions.

During the second phase Ruth was able to convey a picture of her 'false self' as well as a picture of members of her family. This enabled me to gain some understanding of her early identifications as well as what

was occurring in the transference. My 'handling' responses were those of interpretation of her material and concrete adaptation in relation to her acting out.

The final phase contained a re-enactment of Ruth's adolescent breakdown. The re-enactment made it clear that Ruth had been fused with her mother in terms of her mother's illness during her adolescence and in terms of her mother's needs earlier in her life. It enabled us to reconstruct the events which led up to her breakdown and to separate what had occured in her body from what had occurred in her mother's body.

During this phase of treatment, my Christmas break became a form of 'object-presenting'. In Ruth's experience this represented an adaptation failure. It allowed her to express her aggression toward me and to see that I could survive her attack. She was then able to 'refuse' the treatment setting and to re-create it for herself.

The final stage of the 'facilitating environemnt', 'object presenting', will inevitably include adaptation 'failures' on the part of the therapist – either through actions or interpretations. In order to tolerate and survive the aggression which occurs in relation to 'object presenting', both the patient and therapist must first have experienced the concern which develops in the therapist through the stages of 'holding' and 'handling'. This is one of the lessons to be learned from the concept of the 'facilitating environment'.

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LETTERS TO AN ABSENT PATIENT or The Continuation of Therapy by Other Means

Robert Morley

This is an account of a period during a very long psychotherapeutic treatment of a middle-aged male patient whose work took him abroad at irregular intervals and for variable lengths of time. While he was away he would usually send me a postcard of greeting, looking forward to the resumption of our work together. He had occasionally written letters to me before, usually between sessions when something of special significance had happened during the previous session, or if an event of importance had occurred between sessions. These I emphasize were not frequent experiences, but sufficient to make me aware that contact during intervals, or absences, in the treatment was important for him. The importance of separations and absences was a key issue in his work with me.

This led to a particular arrangement about his fees during absences. It was my normal practice that patients' absences for unavoidable work reasons, such as brief assignments in other parts of the country or abroad, should be dealt with by payment of half fees during such periods. This system I instituted with Michael, and for much of his work with me these absences were of relatively brief duration. Michael, however, objected to the arrangement about half fees because he was in a position to earn more money during these absences than he did when he was at home, and felt that therefore I should not lose while he gained. More importantly for him was the feeling that I should not experience him as of less value while he was away and perhaps in consequence not remembered. Usually when he returned from these trips he brought me back simple but quite original gifts which I kept in my consulting-room and they stood for him as an enduring presence during his absences. My own feelings of guilt about this arrangement may have had some influence later on the initiation of the correspondence which is the subject of this paper.

Towards the end of his treatment (during the final two years, as it turned out), Michael was offered and accepted a Visiting Professorship at a university abroad, where he had previously held another non-tenured appointment earlier in his career. This involved a longer absence than had been the case before, and he was to be away at least eight weeks; and this absence was to be followed immediately by another, when he made one of his business trips. As usual he wanted to make arrangements for his sessions to be kept for him on our usual terms. He coupled this request with another – that I should write to him while he was away. After thinking about it, and discussing it with him, I agreed and in this paper I want

to consider how I dealt with this correspondence and the need to write regularly to a patient during a prolonged absence.

This correspondence later could not even be conducted in the usual way, with letters alternating so that one letter could be written in answer to another, because he would be moving from one place to another. So that while I could receive letters from him, he could receive none from me, since I had to write poste restante to the last place he was to visit before returning home.

First, however, something of Michael's history and the development of the therapy to set the correspondence in context. I have already indicated that the theme of separation and its meaning was of great importance to Michael, and indeed it would not be too much to say that for much of his life he had been attempting to deal with a trauma which had occurred some time between his second and third birthdays, when his parents had made a long trip abroad, leaving him in the care of a young nursemaid. He could never consciously recall this event, though there was little doubt of its traumatic effect and its life-long consequences for him. He remembered the nursemaid, Anna, with great affection, and she continued to be with the family after his parents returned from their trip. Somehow he seems to have lost her and could not remember her leaving. Significantly, when he was bringing some photos of her to a session to show me, he lost them too on the way to the session and never found them again.

After this prolonged absence, his parents continued to take regular summer holidays abroad six or eight weeks' duration, leaving Michael and his elder sister behind with various arrangements for their care, often involving a summer camp. During these holidays the trauma of the first separation was reinforced, although it was never experienced quite so acutely again. This was partly a consequence of Michael's creation of a 'family romance', in which he fantasized that he was really the son of some other grand family and that these actual and absent parents were only his adoptive parents. As he grew older he would tell his schoolfriends that he had been born in another country and his real nationality was not that of his parents.

The trauma of the separation was dealt with by repression, and the distress of his parents' first absence could never be recalled consciously. Needless to say, this way of dealing with it created great problems for him in adult life. Relationships with women and marriage were especially difficult. He found it hard to settle for one partner, and even when married he had a number of other sexual partners before, during and after. Both his marriages ended in divorce, and most of his other relationships with other women were relatively fleeting, although very intense while they lasted. It was as if the original abandonment had created such an anxiety for him that he could not commit himself wholly to a relationship for fear

of the potential separation and loss that might occur. To minimize the risk still further, Michael had to ensure that any relationship was concluded by him, so that he became the partner who was leaving and not the one being left. Moreover, in order to reduce the pain of separation even more, he would almost always ensure that there was another partner, and sometimes more than one, ready to step into the breach, a process which we referred to as 'stock-piling'. Even temporary separations from a lover had to be dealt with very carefully if she was going away on a short holiday or a brief trip: he ensured that she took with her a number of little gifts and momentos to keep him in mind until she returned. On the rare occasions when he was the abandoned partner, as when he was divorced by his second wife, his distress was very painful and difficult to bear. His grief for the loss continued very actively for a lengthy period and sometimes seemed almost unendurable.

Until the sixth year of his work with me, the breaks for holidays seemed manageable and he usually ensured, but with some exceptions, that my breaks coincided with trips he was making himself, for business or pleasure. While away he would usually send me a card, sometimes a short letter, again to ensure that he was still in my mind. Sometimes the card was a picture of the place he was visiting. Sometimes it was of a picture or object which had special significance for him.

In the sixth year, because of his growing reputation in his field he was offered a Visiting Professorship in a college abroad, where he had formerly been an untenured member of the staff. This was to involve a whole term's absence and was a much longer break in the treatment than we had previously experienced. For a variety of reasons the offer of this appointment was particularly important to him and aroused special anxiety for him as a result. In consequence he was even more concerned that I should keep his place for him and this added to his anxiety about separation.

So in addition to our usual arrangement about fees, he asked me if I would write to him during this period. He reminded me that I had said that his sessions really belonged to him, even if he was absent and he thought that I should use them to write to him. After reflection I agreed, although I was not really aware, at that stage, of the problems that this might set for me. But as important was the sense that he needed me to be in touch with him in a real and meaningful way. Although he was the one going away, abroad, it was if it reminded him of the long summer trips his parents took each year. During these holidays his mother wrote to him to say how much she was missing him and how she wished she was not away with his father. These letters were, he always felt, insincere. And he did not believe her protestations that she would prefer to be at home with him and his sister. What he seemed to want from me was a

real and significant contact during this lengthy period which would have a different meaning for him than those letters from his mother.

This latter requirement presented me with a considerable problems. Psychotherapy is essentially reactive and responsive; at least it is in the way I try to practice it. The patient brings material to the sessions and within the transference I try to understand the meaning of the communication and to convey that understanding to the patient as seems appropriate and relevant to assist the patient with his struggle to know about himself and to grow psychologically. The conditions of the correspondence that I was undertaking to participate in were not like this, however. The interval between writing and receiving a letter made any sense of immediacy of response impossible. What seemed important was that I should give evidence that he was 'present' to me in his absence. Since this was what seemed to matter most for him the actual content may have been almost immaterial. Evidence of his anxiety about this accumulated as three of his letters were written to me before my first had reached him, and in the second and third he began by expressing his growing concern that he had still not received any letter from me, although I had in fact written to him. In his third letter he wrote:

> "Its a strong feeling that if I am committed to some of your time and you to some of mine that this must somehow be more than a theory and a one-way street. I suppose it's difficult for an analyst to write to a patient since that is not the usual form of communication but either *(sic)* is my writing to you our normal mode ....."

I had in fact been away on holiday for a little more than a week and he left for this appointment just at the end of the time our work would have been interrupted for the Easter period. Two letters from him were waiting for me on my return and I responded to them and commented upon some of the matters he referred to but found it difficult to deal with this in the same way as in a session. I qualified one of my comments as follows:

> "I put it rather tentatively because it is difficult to *know* from a letter in the same way that I can know something in a session."

I did, however, refer to the issue of separation and the way in which he had dealt with it in parting from me on this occasion. It was also evident from his letter that what was left behind was present to him in a way not evident before. Importantly, he was arranging for his current woman friend to join him for a short holiday and this too was new. I commented:

> "It suggests that you are at least working towards a different way of coping with separation and absence than you have managed before. The same seems to be true in your relationship with me and there seemed to be a different quality in your parting from me this time than on previous occasions. And this is coming through in both your letters too. It is a kind of concern about what seems to have been left behind with me which I haven't been aware of before. It is as if I am in some way identified with your abandoned infant self, but which you are allowing yourself to be aware of instead of denying."

In making this comment I was using not only the content of his letters but "the remembered experience of our last sessions" before he went away. In this sense it was no different from any other interpretation, bringing together the immediate experience with other evidence from past sessions. The difference was that the current experience was not immediate since his letter had been written almost ten days previously and mine would not reach him for another seven days.

By now, however, letters were arriving regularly from him to which I was able to reply. Two written three days apart arrived together because one had been incorrectly addressed to "London USA", and had the added cryptic message "Try London, England". The first letter with the erroneous address expressed his concern that no letter from me had yet reached him. The second was to say that a letter had now arrived and he had not been able to read it at once and in fact had read it for the first time over the telephone to his woman friend in London. In my reply I took up the error.

> "Without any associations it is impossible to interpret what the error may have meant, but to hazard a guess in the light of the contents of that letter, written before you had received mine, perhaps it had something to do with a wish that I, and Ruth, were really in London USA (if there is one) or, less literally, that either or both of us were in the same place as you."

His response to that came about ten days later, during which time I had received another letter from him to say that Ruth had now joined him. References to that impending visit had been made in all his other letters. This reply was one that he asked Ruth to take with her to post in London when she returned. I mention this as some confirmation of a need to put us all together in an important way which was also apparent in other ways. However, he denied my interpretation as follows:

> "I suppose or feel that I slipped in the address in that I was very anxious about sending you what felt like a scolding disappointed letter saying you should have written me. It may be that it's because I was confused about where you were – are – but that doesn't feel right. I do feel the anxiety, or remember it."

It will be seen that I had not said anything about a confusion but about a wish that all three of us should be in the same place. His second error was perhaps indicative of a deep sense of confusion about where he was in relation to the parents who had disappeared and perhaps a feeling of fragmentation which his slip and subsequent behaviour with my letter and Ruth was attempting to heal. It is much more evident to me when re-reading this correspondence than it was at the time, that the term he was spending as a Visiting Professor at his former college was providing him with an opportunity to bring a number of things together from the recent past, as well as those unconsciously from the distant past, in a healing, reconciling way.

The second letter from him, following the receipt of my first letter, refers to many different things and people in a containing, integrating way. It enclosed a cutting from the college newspaper about him in the past and present, and referring to his personal history and the separation from his parents in infancy. The letter is written with Ruth sitting near him, and refers to their relationship and activities together. It also includes references to the women who have been imporant to him and to his second wife who was to visit the same college. (She was an academic.) He had borrowed my copy of Bertrand Russell's autobiography and made reference to it, prompted by something I had written in my book about Russell's marriages and relationship with women, with which he identified.

In my reply I took up the theme of reconciliation and reintegration.

> "The whole gives an impression of confidence and of reconciliation, of a knitting together of the past and present, eg your references to your parents in Russia, the missionary whose advice to learn Russian was like the voice of God and the reportage about your Vietnam war and protest experience ... It is a kind of coming to terms with what was and is now, which must have some counterpart in your inner world."

I went on to make reference to the contrast between what he reports about Ruth and himself in the letter and what he understands about Russell's

inability to communicate his longing and need to the beloved woman.

> "... your letter conveys something of your feeling about the disappointment in relationships with women who don't finally give you the ecstasy you want. I wonder whether, despite his preface, Russell found it either. Almost certainly not in the terms he writes of it, a kind of elusive Paradise, always beckoning but never attainable with real flesh-and-blood women except fleetingly. The everyday gratifications of closeness, sex and being together or apart somehow do not seem enough when measured alongside that ideal. The longing in Russell and perhaps in you too was not assuaged sufficiently in infancy to quench his hunger or to allay his longing for something he hadn't had, and which is never again attainable, at least in that form, in the rest of life. He, a bit like you, had to go on demanding, but not obtaining it, from one woman after another ... at least with Ruth you seem to be beginning to sustain a complete relationship with her, to enjoy what she can give you despite its falling short of this intense longing for a sublime relationship with her, with anybody."

His last letter to me before he returned home continued the theme of integration and reconciliation. It was brought to London by Ruth. It made important references to his father; his own relationship with Ruth and a declaration of love for her; to my response to his address slip; further comments about Russell's relationships with women; to his Vietnam war experiences as a conscientious objector; to his protest experiences; and to his second wife; and finally to the belief our correspondence had given him that "there will be a relationship when I stop being your patient."

In my response to this letter I took up at some length his statement about his love for Ruth – and his relationship with her.

> "I don't think I've ever heard you say quite directly that you loved anybody, not even Rose (his second wife). That women love you has always been clear, but what you feel about them had never really been directly stated and has largely to be inferred."

I went on to wonder about the meaning of the absence of any direct reference to his own loving feelings and continued

> "Anyway, there does seem to be something different and

> important about the way you wrote and feel about her (Ruth). I think it's worth commenting upon the healing quality in the relationship which at least for her seems to have brought some tranquility and freedom. My experience suggests that these things are rarely one-sided and that perhaps there is a healing quality for you not so obvious as is hers (in the sense that you express it in behavioural terms). Tho' as I write I realize that I've overlooked the compulsive seeking of relationships with successive women which are never fulfilling and never relieve, except in the short term, the inward pain. That you have begun to withdraw from these relationships and at first tentatively, and perhaps now more confidently, suggests that the healing quality of *this* relationship may extend to you."

I concluded that passage with the thought that we might be beginning to come to an end of our lengthy journey together (although in fact our work did not terminate until a further two years had passed). The letter ended with references to the arrangements the week he would be in London before setting off once more.

This was long enough for him to take up a few of his regular sessions and he told me how much the correspondence had meant to him. Moreover, as his letters to me had indicated, he had been able to experience some of the gains he had made in therapy as a reality. Very important to that reality-testing was the way he was able to test out the new love relationship he was building and which had begun some considerable time before. He had been able to discover that there were quite important developments in the way he could experience absence from her. He left almost at once for a trip which would involve continuous journeying, staying only a few days in each place he visited. He wanted me to continue the correspondence with him, although he could only let me have a post restante address at the place he would reach at the end of his journey before returning home.

This presented even greater problems for me that the earlier letters because there was no sense in which there could be any exchanges; and as will have been seen already, the sense of an exchange was quite difficult to sustain because of the time-lag between letters being written and received. Letters from him in this new place could be responded to and commented upon but none of that would reach him until the correspondence ended. He would, however, know that I would be writing to him regularly and that all my letters would be waiting for him when he arrived at his journey's end. Even less than with the previous correspondence, there was no possibility of being able to make any direct link with whatever feelings he expressed in his letters to me, nor to be able to affect them in any way.

I wrote and posted my first letter to him before anything of his reached me. I had seen a piece he had written for publication and took that as my starting point. So the beginning of my letter was concerned with rather fewer personal issues than usual. I was seeking an amplification of his views about what he had written publicly. At that point I felt somewhat inhibited and commented:

> "I'm having some difficulty in writing anything here at this point since I feel a bit out of touch with you and I'm a bit inhibited by the thought that on this occasion it will not be possible to have a direct exchange with you ..."

I went to to refer to the difficulty of initiating anything as a psychotherapist, and to be other than responsive to a patient's material, and commented:

> "... what I'm trying to be responsive to here is a total lack of a private communication to which I can react, but at the same time I'm trying to understand the feeling content of that absence of contact."

And then I interpreted

> "I suppose when I reflect about it, it must have some echo of your own bewilderment as an infant when there was such an inexplicable loss of contact with your mother."

He could not, of course, react to that interpretation but since it was made from my countertransference to the total situation rather to the immediate interaction between us, or to what he had said, I felt that it might be able to offer him something valuable when he read it.

I continued

> "I don't know what more to make of it than that, and perhaps, in time, you will be able to fill it in a little more than I am capable of doing at present. I am left feeling that it is important to struggle with this experience and make some sense of it since it seems to lie at the heart of your problem."

His first letter to me referred in various ways to his sense of alienation from the place he was visiting and also an internal sense of alienation, comparing himself in that way with DeQuincy, whose biography he was

reading. He also referred to a kind of 'revenant' experience when he met with a dance band whose members had been exiled many years before, but had recently been rehabilitated. They played just as they did in the period before they were exiled, and others with them seemed caught in a similar time warp.

> "A young singer," he wrote, "told me her favourite singer is ... Vera Lynn!! I told her that her hey-day was 30-40 years ago. She was staggered."

He made a link with his own frozen time-warp which might be melting.

I was prompted by this reference to the dance band to discuss in my next letter the issue of the exile of many people which had occurred many years before and to which he often referred in his written publications and his sessions with me.

> "I wonder what it is about the persecution, apart from its brutality, that seems so important to you. Is it about the idea of people being silenced, sent into exile where they are lost to all who know them?"

I speculated upon the significance of the dance band's rehabilitation and its resumption many years later as if nothing had happened.

> "But it is not the same as it was before and a kind of failure to acknowledge that the clock can't just be put back."

My sense here was that his life was preoccupied with the past, with the wish to know what had happened then and somehow to resume life as it might have been. The experience with the dance band had somehow affected that in an important way.

Later in this letter I took up his sense of alienation both within and from the people he was travelling among. He was a relatively fluent speaker of their language but had difficulty in reading it. (I knew this from his sessions with me and not from his letters). I referred to that and wrote:

> "That makes me think of the preschool child who can usually speak its native language quite fluently, but can usually neither read nor write it ... Are you wanting somehow to remain in the 3, 4, 5-yr-old state?"

Much of this letter was concerned with raising issues and questions

which I hoped might be of value to him when they eventually reached him. But in closing I referred again to the sense of not being able to react to him immediately and called our correspondence a "fractured dialogue".

His next letter to me arrived before I had written again, and I was in some way able to 'answer' what he had written. He had referred to his 'enormous rage' with the local people who appeared

> "not to be doing what I want. It is the helpless and inchoate rage of an infant."

I responded

> "I think your discovery of impotent rage may be very important. I have often wondered where it had gone while you have been here, but perhaps your normally ward it off through the reptition of what must be becoming now fairly well worn memories from which the feelings have been drained. In the immediacy of the experience, however, perhaps the reservoirs of rage can be more easily tapped."

I went on to make some comments about a concern he had expressed about being stared at by the local population. (It was a charcteristic of that country to stare at strangers.) These, however, seem like my own associations to his reference to staring and I think I had in mind that he might make them the starting point for further associations of his own when he received the letter.

He had also made a reference to contacts he was maintaining with Ruth by writing and by telephone and I commented upon his unusual efforts to keep in touch with both her and me and thought of it as

> ".... absence not being quite such a total experience as before and perhaps an attempt to disconfirm the profound inner sense of complete loss when people are away from you."

When his next letter arrived it was rather short, and mostly descriptive of his various activities and the journey he was making by public transport as he wrote. Then suddenly and briefly he referred to a patient and his wife he had 'referred' to me and via this to some thoughts about *his* recently divorced wife and Ruth. It was as if the distance and absence of communication was making it almost impossible to maintain the link with home.

In my 'reply' I wrote

> "I judge from your letter that you are experiencing something

> of the difficulty I am having in not quite knowing how to write, ... it is impossible to gain any sense of a dialogue about any issues you mention."

He made a slip, which he had corrected, in a previous letter and I commented how difficult it was to understand this in any helpful way. However, I did feel able to take up another issue which was easier to understand.

> "As I write ... I was struck by your comments ... about the split you make between motherly caring and sexual passion. I wonder if you have to make, and reiterate, the distinction because your mother was so seductive, and perhaps not all that motherly in some ways?"

This was the last letter I wrote to him since anything posted later would have been unlikely to reach him before he set out for London. I concluded the letter by saying.

> "My impression is that you are a very long way away at present ... I suppose all I am saying is something about emotional rather than physical distance and I guess this may be what is behind your childhood trauma – an incomprehensible distance from mother, parents, which was impossible to bridge."

Two further communications reached me before he returned. One was a letter in which he reported a frightening dream in which I had discovered some terrible thing about him and as a result was going to discontinue therapy despite his desperate entreaties. He provided his own interpretation.

> "Well, I suppose this is fear, no? Of what is happening in your mind about me while I'm gone. Or is it one of those reversals? The opposite of what happened in the dream. I *really* feel *secure*. No. That feels wrong. I think as I get near the end of this trip I'm worrying about what I will find when I get home. One thing, of course, is that you *actually* will be leaving quite soon, within a few days ..."

What he does not say is anything about his anxiety that I might have forgotten him (and he still had not received any of the letters I had written).

He had in fact forgotten his mother while she was away on that important early trip, and when she returned he did not remember her.

A strange woman in black had come into the room, where he was lying in bed, he had recalled during a session some years before. It was his mother. I always had the feeling that he had not really believed it was and that his mother had not returned. Some of his wish to know about this country was perhaps the unconscious hope that he might find her again.

His final message was on a picture postcard, sending me his warm greetings and a reference to the picture on the front of the card which I haven't ever quite understood.

This episode in a long therapy raises a number of interesting questions. There was no doubt that during this prolonged absence, even in the period when our actual exchange of letters was impossible, that this patient was 'in' therapy. In a different way he was continuing with the work we had been doing together, but differently from the way in which patients continue with their therapy during holiday breaks. He was trying to ensure that I was present to him in a way not usual in normal interruptions of therapy. But he was also ensuring that I was present to him in a different way – not just that he carried a memory of me with him. He received letters from me, or in the case of the foreign journey, would eventually receive letters from me, and then was able to write to me regularly as he had not done before. An important emotional interaction was going on for him which was more alive than in other breaks in the treatment. What does this mean for the understanding of what therapy is?

I suppose most of us would subscribe to the notion that the operative aspects of therapy have to do with their being an exchange between patient and therapist which takes place in the intimacy and immediacy of the therapeutic session. "Interpretation is at the heart of Freudian doctrine and technique. Psychoanalysis itself might be defined in terms of it..." say Laplanche & Pontalis (1983). Strachey's (1934) concept of the mutative interpretation adds weight to this view. Nothing like that was going on in this correspondence. Such interpretations that I could make, even where they were in response to his material written seven days before, were disconnected from his experience and perhaps reached him when the feeling prompting it was long past. So my feeling is that the therapy in this context was more about process rather than praxis. It will have been seen that I did not refrain from interpreting from time to time, even though my interpretations could have none of the consequences that they might have been expected to have in the immediacy of the session. Why did I do it and what did I expect the consequences to be?

I suppose this lay at the heart of the dilemma for me in writing these letters. Although I was aware that the content might of itself not be important and significant as the fact of writing, nevertheless letters have to be about

something and they could not simply be the kind of letter I might write to a friend. Moreover I had a role as therapist which was the reason that I was writing. How do therapists write to patients if the correspondence is protracted, and an aspect of the therapy itself? I only know of one similar correspondence, and that is the exchange between Winnicott and Guntrip when Guntrip could only manage sessions with Winnicott at about monthly intervals and the therapy was carried on by correspondence in the intervals. But so far as I know, this correspondence has not been published; nor had any detailed discussion of it been made by either Winnicott or Guntrip. There were the no role models for me. I felt it was important that I remained in the role of therapist. So I did what therapists do – I interpreted, trying to bring together past and present in a helpful way as the opportunity seemed to be offered by the material in Michael's letters. I also made use of my own countertransference as I sat down to write. I was aware of my own feeling responses to the letters and to the circumstances of Michael's absence.

I had found such feelings of great use on the occasions in other contexts when I have been working at a distance and had come to trust my own feeling states as a guide to what may be important even though the 'other' was not physically present. This was especially important and helpful during the period when nothing I wrote could reach Michael and when I was totally unfamiliar with the circumstances in which he found himself.

If the significance of my capacity to interpret was firstly that it maintained my stance as a therapist and gave me some professional 'legitimacy' in the correspondence, did I think it had any other value? In answer to that question I find myself on more uncertain ground because of the disconnection in time between his writing, my response to what he had written and then his receipt of my letter. I hoped that he would remember what he had written and then make some sense of my reply, even though his feeling state would be very much different by the time my interpretation reached him. My only evidence that it did was in the exchange about the slip in the address, where he denied the interpretation I made. Whether my interpretation was correct or not, the evidence about the process of integration continued to present itself, both in his letter and in his life. Whether I made this more conscious to him with this interpretation and therefore promoted his mastery of the fragmentation, which has continued to be an enduring consequence of his therapy, I find it difficult to say. With most of my interpretations I hoped that they would offer him something on which he could reflect and perhaps have further associations. Even if he did not communicate these to me they might nevertheless help him in his emotional and psychological development.

Finally, this episode could be seen as a benign acting out of an

unconscious, and perhaps in terms of memory, an unrecoverable experience. I am unable to say whether the basic traumatic episode occurred at a time of his life when infantile amnesia was absolute, but suffice it to say that his whole life gave evidence of its impact upon him. It gave ample support to Freud's comment that what one cannot remember one is condemned to repeat. It was not recoverable in his therapy sessions except by way of an awareness that his present responses, reactions, and even his choice of career, were profoundly influenced by that experience. The absence, first as a Visiting Professor to his old University and then to the remote part of Russia, was like a progressive regression which he was unable to experience in his sessions. In my countertransference to the second phase in this period I was very much aware of my own physical and emotional distance from him and of my complete unfamiliarity with the terrain or the country in which he was travelling. For him, although he was able to write to me, the lack of contact with me must have been very like the total blankness of his parents' early absence from him. It is interesting that, in this context, although he could have telephoned me, as he did others, he chose not to do so. Consciously his letters make no reference to this, but they are preoccupied with the past and the present and the rupture of intimate relationships and gave me a sense that an important matter was being worked at, to which I responded in my letters. So perhaps the process is not best described just as the acting out of an important unconscious conflict but as reality-testing and working through in a way not available to him in the therapy sessions.

In so far as my countertransference could be any guide to that working through, I was aware that somehow I was both the abandoning mother who left him inexplicably alone and who could have no contact with him and was also his abandoned infant self, especially in the second phase, cut off from the parent. But in both cases, the connection was maintained literally, and more importantly psychologically. We were both able to be aware that we remained alive for the other during those absences, which served to enable the reworking of the original trauma and the healing of the fragmentation which it had produced.

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A RING AROUND THE SELF

Patricia Allen

Introduction

Rage, envy, hatred, violence, isolation, fear, cold, shame: some of the ingredients of the story to be told here. I am going to describe the major elements to emerge in the first two and a half years of psychotherapy with a female patient in mid-life, who has sustained a deep narcissistic wound, and who has revealed a psychic functioning which is both primitive, and at times malign. It has become clear from re-construction through the transference and counter-transference feelings evoked, and the history reported by the patient, that her early infancy, babyhood, and childhood experiences probably provided little that would foster a self feeling, and develop an inner world which might contain good and helpful objects. Indeed, it can be inferred from her material and her behaviour that the interaction with the early environment produced something akin to terror which, for the sake of survival, necessitated a defence system of a total kind. I have been greatly helped in my understanding of this by Michael Fordham's work 'Defences of the Self', in which he describes the total defence exhibited by patients in a transference psychosis. He explains how these patients divide the therapist in two, and seem to empty what self feeling they have into him. They then defend themselves violently against the manifestly 'not-self' part, which is encountered in interpretation and the therapeutic framework and its boundaries, and which they do their best to annihilate. (Fordham, 1974).

The Ring

At first Mrs. B. appeared to be co-operating in the business of being a patient. In the first session she told me that this was her wedding anniversary. In the second session she asked if she might use the couch, and she lay reflectively making associations which seemed relevant and which were interesting to me. However, I began to identify a sense of unease in myself at the smoothness with which the therapy seemed to be proceeding. At the first holiday break Mrs. B. provided angry and sadistic fantasies and offered no resistance to my interpretation of her anger at the separation. A 'confessional' quality emerged when she told me with some difficulty, of her problems in controlling her temper with her children when they were young. It seemed important to her that I realise how seriously she

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took this issue of loss of control.

It was not long before I experienced her temper myself. At the end of one session in which she had become enraged because I had failed to understand what she was communicating, she furiously wrenched the door from me and slammed it shut behind her, missing my hand by the merest fraction of time/space. I was left shaken. At the same time I was becoming aware of the violence done to my interpretations, indeed to my very presence. Mrs. B. would 'half' tell me things, assuming that I must know what she was thinking or feeling. She would then react to my response in one of two ways: either she would shout or sometimes scream, attempting to drown my words in furious denial, or she would simply lie silently with her eyes shut. During these 'silent annihilations' I would be left uneasily wondering if I really did exist as my words disappeared into the ether. Eventually she would exhale and respond from a distance as if to say, 'Oh, are you still here?' I believe that by attacking me and ignoring me she was, paradoxically, attempting to achieve a state of blissful union with a phantasied part of me which she had designated a 'self-part', i.e. a part with which she believed she would fit because she had emptied herself into it. When eventually I decided to comment on her far-away states, Mrs. B. turned to me in amazement. 'But you're holding me and I'm having a good feed', she said. This was very far from my experience of the situation, and I suggested that she felt she had to conjure up a phantasy breast-me from which to feed, and over which she had control, that is a breast which wouldn't let her down or intrude on her as, perhaps, she felt my words had done. This interpretation brought forth both rage and distress in Mrs. B. She said it was 'intolerable' that I wouldn't 'validate' and 'accept' her feelings. I told her that I accepted completely that she felt those feelings, but that I was present too and I was perceiving and experiencing something different.

Fordham recognises the difficulties in working with such patients and the temptation to become passive or guilty about the pain which the patient claims the therapist is causing. He stresses that the pain is a sign of the patient's struggle and will to live, and that the interpretations are secretly valued even while they are negated. (Fordham, 1974).

While Mrs. B. attacked the interpretation of the phantasy breast-me, it eventually became clear that she had indeed secretly given it some value. An external crisis which involved getting help for one of her family seemed to allow her to realise that had it not been for her do-it-yourself policies help could have been mobilised earlier. It was she who made the link between my interpretation and her insistence on handling the difficulties herself. She said she didn't know why but it reminded her of the Golom, a character from J.R. Tolkien's 'The Hobbit'. She described him as a 'hissing creature,

living alone under the deep, dark earth, with only distant memories of childhood and family'. 'The Golom possessed the magical 'Ring' which made him invisible'. I talked of Mrs. B.'s Ring as a phantasied, powerful object, conjured up from inside her to provide good feelings when the outside seemed too frustrating and her bad feelings threatened to overwhelm her. Mrs. B. responded with what seemed like a genuine emotion – 'a kind of grief', she said.

I believe that in revealing her Ring Mrs. B. was giving me a glimpse of the nature of her defence structure, behind which lay her isolation, her emptiness and her separateness. If she was visible to me and I to her, she would have to be aware of that separateness. In identifying with the hissing Golom, I believe she was describing her sense of herself as both magically powerful and inexorably bad. There are many references to 'Golem' in Hebrew mythology:

> 'A creature, particularly a human being, made in an artificial way by virtue of a magic act.'
>
> 'The Talmudic usage of the term is described as "something unformed and imperfect". Adam is referred to as Golem – meaning body without soul, in the first twelve hours of his existence.'
>
> 'Accoring to the legend the Rabbi Loew of Prague created the Golem to serve him, but was forced to restore him to his dust when the Golem began to run amok and endanger people's lives.' (Encyclopaedia Judaicia)

Golem; manufactured, artificial, soulless and dangerous. Tolkien's Golom, who lived alone under the deep, dark earth, had his magic Ring but no good internal objects, only distant memories. An image of a horrible creature in an anal hideaway, where power replaces love and loved ones.

If Mrs. B. experienced herself as the Golom, I believe that the Ring described the nature of her defence – a total defence of the self – a sphincter-like, encircling, powerful object, protecting the self from feelings which threaten disintegration. A bad object used as a good object – power used to manufacture good feelings. A self so protected cannot be flexible. The rhythmic process of deintegration and reintegration – the interaction of original self and environment, in this instance the therapist and her interpretations standing for the breast and nipple, must become stunted and distorted. (Fordham, 1976). Ledermann cites defences of the self as the infantile defence structures in narcissistic personality disorder:

> 'They bring about a premature defensive move from stunted deintegration at the oral stage to anal deintegration; an excessive

> cathexis of the anus, power in place of eros. That cathexis can be reinforced by the defensive phantasy of going back into the mother via one's own anus'. (Ledermann, 1979)

The Claustrom

Bion's model of container/contained provides an image of the healthy interaction of mother and infant through projective identification. The infant evacuates beta-elements, the components of the experience of the bad, absent breast, into the mother who is present. She will identify with the contents of the projection and be able to modify and transform the experience by her understanding and her actions. The infant will then be able to introject a modified experience and, if all goes well, will eventually be able to tolerate the experience of the absent, needed breast. This 'negative realisation' will trigger the mechanism for thinking – what has hitherto been unthinkable. A breakdown in this process may occur if the baby's innate envy and destructiveness are too great. It is also possible that the mother is unable to act as a container and may distort the communication to serve her own neurotic or psychotic purposes. In either of these situations the likelihood is that the developing individual will become someone whose only means of interacting with the environment will be one in which a constant discharge of beta-elements takes the place of the capacity for thought. (Grinberg, 1975). Thought becomes the enemy because it is essentially about absence.

Mrs. B.'s attempts to communicate with me via the projective identification of Bion's model seemed doomed to failure because her envy and her murderous phantasies could not allow me to exist as a container which might modify her states and which she might safety re-introject. If in phantasy she had destroyed me, I was (for her) destroyed. 'I'm talking to you but you're not there!' Mrs. B. once screamed at me in rage. She could not allow me to exist because my existence meant my absence. A vivid example of this occurred when Mrs. B. became very distressed at the appearance of an up-ended couch on the landing outside my flat which is used as a waiting area. (It had been placed there temporarily, but unfortunately without consultation, by my neighbours). Although she knew it was not my couch, the one she was using, she reacted as if it was. She brought a dream about an armchair placed next to a lavatory, and became convinced that the couch was on the landing because it was to be thrown out. She had made it the lavatory-couch-me, in which she had deposited poisonous faeces and urine, which could not be tolerated, contained and survived.

This breakdown of container/contained made inevitable what has been termed 'pathological projective identification', and which Meltzer has sought

to differentiate from Bion's model, and to name 'intrusive identification'. He argues that this more accurately describes 'the essential motive of invasion of an alien personality and body'. (Meltzer, 1986).

This is similar to Fordham's point when he describes the attempts of the patient to split the therapist in two and force his way into him: 'The patient aims to destroy the analyst's internal parents, basically the mother and her babies inside her'. (Fordham, 1974). The Claustrom, the body of the mother entered in intrusive identification (Meltzer, 1986) is the antithesis of thought because it is a way of ensuring that no separation is experienced. Mrs. B.'s attempts to break into the boundaries of my body and psyche, were also attacks on my ability to think. The following series of dreams illustrates her aim to invade:

> I was banging hard on a door trying to get in to speak to someone. I think it was about you because the person I wanted to see was a barrister with your colour hair. When I got inside, the room was divided in two; one half was like an empty courtroom and in the other a couple were having a good time.
>
> I was in a kitchen which was also a garden, but I wasn't paying much attention to the pots and pans and brushes and brooms, just looking at the lovely flowers. Then someone, I caught a glimpse of red hair, came up behind me and got me round the neck. I struggled and bit, then something like chloroform was pressed into my face and I woke up smelling it.
>
> There was a woman in a bikini standing with her back to me. The bottom of her bikini fell down and I playfully slapped her buttocks.

In the first dream the division of the therapist which Fordham describes is clear. The first part of the room, standing for the therapeutic framework, is a courtroom, formal, statutory, empty. While in the other part, the inner sanctum, intercourse is taking place. In the second dream Mrs. B. is inside the body of the therapist/mother, kitchen-breast and garden genitals, but she is paying little or no attention to the functions of the feeding or cleaning mother. She is concentrating on the lovely flowers – the genitals and internal babies. Here there appears a note of conflict in the form of a retaliatory therapist/mother who suffocates her. This is another aspect of the Claustrom, and one which was to become important later in the therapy. In the last dream Mrs. B. is playing with the breasts behind my back, my buttocks. She has displaced the breasts to the anal area, and is playing at the entrance to my body.

Mrs. B.'s aim to invade was not confined to dreams and unconscious

phantasy material. For her the experience of separateness was intolerable and she had to act upon her impulses to annihilate it. She began to demand that I extend the length of her sessions. She frequently telephoned me between sessions, once at a time she fantasised I would be in bed with my husband. She 'stole' a letter addressed to me which she found in the hall. She began to use the bathroom to clean up after tearful sessions, using the hand towel placed there for patients, under the impression that it was my flannel, and leaving it soaking wet. After one session she left distressed and returned to sit in the waiting area. A few moments later I heard animal-like howling coming from the landing. If I could hear it then my neighbours could, too. I had been put in a situation where I had to act. I went outside and stood in front of the howling Mrs. B. who was kicking her feet up and down in a tantrum-like frenzy. (Front doors were creaking open as my neighbours tried to discover what was going on without being seen themselves). Mrs. B. stopped her noise; she had got me outside the framework.

She would scream and shout during sessions, filling the space between us with sound, in an attempt to stop me thinking and making interpretations which would have emphasised that space and our separateness. I believe that she wanted to enrage me to the point of involving me in these 'mindless' histrionics. These scenes were similar to the ones she described as characteristic of her relationship with her mother.

I instituted a series of management measures in an attempt to protect the framework of the therapy and myself. I gave Mrs. B. a time to ring me at the beginning of the weekend break. She used this and for a long time the between sessions calls stopped. We had a 'five minute early warning system' which meant that I warned her of the approaching end of the session and she had time to compose herself; there was no repetition of the incident in the waiting area. Mrs. B. began to use paper towelling in the bathroom. Finally, sometimes I just raised my voice to be heard above the screams.

Throughout this time I did not stop interpreting Mrs. B.'s behaviour or her material, although I am aware that at times my actions have been more important. However, it has seemed essential that I make it clear to her that she has not succeeded in her aim to enter me and control me, and that I continue to believe in the possibility of a relationship between us; two separate beings. Mrs. B.'s reaction to her outbursts has usually been one of shame, more despairing perhaps than guilt which might contain within it a germ of concern. She told me that she had used to think of herself as 'like God, I could do anything and nobody else mattered'. On the second occasion she tried to slam the door on me at the end of the session, I was ready for her and held on to it. There ensued a struggle

with Mrs. B. trying to wrench the door from me. At the next session she brought a card which she explained was to say 'sorry'. I accepted the card and drew her attention to the fact that the message printed inside was 'thank you'. I told her I thought she was thanking me for not allowing her to slam a door between us, which was how I thought she experienced the session ends.

Mrs. B. had to enact her feelings. It seemed impossible for her simply to tell me about them. At the beginnings of sessions, and particularly after weekend breaks, she would show signs of disturbance and distress. I should know what she was feeling. If my guesses were wrong they were absolutely intolerable to her. If they were right they provoked a sense of shame, and of outrage that I could allow this to be.

From time to time it was possible to name her sense of isolation, her terrors, and her fears of dying. She once confessed that one of the ways she dealt with my absence was to masturbate and fantasise that she was raping me with a penis. It was a penis which she likened to her 'Ring'. She was linking her anal, sphincter-like, defence with the penetrative means of getting inside me. This reminded me of Ledermann's words '... the defensive phantasy of going back into the mother via one's own anus'. (Ledermann, 1979). This was perhaps an indication that Mrs. B.'s fantasised penis was a faecal one, which gave her powerful and pleasurable feelings when retained, and which she could use to penetrate and form a 'Ring' with me.

At times she would desperately try to assure me that her wish to rape me was a loving one, 'it's passionate'. At other times it was clear that the 'rape' was motivated by envy and tyrannical and destructive rage. It seemed that any contact between us must be 'rape'. I 'rape' her with my interpretations. She 'rapes' me with her 'penis', and we exist together in a state where she is inside me and in control. Whether her aim was loving or hating, and I suspect both, sometimes separately and sometimes together in an undifferentiated thrust of impulses, within the fantasies resided the desire to excite me into actual sexual activity with her.

A Bank Holiday meant that Mrs. B. missed a session, and she telephoned the following day swearing that she would 'take vengeance' on me for going away. At the next session she explained that she was menstruating and therefore more volatile. She said she had wanted to bring scissors to the session: 'To hack at your face, so that no one else will want you'. I talked of her wish to make me bleed as she was, and to disfigure me so that no man would want me and I would have no other babies. She was ensuring her possession of me, and in making me bleed/menstruate destroying my inside babies. She wanted me to be unlovable and barren as she felt herself to be; then we would be together and the same. Mrs.

B. was trying to destroy the thing she longed for most, but the thing which provoked her envy – my capacity to love and be loved. Apparently she had never before been troubled by menstruation, but now she began to experience difficulties and the length of her cycle changed. What she could not consciously know was that this change meant that her menstruation now coincided with my own. I have understood this as an aspect of intrusive identification, and one which had the effect of making both women, patient and therapist, at their most vulnerable at the same time.

Mrs. B. took this physical change to be a symptom of an approaching menopause. She complained that when she became distressed at work a female colleague would cuddle her, but because this wasn't 'that sort of therapy' she thought I wouldn't do that. She told me that she believed I cared about her, but she couldn't believe I found her body acceptable unless I touched her. I said I thought she wanted me to have intercourse with her and to put a good baby inside her, and that seemed the only way to give her something good. She experienced her menstruation as a reminder that this hadn't happened. I said that I thought it reminded her of attacks on my insides which made her despair of any goodness in herself. I said I thought her idea that she must be menopausal was a way of expressing her despair that no baby, no good thing, would ever been inside her. This was received by a distressed Mrs. B. In retrospect it seems that this interpretation marked a turning point in the therapy, in that her physical difficulties began to wane, and her more outrageous forms of behaviour, temporarily, ceased.

Counter-transference

Working with Mrs. B. has been a gruelling and at times brutalising experience. Her contempt, denigration, hatred and defiance have evoked a complementary counter-transference in me. I have felt an intense and sadistic rage towards her. Her consistent use of intrusive and projective mechanisms has meant that I have experienced myself as entered and abused, and have frequently been kept at bay by a discharge of feelings which she finds intolerable in herself. Her inability to use me as a modifying container for these feelings, which I illustrated earlier, has had the effect of my being bombarded by contents which I may process and understand, but am not often able to return to her. The rigidity of her defence is such that at times she exhibits a profoundly schizoid presence, in which all the bad, mad feelings are outside her and within me. Mrs. B. has accused me of being mad, 'My only problem is defending myself against your undermining, you are the one with the problem!'

Indeed I have often experienced myself as the archetypal, vengeful,

monster-mother of her projection. More insidious, and more difficult to make conscious in myself, has been the projection of the terrified child in relation to the powerful, perhaps psychotic mother, who enviously distorts and destroys communication. At times I have seen Mrs. B. as immensely powerful in her destructiveness and felt my sense of self under threat from her. I have needed to find a way of understanding her and caring for her which allows me to make interpretations which may be used.

My urge to retaliate has been strong as she has attempted to goad and manipulate me into living out, within the transference relationship, the sado-masochistic battle between these two internal figures. Often my counter-transference feelings have been my only guide as the meaning of words has become distorted, and communications have been withheld in the conviction that I must know what she is feeling.

I think that the degree to which I have felt myself to be both the terrified child and the vengeful mother has determined me to try to understand how such primitive mechanisms have come about and remain unmodified.

I find it significant that Mrs. B. was a Caesarian baby, and that her first two weeks of life were spent in hospital while her mother went away to convalesce. Bion made an interesting statement:

> 'Another problem arises if the patient is extremely unaggressive and fears doing anything we would call 'showing initiative'. This makes me think that the full-term fetus has something to do with the time of delivery; it can get so frightened of precipitating a catastrophic or disastrous event that it initiates nothing. Later on the patient learns how to be independent, but this fundamental fear becomes established as an archaic fear, something which is unconscious, something which is not known. Outwardly the person is brilliant, clever, so successful, so marvellous until one day there is a disastrous outburst.'
>
> (Bion, 1978).

At first glance at the facts and style of Mrs. B.'s life, she would never be called 'unaggressive', or described as 'showing no initiative'. Yet if the facts of her inner life as evidenced in her material are examined, a totally different picture is seen. The story of her inner life is one of fear, even terror. While in her outer life she appeared to be successful in all but close relationships, she was cut off from her inner world by her rigid defence system – her 'Ring'.

Earlier I have quoted Ledermann writing on how stunted deintegration at the oral phase effects and distorts anal deintegration. I think that if an earlier deintegrate, that of birth, is not activated by the flesh and blood

experience, then it is possible that the person does not experience themselves as 'born', and that must have implications for all later stages of development.

When we talked of her early days Mrs. B. told me, 'There's something I wanted to say when I first came here but it sounded too mad – I want you to give birth to me'. We expect birth to happen in a particular way. We expect mother and emerging infant to take part in a life and death struggle for life, ending in the release, the gift, of birth. That early battle which totally absorbs both participants and which, I believe, leads to the potential for the bonding of two separate individuals, was missing from Mrs. B.'s life. Her early experiences and perhaps, as Bion seems to suggest, those tendencies present before birth have contributed to the stunted development of a self which is unable to interact with an object in a way which promotes growth and ego development, but that interaction is distorted and experienced as a violation, a 'rape' of or by the self.

The personality which has grown up with Mrs. B. has, it seems, become Golom-like, manufactured, created by a magic act, an act of will; fed and nourished only by the power of her 'Ring'. There have been a few moments when she has allowed me to see what I believe to be a real part of her. At these times she has appeared to lose her rigid musculature, and her whole physical presence has undergone a change. Her skin has quivered with movement which is unlike the shaking tensions of her rages, and reminds me of a butterfly which has newly emerged from its chrysalis state. She complains of feeling very cold. On these occasions she seems to have given up her 'body Ring', her own defensively, containing skin and allowed the couch/blanket/therapist to do the holding. (Bick, 1968). In these rare moments she has evoked tenderness in me. However, these moments have been rare indeed, and more often I have had to contain rage and my wish to retaliate. The following brief extract from a session illustrates my struggle to maintain my position in the face of attack and my own retaliatory feelings.

On Friday Mrs. B. had complained of exhaustion, and I had unthinkingly said that perhaps she could rest at the weekend. On Monday she was raging at what she called 'your clichés'.

Mrs. B.: You said I should rest – you stupid cow!

PA: Thank you!

Mrs. B.: You said I could say anything I like here.

PA: I think you know that you are insulting me, and that what you call a cliché was said with some understanding of how you were feeling.

(Mrs. B. crumpled and lowered herself on to the couch and lay in the foetal position sobbing).

PA: So, it was 'how can the baby rest if Mum has gone away?' 'Mum should know that.'

Mrs. B.: Yes, I wanted to say, 'stupid, stupid Mummy'.

It has always been difficult to decide whether Mrs. B.'s responses at times like these have been genuine relief, or an outward compliance masking an angry determination to 'win the next round'. I suspect that both feelings were present in this exchange, and that my doubts reflect her doubts about her ability to feel and express genuine emotions.

Mrs. B. told me that she had a fantasy that I talked about her to a man. The seeming absence of any persecutory feelings surrounding this fantasy (and my response to it) led me to interpret it as her wish for a good primal scene. I believe that at this time she was expressing her need for a strong parental couple, a mother supported by a father in her care of the child. The absence of her father from her inner world has been striking. When he has appeared in her material it has been as an impotent man who made no attempt to intervene in the battles between mother and daughter. Mrs. B.'s interest in my husband and her reported fantasy of my possessing breasts and a penis suggest the need for me to be a mother with a father, but there is some ambiguity here. This was reflected in the wish for the mother-me to give her a good baby, and was perhaps illuminated further when Mrs.B. told me that she thought men made better mothers than women. However, it was when an event in my life produced in me a state of mourning and depression that this ambiguity became a central issue of the therapy. I believe that because of her use of primitive projective mechanisms Mrs. B. was more aware of my internal processes than most patients. It was as if she sensed a difference in me brought about by my feelings of loss and became frightened, talking of ending her therapy.

She reported a recurrence of panic attacks of a *claustrophobic* nature. She suddenly 'remembered' occasions when, ill as a child, she had slept with mother in the parental bed, father being banished. Apparently some sexual activity of an anal masturbatory nature took place between mother and daughter. She brought a dream at this time:

> There was a plug with other plugs going into it, and it exploded. There were brown marks on the wall. I waited and waited for the electrician to come and felt despairing.

It seemed that Mrs. B.'s adaptor was overloaded. In the sense that I represented her mediating ego adaptor function, then this was a projection with which I could all too easily become identified at this time. Her fear was that I had become the mother with an impotent, perhaps murdered father, who could be excited into incestuous behaviour, and whose abilities to maintain appropriately adapted channels for the life force were impaired. She began to talk on the one hand of ending her therapy, and on the

other of desperately needing me to touch her.

Intercourse with me has been a recurring theme, whether it has been her 'passionate rape' of me, her defensive phantasy of getting inside my body, the wish for the 'good thing' from me to be a 'good baby', or her reference to our first session as her wedding anniversary. Oral, anal, phallic and genital impulses have become distorted, confused and combined. When Mrs. B. experienced herself as inside her 'Ring' or inside the Claustrom, she was omnipotent and protected from her oral needs and dependence on an external object.

However, I have come to understand her wish for a penis with which to penetrate me as not simply defensive and tyrannically destructive, but as perhaps a yearning to be the potent little boy whom mother would have loved more than daughter or impotent husband. It is like the remembered or fantasised masturbatory experience with mother, which seemed in its positive aspects to be an attempt to create an intimacy or bonding belonging to an earlier stage, and which was not satisfactorily achieved. Both appear to be an urge to concretise the symbolism of incest within the relationship of mother and child and therapist and patient. (Jung, 1946).

Lambert wrote: 'The motive power that keeps the therapeutic encounter alive and moving is, as Jung has pointed out, incestuous love and in my view the agapaic capacities of the analyst. It often arises out of power struggles, out of fears of engulfment and swallowing, or out of periods of mutual gratification and gratitude, especially when the destructive aspects of talion law are sufficiently overcome on the analyst's part.' (Lambert, 1981).

Last Words

Mrs. B. did not end her therapy at that time. Her struggle intensified as she became more aware of her real feelings of powerlessness in relation to me. This time it was an unwelcome primal scene which proved to be the battleground. Although at the start of her therapy Mrs. B. had given me permission to involve her GP, she now became enraged at my decision to contact him in the face of her desperate flight from me and her appearance of breaking down. She returned to let me know how much she resented my action. It seemed impossible for her to accept that my request for his support and his willingness to help were aimed at assisting her. It was outrageous that an 'other' be introduced. Mrs. B. tried to insist that I see her over the approaching two week holiday, or send her to a psychotherapist colleague but not her doctor. She told me that my insistence on her GP providing holiday cover meant that I thought she was going mad. I was left with the feeling that this was a familiar situation in which the sense of 'otherness' resided mainly in the fact that it was I, not Mrs.B.,

who had suggested the doctor. It was an idea which did not 'fit' with her idea, and she fought against it, furiously attempting to bend me to her will. I held firmly to my position and the break was weathered.

This challenge to her omnipotence seemed to usher in a change of mood. A new and more depressive quality emerged, and Mrs. B. and I began to find ways in which she could tell me about her feelings without screaming at me and with less fear that she was putting these 'bad bits' into me, and that they would destroy me. She was experiencing pain and feared breaking down, but she seemed more real.

I believed that there was a risk of her breaking down at this point; it sometimes seemed that the attacking part of Mrs. B. had now turned inwards. I began to gear my interpretations more directly towards that adult part of her which, despite the turmoil and distress within her and within the therapy, had continued to function in the external world. I believe that I was able to do this with some useful effect because the delusional quality of the transference had diminished. Mrs. B. no longer saw me as a 'monster'. I was someone who had held firm against her 'monstrous' wishes and survived. I was still 'not right', not what she wanted me to be, but she began to reveal that she had, as Fordham predicts, secretly valued some of the interpretations which she had previously seemed only to distort or negate. (Fordham, 1974). She began to make it clear that in spite of everything, she had valued me.

There began a building and consolidating phase of the therapy in which Mrs. B. was more able to use me as a supportive and reasonably good figure. She now sought my help in thinking about difficult realtionships at home and at work. A certain realism seemed to emerge; nothing was easy or perfect, but more was possible. I think that Mrs. B. had moved from her defensive position of feeling 'like God', to its opposite of complete powerlessness, and was now beginning to realise that a state of relatedness with me could be a source of strength as well as pain, and might help her to use the many resources which she undoubtedly possessed. During this reintegrative phase Mrs. B. asked to terminate her therapy. She felt she had come as far as she could. Eventually we agreed on a termination date which was nearly a year into the future. Mrs. B. left after what would have been our last holiday break. In a letter she told me that her ambivalent feelings towards me made it impossible for her to continue to the end – it was too painful. She was sorry that our relationship had been so difficult at times, but she felt that she had changed for the better through her therapy and she was grateful to me.

Therapy ended thus, four years after it had begun. We had both been through an ordeal, and had both been changed by it. Looking back over the period of her most intense struggle Mrs. B. told me, 'It was madness

– I have been shaken to my roots'. For my part and with respect for that struggle, I believe that what had been shaken was the Golom's belief in the power of his 'Ring'.

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LIFE IN THE DESTRUCTIVE ACT

Glenys James

Introduction

This paper is based on my work with a 29 year old man named K. I focus on what has happened between K. and me and on my understanding and analysis of the intense transference and the equally intense countertransference. I describe how K. attempts to cancel external object relations and live in a detached withdrawn way, in a state of emotional apathy. I link such a retreat with the formation of his weak ego and his impoverished inner world. I try to show how K.'s primitive projective and omnipotent defences are mobilized in the therapy in an attempt to avoid a regression to an early phase of development. I hope that I have been able to demonstrate how an analysis of these defences has allowed some regression to the oral phase of development and how this has begun a process of integrating his aggression and rediscovering parts of his real hidden self.

Meeting K.

I first heard of K. when the reduced fee scheme co-ordinator rang to describe an eager young man of twenty seven, ripe and ready to work his way into a therapeutic relationship. He had impressed the assessor as a good training case and he could start immediately; I heard the referrer say "I don't think he'll keep". I felt quite unable to give the matter any thought or even consider that I could ask for time to think; it seemed I had no choice but to 'take K. on board' and urgently relieve the referrer of K.'s daily demands for the name and telephone number of his therapist. During the following days, as I scurried around London with a kind of compulsiveness, looking for a supervisor and arranging times and a room for K., I realised that, although I had not yet seen him, K. had made his impact and I was already becoming his slave, full of resentment and anger towards him.

I had read descriptions of this very neat, small, dark but pale faced, City Bank Clerk who was somewhat remote and anxious but with the occasional hint of a fleeting secret smile. A larger and more grand picture of him emerged as I spoke to him on the telephone; here was a powerful, important and splendid pin-striped business gent from the city who had difficulty in fitting me into his busy schedule, one that clearly mattered

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more than mine. I was startled by the intensity of my feelings towards this man, a mixture of rage and submissiveness in response to his attempts to control and dominate me. His demands to meet at a time that was convenient to him contained no hint of mutuality and co-operativeness; I felt compelled to oppose him. We were already in the grip of, what seemed to me, to be K.'s primitive omnipotence.

We soon met at the time I had originally offered him. The image I had formed of him and the hostility I had felt for him both dissipated as I was greeted warmly by a smiling enthusiastic K. in the waiting room. His dark suit, his gold-rimmed spectacles and his trim moustache could not conceal a kind of insubstantiality. In the consulting room he seemed so far away from me and so alone in his chair, into which he seemed to shrink more and more as time wore on. As he spoke quietly and monotonously of his lack of interest in everything and everyone and of his wish to have more enthusiasm for life, my attention began to wander and for a while I became pre-occupied with how small K. was and that he appeared to have a sunken chest as if his rib cage was concave. He explained to me that he failed to involve himself wholeheartedly, full-bloodedly in anything, "I am only living seventy five percent", he said. He felt that when people he was supposedly fond of moved away, he ought to have missed them more than he did. His friends complained that he was difficult to reach and to get close to; he wished he could be more in the centre of things. He experienced other people as having a sense of purpose and direction in their lives; he believed that rules existed about how to live and how to relate and felt that he wanted to discover them. He described such a meaningless existence with so little feeling that it was difficult for me to identify and to empathise with him; he seemed weak and tepid. I began to remember what others had said about K.: the assessor had written, "He describes in fact a typical schizoid state and he is more aware of it and more unhappy with it than such people often are". The Marriage Guidance Counsellor had said "I had a sense of his almost overwhelming isolation and fear".

K. and I made arrangements about session times and fees and we ventured forth into our therapeutic alliance. It occurs to me now as I look back that those three encounters with K. – in the consulting room, on the telephone and through the experience of his referrer, contained the essence of his psychopathology and the nature of his object relations. We see both his feelings of impotence and his strivings for omnipotence. Paradoxically, in his weakness he exercises a powerful influence on others and his own lifelessness contrasts markedly with the intense feelings he generates in those around him. I felt that we really had met and that K. had given me a taste of what was in store for us.

K.'s Life

K.'s Sicilian parents left Sicily to settle in this country in the fifties. They had two children. K. was born in a London hospital with a congenital inguinal hernia. His mother rejected him from the moment he was born and it was only with the patient persuasiveness of the hospital nurses that she began to relate to him. He experienced severe feeding difficulties and became a "scraggy infant" who "nearly fell through his mother's arms". When he was two and a half months old he was readmitted into hospital for an operation to repair the hernia; this was repeated at age five months and yet again when K. was five years old. Two years later, he had a further period of hospitalisation for a tonsilectomy and at age ten underwent a fourth hernia operation because all the other earlier surgical efforts had been unsuccessful. He was a slow developer which caused great anxiety to his parents. He did not walk until he was eighteen months old and his father tied him by the rein in an attempt to train his son to walk. Until his eighth year, K. was a persistent bed-wetter.

He was reared, along with his sister, who is fifteen months older than him, by parents who found it hard to settle and make a living in this country. His mother responded less well to the cultural, linguistic and social adjustments demanded of them and she remained nervous and insecure for years. K. remembers her as a somewhat depressed, overanxious mother; he thinks that the overprotective and intrusive maternal care he received in his early childhood hindered his development and left him unable to take risks, to learn about life for himself and to gain a sense of himself as a separate person. His mother both envied and disapproved of her husband's more confident, assertive and outward going nature; his active social life and his great interest in sport took him away from his wife and children and throughout K.'s childhood, his father remained largely unavailable physically and emotionally to him. The small, delicate, timid K. was a great disappointment to his father who bought him a pair of boxing gloves in the hope that K. could be encouraged to assert himself with his peers. But he was never able to stand up to his father's supreme authority which was experienced by K. as merely crushing the little spontaneity and enthusiasm that he was able to muster in his father's presence.

In contrast to K., who was a shy, withdrawn little boy, who played largely on his own, his sister was a vivacious extrovert like her father and in their childhood she was "the star of the family" who outshone her younger brother in every way. This aroused a formidable envy and resentment in K. and from the shadows of his miserable world he was contemptuous of and vindictive towards his sister.

He constructed for himself a self-sufficient life style and persona; from

the age of eleven onwards he would get himself up and ready for school in good time; he discussed very little with his parents and made his own decisions about his schooling and future careeer. He survived as an isolate, at home and in school, harbouring his worries, his loneliness and his anxiety about his feeble masculine identity. He grew up to feel he should emulate his father who was a self made small business man. K. left school at eighteen with 'A' levels in Maths and Economics which led him into the world of Banking where he has always worked.

In his early twenties, he married a quiet English girl whom he had known for six years. There were major relationship and sexual difficulties from the outset. K.'s sexual impotence created intolerable anxiety in him, resulting in prolonged and frequent battles between them. Following two years of unhappy married life and two periods of marital counselling, K. decided to terminate the relationship because he was very frustrated and bored in a marriage which he had felt pressurised into by his wife. This crisis was precipitated by his wife's improved self esteem subsequent to the counselling they had received and her wish to conceive a child. He left his wife, the marital home was sold and within a year K. had come into therapy with me.

The Empty Vessel

By our second meeting, K. was already leading me into his internal world of emptiness, futility and despair, of isolation and hopelessness: "I am so bored with everything, I'm hollow really, I'm spiritually dead". Was this what had been conveyed to the Marriage Guidance Counsellor and the referrer when they had felt such urgency to find therapy for him? It had the quality of a life and death matter; this could explain why I had not questioned whether I should take him into therapy or whether he was a suitable training case. And then, he led me as if further into himself: "I am in a dark damp cold dungeon chained to the wall; there are chains around my ankles and wrists and around my body, it hurts to move. I have been here a very long time". Is this where the real K. had retreated to, leaving his other self depleted and barren? This could be the very withdrawn part of the split ego that retreats into a safe fortress, a kind of symbolic womb within the self, that part that has escaped even from the world of internal objects. (Guntrip, 1974). It seemed to me that the K. in the dungeon was the terrified infant who had retreated from life, hiding his inner citadel.

The cries of chronic dissatisfaction with himself, with me, with others, with the world, pervaded the hours, the weeks, the months: "You say things but I don't have any opinions, I have no thoughts of my own". K. would say "I neither like you nor dislike you, I am quite indifferent to you".

He made me feel that for a moment, I did not exist. He complained, "if you talk, I feel empty and if you don't talk I feel empty". There did not seem to be a satisfactory way for us to be together.

Each of us, in our own way tried to escape the deadening and unrelenting sense of futility that permeated the sessions. K. spoke of wanting to speed things up by trying other forms of relief/therapy eg. what did I think of ECT, pot, hypnotherapy? He would say "I think I need to have my mind blown open, I haven't the time for this sort of therapy". He spoke of having wasted enough time in his life already as if what had gone before had no meaning or relevance: "I have never been myself", he protested. I was reminded of Winnicott's description of one of his patients, "she contains no true experience, she has no past. She starts with fifty years of wasted life but at last she feels real". (Winnicott, 1982). In Winnicott's terms, the K. in the dungeon was the true and real self, chained, locked up, undeveloped but protected by the false self who could not experience life or feel real.

The unreality, boredom and apparent meaninglessness of our time together drove me into extreme drowsiness accompanied by a strong desire to curl up like a foetus and withdraw into a deep sleep. I felt that I, too, was becoming empty and I began to entertain fears that K. was really unreachable and that therapy for him was useless. This kind of unreachability could be understood as a withdrawal into a state, beyond the level of internal objects, into 'a return to the womb state', leaving a depleted part ego which feels nothing but futility and emptiness. (Guntrip, 1974). I felt I did not want to reach him and I was unable to think of anything to say to him. The deadly emptiness aroused in me a strong counter-resistance with retaliatory impulses; I felt like saying, "All right then, I'm not going to bother about you anymore and you can stay in your hell". The therapist's boredom often reflects the absence of any significant object relations in the patient's inner world and I was aware that one of the dangers in the treatment of such a narcissistically damaged patient was my passive indifference and withdrawal with the risk of abandoning him. (Kernberg, 1975).

Reconstructions that linked his fears of experiencing anything with me to his early experiences with his mother, led absolutely nowhere. It seemed that both patient and therapist were sinking deeper together into a cold dark pit, into an overwhelming darkness. Such darkness is referred to by Jung as the psychological parallel of the alchemical nigredo, "a black, blacker than black", a return to chaos where "at a certain moment something establishes the unconscious identity of doctor and patient". (Jung, 1954). He thought that such an experience can occur in the case of a patient who shows violent resistances coupled with fear of the activated contents

of the unconscious.

Slowly, and what seems in retrospect to have been exceedingly slow, it dawned on me that most of what I said meant nothing to K. His withdrawn unemotional attitude and a kind of detached hostility which pervaded his whole relation to me, month after month, was typical of the introverted regressed schizoid. It had created a very difficult type of resistance. But, I began to believe that K. really did feel empty and that he did not experience very much inside himself. I had almost insisted, like K.'s father had insisted, that K. should be active, strong and more alive, as if I had been in a state of syntonic countertransference (Fordham, 1957). I realised that when K. responded to me with "I don't know" and "that doesn't mean anything to me", it did not necessarily imply an active rejection of my interpretations. The meaninglessness of everything to K. was more likely to be due to what Klein describes as a large part of the personality and of the emotions being split off rather than as a resistance to the therapist (Klein, 1975).

The shift in my perception and understanding of K. brought about a corresponding change in him. It seemed as if more trust had been generated within him which allowed him to regress to the couch. I had been conscious from the beginning that K. had little trust in me or in anyone and that setting up an empathic environment for the development of a basic trust is of crucial importance for such patients (Lederman, 1982 and Erikson, 1977). I realised this was no easy task; many times bitten, many more times shy. K. now began to exhibit more clinging behaviour; he experienced some difficulty in getting into the house, claiming that the entry phone would not work for him; he complained that fifty minutes was too short a time for us to be together and he showed reluctance to get up from the couch and leave at the end of sessions.

I became aware of a sense of K. wanting to adhere to me and that the regressive move was partly a wish to merge with me. He had phantasies of us becoming as one, "I'm worried that my not having anything to say will stop you saying things and then we will be the same". I said to K. that I thought a wish lay behind that worry, a wish to reduce our differences and our separateness, a longing to fuse and be at one with me. In this way, he could avoid becoming dependent on me because dependency, as he had experienced in childhood, was presumably not something he wished to repeat because it had been too painful.

An interpretation of this kind would drive K. back into his retreat and the sessions would be filled again with cries of emptiness. In one session K. worried that my silence meant that I was becoming as empty and hopeless as he was; I translated this into his being anxious that my hopelessness would make me turn away from him and leave him. He remarked that he cared nothing about that because what I would be leaving would not

be the real K., so it didn't matter. He withdrew from me, almost visibly; he seemed to be getting smaller and smaller on the couch and so still. K.'s emptiness then represented a depleted and weak ego. The danger for such personalities is that the traumatized part of the self that has retreated into its safe citadel exerts a pull on the rest of the ego and draws the internal part objects into itself, leaving an empty internal world. (Guntrip, 1974).

It was during this phase of the treatment that K. saw the film 'Psycho'. He felt pleased that unlike the character in the film, he had always opposed his mother and had kept her out to stop her filling him up with herself. When I compared his attempts to keep his mother out with his efforts to keep me out, he said, "I'm beginning to talk like you, perhaps you are taking me over". He announced one day: "I've reached a state with you of either letting you in or keeping you out". Both were equally frightening to K. Keeping people out cancels external object relations leaving him isolated and detached without any chance of further ego development. Letting people in leads to the terror of the ego being taken over by the 'devouring mother', leading to the annihilation of the self. K. was caught in an irreconcilable conflict which Glasser refers to as the 'core complex'. The infantile, all-consuming, needs create a longing for fusion with the object, a state of at-oneness. But such a concept of fusion carries with it the inevitable complete possession by the mother and thus annihilation. This is reacted to by a narcissistic withdrawal into isolation with attendant feelings of complete deprivation and abandonment. The intense anxiety of abandonment and the pain of deprivation prompt further longings for union and the vicious circle is completed. (Glasser, 1985).

I linked the way K. is with me to how things are in every relationship he attempts and to how things presumably were between K. and his mother. Throughout his life, his ultimate choice has been to withdraw and remain as an empty vessel.

From impotence to omnipotence

K., the corpse like figure on the couch, did however, begin to stir. He now began to experience physical restlessness as he cried out "I can't let you in, I can't". On one occasion he shook uncontrollably and then sat up on the edge of the couch, holding himself together. He remembered physically and emotionally his experience in the hospital bed whilst waiting for the surgeon who was to perform his hernia operation. I said that he seemed afraid that if he let me in, I would cut him inside and hurt him like the surgeon had done and like his parents may have done when he was little.

This session marked an entry into a new phase of the treatment which was now in its eighth month. The stagnation and inertia began to give way as if the revival of a past experience had awakened something within K. The chronic claims of impotence and futility became substituted by a flood of omnipotent wishes and phantasies. In this section, I would like to show how K., in the transference relationship, desperately and omnipotently tried to control me, to parasitize me and to possess me.

He now came into the consulting room in his shirt sleeves leaving his jacket in the hall downstairs. I was struck by the fact that he looked less well defended without his jacket and also that he seemed as if ready to get on with the job. It occurred to me that if he had also left his wallet downstairs, he ran the risk of having his money stolen; the house has eight consulting rooms with many people coming and going. He denied that this action had any significance but a week later announced that someone had stolen his Evening Standard from the hall the day before and that if anything like this happened again, there would be trouble. On further exploration, we discovered that K. was setting the scene to get the Police into the house and to implicate me in the 'crime'. He then asked me whether it was possible for patients to change their therapists and find new therapists in the same house. Through splitting and projection, the house now contained the bad thieves downstairs, the bad me who might be visited by the Police and the good therapist in another consulting room. Delays occurred in his payment of fees and he spoke of selling his flat, going to live with a friend, an older woman (of my age) and of giving up his therapy. In this way he could leave the bad mother/therapist and go to the good mother/friend who did not rob him of his money or desert him in the holidays. He imagined that one way or another, he could be rid of me and thus be free of the undesirable parts of himself which he had projected into me.

The splitting is well illustrated in K.'s first dream which preceeded a two week break from therapy. K. dreamt that he was travelling on a London bus. He was using a replacement travelcard for the one which had been stolen from him the week before. The passengers paid as they left the bus and K. noticed that the black man in front of him had K.'s original travelcard. He accused this man of being a thief and tried to involve the bus conductor and other passengers. No one would believe him and K. began to worry that the others would think that he was the one who carried a false bus pass whilst the black man's was authentic. On alighting, he met me on the pavement and told me his story but I merely reacted like the others and then walked away. In the dream, the good is located in the hard done by, innocent K. and the bad is contained both in the thieving black man and in me, the indifferent, abandoning therapist.

The withdrawal of the early months had given way to an emerging and a more provocative K. He admitted that he would like me to become angry with him because he believed this would make it easier for him to be angry with me. He came back after one weekend thinking that he had actually felt some anger towards friends who had beaten him at Monopoly. But a dream that soon followed indicated how dangerous and frightening it still was for K. to experience feelings. In the dream he is standing by his gas stove, cooking. The gas flames rise high and get out of control; he tries to blow them out only to be overcome by gas fumes and he becomes unconscious but survives. At another time he toyed with the idea that we did have a relationship and that perhaps he did mean something to me after all, if I was still prepared to see him despite my heavy cold. It was clear that K. needed to get into a relation with me so that the deintegrative processes that had been so badly impeded, if not arrested in infancy, could be continued and allow the growth of his ego and the development of his personality. (Lederman, 1982). It seemed to me that "his hidden self needed to become active". (Fordham, 1980).

The Christmas break was a watershed, releasing a flood of feelings in K.. He had felt bereft without me, fearing he had lost me forever and phantasizing that, in readiness for the next break he would get the keys to my flat and sit inside, awaiting my return from holiday. In the next session, this idealising transference and the wish to be inside me had turned into a tirade of complaints about my callousness; if he could not be that special for me, that is, to take him with me in the holidays or not leave him, then he had no intention of letting me be special to him. But, the longing to be with me all the time persisted; he wondered if I could give him, free of charge, the sessions which my other patients cancelled. He searched for me, the lost object, by telephoning me at work, in the evenings and during weekends at home. He pleaded for a fourth weekly session but when offered it, complained that it was at the wrong time. He would say, "I'd like to have you there by me so that I could turn you on and off like a tap" and "I want you to be everything to me, all rolled into one", in other words, the archetypal Great Mother. He felt the need to stoke himself up with me to tide himself over until our next meeting. He imagined himself as the alcoholic who yearns to be fed intravenously, which I likened to the foetus who is fed umbilically.

This was not a wish to relate to me as a separate person, as a real human being. It seems he had delusional phantasies of once more being inside the mother. This kind of idealising transference is a wish to merge, an attempt to get back to the period when the idealized parent imago is still almost completely merged with the self (Kohut, 1971). K. seemed extremely sensitive to even slight imperfections in my ability to achieve

immediate empathic understanding of all shades and nuances of his moods and experiences. Had K. been subjected to intolerable disappointments and frustrations in his infancy leading to a failure in establishing a self-soothing internal structure?

The wish to merge with me and to cling to me aroused strong countertransference feelings. I felt that he was in my hair, that he was a leech burrowing into me. I imagined that he was following me down the street, that he would be waiting for me at my front door, that he would appear at the hospital where I work. He entered into my dreams; I thought about him as if I was a mother pre-occupied with her growing foetus.

The most striking feature of this clinging behaviour was not, however, its dependency but its controlling aspect: the wish to switch me on and off, the wish to eliminate the real me and only have the phantasy me he had created when he was away from me. The phantasy me was totally within his control and she was, therefore, far superior to the me of the sessions.

The failure of his omnipotent wishes intensely frustrated and disappointed K.. The yearning to be close went hand in hand with complaints about this uncaring, withholding, independent therapist/mother. He likened himself to a man who has been in the desert, his lips are cracked and his mouth is sore, his tongue is swollen, he is dehydrated; when he is offered water he cannot even take a sip. The rage with me at the wait between sessions and the frustration about being unable to control me were so damaging that he could then take nothing from me. At other times, he would retreat into a hostile silence for a whole session only to enthusiastically engage me as it was time to part as if to demonstrate that I really was the 'terrible mother' (Stevens, 1982).

His omnipotent self was increasingly emerging and I was now cast as his slave. He had needs but I was not allowed any: "will you see me if I don't pay you?" He phantasized that I was there only for him and he took longer to leave at the end of sessions. He could not understand why I was unavailable when he 'phoned and he thought it quite unnecessary for me to take holidays. During an Easter break he rang many times from various London rail stations without enough money for the call and fully expecting that I would ring him back and pay for the calls. On arriving late for sessions he smiled as if enjoying seeing me there waiting for him.

Interpretations about his disappointment with me as being anything less than perfect and about his envy of me enjoying myself without him, were all denied and swept aside with a contemptuous remark about his needing nothing from me. This need to devalue me could be seen as an attempt to avoid feelings of envy and hatred. But a constant devaluation

of the external object creates an empty external world and reinforces the individual's internal experience of emptiness (Kernberg, 1975).

K. tried to call the tune for a while by coming to the sessions sporadically. On turning up five minutes before the end of sessions, he would not be able to hide his sadistic pleasure at having had the power to keep me there for him. It gave him a sense of being the one in control. He made attempts to take over the sessions and played at being the therapist "you have ten minutes left to come up with something convincing, now there are three minutes left, how does it feel then?" As he left, he threw the bill on the couch, saying contemptuously "I think this belongs to you" and then swaggered out of the room.

From time to time, he abandoned the couch and resorted to sitting in the chair, legs outstretched, hands in pockets, presenting an image of power and bracing himself as if to go forth into battle. With a sneering expression on his face and a condescending tone of voice he would speak of his own stupidity for having listened for so long to my "half-cock ideas". He felt only disdain and scorn for "people like me who feed off people like him". He thought me "lousy at my job" and felt quite sure that "I did not have a clue about what I was doing". There he remained in his splendid isolation, in a kingdom where he reigned supreme over me, his slave, whom he denigrated and humiliated, mocked and despised. It gave him an illusion of potency.

I shared with K. my thoughts that he desperately wanted to have an effect on me. To be able to effect something or someone is proof that one is not impotent but that one is alive and functioning; it is at least proof that one exists. This is perhaps what had been lacking in K.'s childhood; there had been nothing upon which he could make a dent, nobody to respond or even listen to him, leaving him with a sense of powerlessness and impotence. It is such powerlessness that can create the sadistic character (Fromm, 1977).

These dramatic oscillations between an idealising transference and a negative transference, with sudden switches in K.'s emotional attitude were very difficult to tolerate. An intense transference had developed, one moment manifesting itself as a regressive move into an incestuous relationship (Jung, 1961) and in another revealing an active process of denigration and spoiling. Whereas in the earlier part of the therapy, the fear of annihilation following the incestuous pull had been counteracted by a withdrawal into isolation, K. was now reacting to such a fear by attacking me. It seemed to me that the aim of his denigrating attacks was not solely to negate the danger of being engulfed by the object but also to hurt and control the object. He did not wish to destroy me or lose me; he needed to engage me in an intense sado-masochistic relationship but always at a safe distance. This

served to avoid both intimacy and total isolation (Glasser, 1985).

And so his state of aloneness was perpetuated. He spoke of the idea of becoming a lighthouse keeper as he had by this time left his job in the city and was now unemployed. He had felt that the City Bank Clerk belonged to the false K. of the past and his suits were now hanging in the wardrobe like cast off old skins. But the complete withdrawal of interest from the outer world and an indulgence in the regressive longing for the mother was not a solution for K. But neither was his escape into omnipotence and the will to sadistic power.

Harnessing K.'s destructiveness

"Patient found dead on therapist's couch". This is an imaginary newspaper headline which K. composed in one session. He admitted that he felt so enraged with me that he began to imagine that he could will himself to die on the couch by stopping breathing and "collapsing inwardly". He wanted to cause me some trouble, he said. It amused him to think that I would have to cancel my next patient, call an ambulance and the Police and be interrogated about what I had done to my patient. Not even a post-mortem would be able to reveal the cause of his death. "It could ruin your career", he said with great satisfaction. K. saw that so great was his wish to hurt me that he could conceive of sacrificing his own life, the ultimate revenge on the parent.

He dreamt that he was sitting in a bar with a female colleague, a British girl, along with her Nigerian husband. K. had a strong desire to suck milk from the girl's breasts but when he did so he received a mouthful of milk and blood and it was so horrible he had to spit it all out. I linked this dream image to the experience he has with me; his rage with me for my imperfections and for not being under his total domination, turns me bad, spoils me. Any good I have is turned horrible and he has to spit me out like the bloody milk in the dream.

From time to time he tried to end the therapy. He would telephone me during his session time to announce that he was not coming anymore and a request that I send him his final bill. I interpreted to him that this was his attempt to destroy me, to obliterate me from his mind and from his world in the way that he destroys all his relationships. I felt that he needed to be helped to tolerate his own destructiveness and to see that I would still go on being there for him at the next session.

In some sessions he sighed excessively and this he attributed to his shallow breathing which from time to time leads him to take a deep breath. His general difficulty with taking things into himself reflects a paranoid relationship with the external world which contains his projected destructive impulses. It was as if the projected destructive wishes had filled the consulting

room with 'bad air' which he then experienced as suffocating.

K. felt that I had misled him into thinking that there was something wrong with him but he now became convinced that the only thing that troubled him was having to associate with me three times a week. How easy it seemed for him to dehumanise the therapeutic relationship and to dismiss everything and eveyone in a callous and ruthless way. He had no sensitive appreciation of the way he hurt other people; the provocation to retaliate was considerable and at times I felt exceedingly angry with him. It was as if K. wanted me to hate him; perhaps he could only believe in being loved if he could see that he was first hated. (Winnicott, 1975 (a)). It has not been easy to deal with the wish to hurt him as he has hurt and denigrated me. I had now some awareness of how the hatred in the sick person can be transferred into the helping one and thus destroy the helping person from the inside. The task of converting my anger into interpretations which were non-punitive but confronted him with his own destructiveness, has been very difficult (Lambert, 1973). On one occasion, for example, I was sorely tempted, when planning a weekend trip, to cut out K.'s Friday evening session. Fortunately, I realised in time that I was on the verge of acting out my revengeful feelings towards K. and reject him in the way he had rejected me, session after session by arriving late or failing to turn up.

His debilitating envy of me drives him into a state of stubborn opposition, experiencing me as his enemy. He feels himself to be stronger when he is away from me; he has admitted that he thinks I have 'too much' and that he would like me to suffer in the way he does; I imagine this to mean that I have 'too much life' in me and that he wishes I could be 'dead' like him. On being handed a bill he enters into a piece of ritualised behaviour; he sits on the edge of the couch, folds the bill many times into a minute package with his head bowed and his shoulders hunched. He then buries the packaged bill deeply in his back pocket before he retreats to the couch in silence. It is as if he has to pack away in pellet form his anger and resentment with me for expecting that he should give me anything when he is so deprived and I am already so satiated with plenty.

K. dreamt of a man who was dressed like himself kicking another person who was sprawled on the ground. His victim was dressed in red; he associated the red clothes with Liverpool United Football team who were due to play the Italians at football that week. The dream highlights how he (the Italian) kicks me around like a football with his derisive and contemptuous attitude.

As the therapy has progressed, K.'s skills in attacking me and the relationship have developed and become more varied. Despite at times feeling quite exasperated with K. and feeling hopeless about my ability as a

psychotherapist, I believe I have kept pace with him and have matched his determination to destroy with an equal will to survive, to stand firm and to contain his sadism.

Following the summer break he launched a campaign of eroding our therapeutic time by coming very late to the sessions. This escalated to a point when he came only for the last five minutes. He began to miss sessions altogether and for a few weeks he had sabotaged the therapy to that of meeting only once a week. He often rang towards the end of missed sessions to explain his absence. By this time he had become a self-employed removals contractor, carrying out small removals in his newly acquired blue Bedford Van. This meant that to a very large extent he could avoid human contact in his daily work and deal only with crates which could be more easily deposited. He claimed that his therapy was being eaten into because of the demands of his work. However, when I interpreted that he might be secretly pleased to have a good reason for eroding our time together, he admitted his pleasure at the thought of my sitting there waiting for him. I said that his ringing me towards the end of missed sessions might not only be a way of checking up that I really was waiting for him but also a way of reassuring himself that his destructive wishes towards me had not been realised.

This behaviour changed back into regular attendances and punctuality without there being any corresponding change in the circumstances of his external world. I was seduced into thinking that my efforts to understand and to interpret his acting out behaviour had brought about some shift in his internal world. I was soon to be disillusioned as he announced that since he had set himself up in business, he was not now earning enough money to pay for his therapy. He was clearly short of money and I made some attempts to negotiate a new and temporary contract with him about his fees. He claimed that he was unable to pay even a minimal sum for the time being and admitted that he was glad to be jeopardising his therapy. He said he did not care about it, he did not care even if it was self destructive.

It was during this time that he began to visit his parents in the evening and to allow his mother to feed him suppers. The move back towards the bosom of the family, with its apparent wish for dependence, contained a hidden motive. He admitted that his visits were motivated by his wish to hurt and to have his revenge on them.

The period of non-payment coincided with a phase of protracted and bewildering silences accompanied by extreme passivity. The silences were always interrupted by my remarks; maybe he was having difficulty in communicating his thoughts and feelings. He denied having any thoughts or experiencing any feelings and therefore there was nothing to say. Some sessions were completely silent and I began to think that K. had subsided

back into the state of withdrawal and emptiness that we had lived through in those early months of therapy. K. was not speaking to me, he was not relating to me, he was not paying me but he came faithfully and punctually to every session.

I was invaded with powerful and intense feelings and sensations in the silent periods. As K. entered the consulting room, I would feel a cold chill running down my spine; as he lay silent and motionless on the couch but sighing heavily from time to time, I experienced a tightness in my chest. At times I found it extremely uncomfortable being with K.; I had a strong desire to scream, I longed for the end of sessions, I had an image of depositing K. in the dustbin downstairs. In one session, I felt so enraged with the deadness and vacuum that I had a phantasy of shaking K. vigorously or throwing something at him to bring him alive. I felt I was sitting in a morgue with a corpse. To counteract this sensation I thought about the comforting and life giving things that I could do after the session such as meeting a friend and eating hot tasty food. In an interminable, impenetrable silence I wished I could put the vase in the room over K.'s head, hang him upside down and beat him. I was concerned and alarmed at the violence in my fantasies but also interested in these new developments in the counter-transference.

As the weeks passed I felt increasingly troubled and caught in a web of confusion. I began to think that K. had regressed to a pre-verbal stage where words were insufficient and meaningless. I did not know whether I should break the silences or wait. At this point, perhaps there was an important unconscious process at work that needed a holding and containing environment but which did not require interpretations. (Winnicott, 1975(b)). I struggled with not knowing whether this was a necessary and healthy regression to an early dependent phase, where the real self awaited a chance of rebirth or a pathological resistance to life and a retreat away from object relations. I felt an overwhelming sense of aloneness, I felt cut off and cold. Was this how K. felt in his cold dark dungeon? I longed to be rescued from this. Slowly I began to think of these silences as part of a defensive pattern. Instead of attacking me and destroying me K. had turned his destructive impulses against himself, against his desire to live, leaving him half dead. It was as if he was wiping himself out rather than having to face that he wanted to wipe me out. (Rosenfeld, 1965). This was therefore an attempt to avoid a true regression to dependency and an avoidance of re-experiencing his intense oral sadistic rage in the transference relationship.

I felt free to make some interpretations about the way he had been and the way he had treated me over the past weeks. He acknowledged that silence was a way of opposing me and thus keeping me at a distance.

"Not answering you makes me feel I have some control left". He was relieved to think that the way he treated me was a repeat of how he may have been treated as a child – left high and dry, left 'out in the cold', not responded to, dismissed, ignored, neglected. This was followed by a period of talking about his relations to others, sharing more about his money worries, and about the difficulties in trying to sell his flat so that he could have money to pay for his therapy.

It also became clear to me that I, too, had been avoiding things. His debt was now running into its fourth month with no obvious sign of K. being able to find the money other than to wait for a buyer for his flat. I realised that I had been colluding with K.'s idea of the all-providing mother. His sessions had to be reduced to once weekly until such time as he could repay his debt and afford more intensive therapy once more. After a period of three months he sold his flat, returned to three times weekly therapy, ceased working and went to live with his sister and her family.

The therapy, however, continued in the same vein. If I made an interested gesture towards K., after a break or in a silence he seemed cross about it. I endeavoured to show him how he destroyed the loving; perhaps this what was done to him as a child. Maybe his enthusiastic, loving gestures, his lively reaching out had been met with indifference or criticism. Perhaps his mother had not been able to reciprocate; maybe she had been cold and withdrawn, even depressed. So it was me who became the rejected, unloved baby and he became the half alive, indifferent, uninterested mother. It captivated K.'s interest to think that we do as we were done by and he began to acknowledge that this was exactly how he did treat me and others.

K.'s destructiveness was then becoming more conscious and he was beginning to recognise it and re-own it. He was able to admit to his extreme provocativeness, to his sadistic pleasure in making other people angry and in tormenting them, only in the end to leave them with their bad feelings towards him. He destroys their love, he is left feeling unloved and history repeats itself. For a brief spell K. contemplated the idea of seeking work in a betting shop but he realised that what appealed to him about this was to get into a position of power where he could take away people's hope, in this case the hope of winning money. He compared this with what he tried to do with me, that is, to take away my hope of ever seeing him as a happier K., living a richer and fuller life.

On my return after a week's break, due to illness, K. was in a talkative mood and I detected some anxiety in him that his destructive phantasies really had damaged me and made me ill. It was then that he told me a dream which showed the more creative and loving side of his personality.

In the dream K. stumbled across his cousin; he noticed that this young woman had stuck pins and needles into herself, they were all over her body and face. She was bleeding and in pain. As K. approached her she was at the point of piercing a long needle into her chest. He rushed towards her and saved her from inflicting this injury. She cried and as K. comforted her and held her in his arms, he cried too; they held on to each other and wept. He was crying when he woke from his dream and had been very moved emotionally, not by the violence nor by the sadness in the dream but by the loving closeness between the persons. He thought that the characters in the dream were two aspects of himself, the destructive and the loving parts of K.

Summary

I have given a clinical account of K.'s therapy over a period of two and a half years. My thinking and understanding have been largely based on the psycho-analytic theories of object relations and of the concept of the Self.

I have portrayed a young man who feels he has wasted twenty nine years of his life, a life without purpose or meaning, through which he has drifted in a mechanical way with a deadening sense of unreality. His life is emptied of meaningful experiences indicating a severe disturbance in early object relations and resulting in serious distortions in his internal world. In his aloneness, he yearns for, but is fearful of relationships with others. He demonstrates a profound longing for a complete merging with his object in the hope that this will gratify all his needs, provide total security and contain his aggression. Such a longing not only reveals an intense anxiety of abandonment but also the pain of gross early deprivation. This yearning, however, brings with it the fear that the remnants of the nuclear self will be engulfed and destroyed by the yearned for, all encompassing union. The longing for an object, which is then experienced as annihilating, presents K. with an irreconcilable conflict, resulting in a perpetual oscillation towards and away from people.

K. has developed two major defences against the terror of not existing. He experiences a powerful urge to take flight from life as if seeking a return to a vaguely 'remembered' archaic safe place where there are no people. A retreat, however, can only be an autistic withdrawal into emotional isolation, compounding his feelings of deprivation and abandonment with the risk of further diminution of his ego. At these times, one experiences the 'disappearance' of K. as if he has evaporated into thin air. The libido sinks back into its own depths and the ego is swallowed up as if returning to the abyss and becoming identified with the collective psyche.

His other response to the longed for, but feared object is that of aggression, domination and control. He persistently seeks to devalue the analytic process by tormenting and enslaving the therapist. The intention which lies behind his aggressive attacks is, however, not merely to eliminate danger in order to preserve the self, but also to engage the object at a safe distance. The wish is not to destroy the needed person but to involve her in an intense sado-masochistic relationship at arm's length, thus avoiding both intimacy and loss. The experience of controlling another being also serves to create the illustion of transcending the limitations of human existence particularly for someone like K. whose real life is deprived of productivity and joy.

The intense primitive transference indicates that K.'s psychic functioning is dominated by a very early phase of his development, when he experienced his mother as sometimes neglectful and abandoning and at other times as intrusive and annihilatory. A defensive protection of the primal self was set up, hindering the development of an inner world, followed by a stultification of all later maturational stages. Throughout his life, K. has only been able to repeat that original experience with each person he meets. But, despite the presence of strong defences of the self, he is still left with a desperate wish to reach a satisfactory object relationship, indicating an archetypal expectation of a good mother.

One of the main tasks in K.'s treatment has been to tolerate the very strong emotions evoked in me. The experience of giving something good and receiving something bad in return reactivates the therapist's masochism, leading to feelings of inadequacy, doubts in one's own ability and exaggerated fears of criticism. On the one hand, this stimulates the Talion response and on the other, the wish to withdraw into detachment and indifference with a loss of empathy for the patient. The patient's attempts to deny meaning to the therapeutic relationship erode the therapist's feelings of concern. In my encounters with K., concern means the maintenance of hope and a continuous search for ways of withstanding the forces of human destructiveness. It has not been sufficient to endure and survive the attack and insult; K. has needed to experience me as a real person and to be confronted with how his treatment of others affects them so that he can develop a sense of who he is and to gain a belief that he has both substance and power. It is through this process that he begins to feel real and to find himself.

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BOOK REVIEWS

Our Need for Others and its Roots in Infancy

By Josephine Klein. London: Tavistock Publications. 1987. Pp. 444. £29.95 – hardback. £14.95 – paperback.

"We do not start life as individuals" (p. 128). This statement represents the central theme of this book. The authoress is clearly interested in the impact of the human environment on the development of the young infant in the very early stages of its existence. In the book she explores the concept of relatedness in its various psychological dimensions. She seems, throughout her book, to be wholly devoted to the notion that the young baby begins its life undifferentiated from others and she enthusiastically conveys this basic notion and its implications to the reader. She is, of course, not alone in having this view and indeed she quotes from and summarises extensively other writers who have this approach. This book will probably gain a place in the library of developmental psychology but it is not strictly an academic book. It does not seek to promote a clear and cohesive theory on the processes involved in bringing about personality structures. However, the book has a clinical dimension in as much as it deals with the requirements on the part of those attending to the baby and the type of responses that would promote healthy development. It also describes pathological states of mind when those requirements in early childhood fail to be met.

The book comprises six parts each of which deals with one aspect of the development process or with an aspect of pathology in the personality. The last part handles the role of pyschotherapy in healing. The various chapters build upon one another rather like the developmental processes themselves. The book starts by describing basic neuropsychological events and how they are connected to rudimentary feelings and other basic sensory experiences which the young baby has in relation to its mother. The writer describes how structures of the personality are very fluid and unconnected to each other in the beginning and how they gradually become more organised with the intake of responses from others. She then proceeds to an attempt at understanding and describing in ordinary language the processes involved in building and creating the infants own unique personality through its relatedness to others. This process is both delicate and complex and is seen by the authoress to be a constant and ongoing movement between a state of merging with the mother and gradually moving away from her. The issue of separation – individuation is central to this argument and the writer comes down firmly on the side of there being no separate existence of an infant or even an adult. The authoress shows

a great deal of sensitivity to and respect for the onset of the baby's psychological life. In the first chapters of the book she describes with great empathy the inner subjective state of the baby who is connected with its mother yet who has to emerge from her.

Most of the middle chapters are accounts of the experiences of self and others both in their healthy manifestations and their pathological states. The personality is referred to mainly in terms of the self. The writer is aware of the theoretical difficulties which arise from using this term in different contexts, and this notion has already been extensively explored in psycho-analytic literature. Much of that central part of the book is an exposition of other writers' views, especially those whose approach is close to that of the authoress. She gives clear accounts of each author's perspective and quotes them extensively to illustrate their thinking. Those quotations are put between paragraphs in which she gives her own individualistic opinion in relation to the emphasis put forward by the other author. The writers most extensively quoted are not the classical originators of psycho-analytic thought such as Freud and Melanie Klein but other authors who studied the "self" and its relatedness to others. They include Kernberg, Winnicott, Kohut, Fairbairn and Guntrip. Miss Klein does not claim to give an accurate account of the various authors she draws upon in her book, and it therefore cannot be regarded as an academic exposition of psycho-analytic thinking on the subject of self and others. More important for the writer is to deliver other authors' views from specific angles which enable an integration with her own personal style which is more fluid, descriptive and empathic than theoretically precise.

Miss Klein has a dislike for professional jargon and on many occasions she successfully puts long newly coined psycho-analytic terms in plain English. For example she explains Kohut's "transmuting internalisation" by "the process we have in mind when we say *'We have really learnt something'* " (page 213).

The book also attempts to connect concepts from different theories into a unified meaning. For instance, Kohut's 'self object'; Winnicott's 'being' and Balint's 'Harmonious interpenetraing mixup" are drawn together as analogous and given an explanation in plain language. But she tends to ignore some differencies in meaning that would emerge were these terms to be studied in their original theoretical context.

The style of the book is not that adopted by someone writing a specialist work directed at the professional practitioner. A variety of analogies from disparate disciplines is used from Geology to Computer Science, as well as poetic metaphors. Central to the illustrative poetic style is a landscape metaphor which also incorporates psychological language and other symbols, e.g.: "There is a pool where we begin to live, a harmonious interpenetrating

mixup, a womb, an ocean ... then new features begin to appear: volcanoes and lava flows of anger, pits of dispair, rocks of detachment" (p. 123). This personal style is perhaps best adopted in the service of one of the main aims of the book, which is to increase the reader's own awareness of and enthusiasm for the young baby's need for others.

SARAH SHAMNI

The Shadow of the Object: Psychoanalysis of the Unthought Known

By Christopher Bollas. London: Free Association Books. 1987. Pp 283. Cloth Edition £25.00. Paper Edition £9.95.

Located clearly in the Independent tradition of British psychoanalysis, this is at the same time a book of great individuality. It offers an original theoretical view and clinical stance on issues which face any analyst or psychotherapist.

The fundamental theme is the infant's early experience of the object. The knowledge of the object-relating that has been lived through becomes a part of the person which cannot be made explicit in thought or articulated in words. This is the "unthought known". We can sense its presence in many ways, through dreams, in aesthetic perception and above all in the transference. Such opportunities for glimpsing the "shadow of the object" are described throughout the book. In the clinical situation Bollas is constantly concerned with the therapist's need to sense what kind of object the patient is drawing him into being. So stated, that is a familiar idea. What is original is the way Bollas uses it, not simply to reveal to the patient something defended against and therefore unconscious, but to enter an area of th epersonality which is structured around what has never been susceptible of thought.

The book draws on several earlier papers, but is far more than a collection of previous work. Although some of the chapters feel rather self-contained, there is a powerfully coherent theme to the book as a whole. It is in three parts, with a concluding chapter. In the first section, called "The Shadow of the Object", the book's main ideas are introduced. Besides the "unthought known", two other important ones are the "transformational object" and the notion of relating to the self as an object. The former designates what the mother is to the infant: an object that transforms its experience of itself. The attempt to find, or to recover, such a

transformational object, pervades not only childhood but adult life as well, in healthy and pathological forms. Bollas understands the clinical situation in terms of how the patient requires the therapist to be such an object. As to the latter, from infancy onwards everyone has an object-relation to his own self, and we manage this relation in our individual ways. There are clinical examples, as there are throughout the book, showing various more and less pathological forms of relating to the self, and also how these are linked to the search for the object which will transform the self. In this first section there is also a chapter on the unthought known in dreams and on a pathological form of sexuality – the '"trisexual".

The second section consists of four chapters under the heading "Moods". It contains Bollas' description of "normotic" illness and a discussion of hatred as an affect valued by people for whom it is the only available way of experiencing a close relationship. There is also a very interesting account of mood as something like a dream, an altered state that one goes into and comes out of, with a particular function in the psychic economy.

In the last section Bollas considers countertransference. If the patient is trying to make the therapist into a transformational object, the therapist's job is two fold. He must allow himself to be one, because it is what the patient really does need. He must also analyze the patient's wishes and manoeuvrings, which means not simply going along with them. The countertransference is what enables him to do both at once. In chapters 12-14 there is a careful discussion of countertransference and of the handling of the moderate regression which not infrequently occurs in treatment, the everyday version of what Winnicott and Balint described in extreme form. Bollas considers the therapist's use of his affective experience of the patient, how this can be used in interpretation and how it should not be used, when to interpret and when to avoid interpreting so as not to cut off the growth of the patient's own understanding. This is an extremely thoughtful discussion and should be appreciated both by those who agree and who disagree with the author's viewpoint.

All in all, a really valuable book.

MICHAEL PARSONS

The Personal Life of the Psychotherapist

By James D. Guy. New York: John Wiley & Sons Inc. 1987. Pp. 321. £31.15.

The author discusses the experience of psychotherapists in the U.S.A. from the time of entering training, through training itself, beginning practice and maturation while conducting a practice over many years. There are chapters on motivation leading to the choice of this profession, training and the satisfaction inherent in the work.

Most training programmes demand rigorous academic achievements and suitability is assessed in terms of academic ability.

Personal therapy is not required for registration as a psychotherapist and a study by Narcross and Prochaska (1982) 'found that more than one-third of those therapists surveyed declined to enter treatment at any point in their lives'. Nevertheless other quoted studies by Ford 1963, Krupp 1955 and Wampler & Krupp 1976 report that 'it continues to be a widely held belief that a trainee's personal therapy will enhance his or her ability by eliminating blind spots and improving empathy and self awareness'.

There is a lengthy discussion on 'choosing a theoretical orientation' – 'a profoundly important decision'. The meaning of the controversy among the different schools of thought is discussed and wondered about 'When one has chosen a particular perspective based on the goodness of fit with one's own personality dynamics, life experience, and the viewpoints of meaningful others, there is likely to be a large investment in this choice. This may lead to a tendency to regard other viewpoints as foreign, erroneous, and threatening', and, quoting Shaffer 1979, 'One's theoretical orientation becomes a world view which colours one's perceptions and perspective, providing a framework for organising data and life experience both in and out of the consulting office'.

Throughout the book there is a focus on the ongoing interaction between the personality of the psychotherapist and the practice of psychotherapy.

The major part of the book (from Chapters 3-7) focuses on the difficulties of psychotherapy once training is over whether the practitioner establishes an independent practice or works in a clinic or hospital. Isolation is seen as the number one hazard affecting the inner world of the psychotherapist and his/her relationship with family and friends. Self awareness of the effects of isolation, he advises, is the first step to counteracting the negative aspects of the work. An intimate relationship with a significant other providing 'feedback' acts as a corrective balance to the daily functioning with disturbed persons. Relatives, friends, a well-balanced life-style, diversified practice with supervision or research are the

helpful adjuncts. Another suggestion is that some psychotherapists develop another part-time career outside the mental health field.

There is a chapter on 'Significant Events in the Life of the Therapist' with a reminder that therapists are subject to the same exigencies of life as all human beings.

The chapter on 'Impairment among Psychotherapists' covers mental illness, depression, suicide and substance abuse. 'Impairment' is defined as 'a diminution or deterioration of therapeutic skill and ability due to factors which have sufficiently impacted the personality of the therapist to result in potential clinical incompetence' and each of the aforementioned examples are discussed. Sexual misconduct, most researchers found, tended to increase anxiety, depression, anger, suicidal behaviour, general psychic distress, sexual dysfunction, mistrust and suspicion and guilt in patients. Guy finds that if all the categories of impairment are considered together, the total incidence of therapist impairment is substantial.

Chapter 7 is on 'Career Satisfaction and Burnout', advising and 'intervening programme for 'burnout'' but stressing how satisfying and fulfilling a career psychotherapy is for those who take steps to ensure their own self-care and well-being.

'Future Trends' looks at the changes ahead, including the fact that patients coming for treatment are increasingly informed. In future, therapists may have to justify the effectiveness and efficiency of their treatment.

This is an extensively researched book, simply and clearly written. There are almost 300 references. Although based on the U.S.A., much is very relevant to psychotherapists and psychoanalysts in this country.

The chapter on 'Impairment' is I think important for the disclosure and open discussion of sexual intimacy between patient and therapist. This and other 'impairments' are usually only known by innuendo or perhaps in the confines of Council Meetings of psychotherapy associations.

The discussion on choosing an orientation is of special interest to B.A.P. where two major streams are joined in the same association, understandably with some tension.

I can recommend this book to all colleagues who are responsible for training and supervision. Those who represent B.A.P. at the 'Rugby conference' will be interested to find that 'psychotherapy' in the States too, is an all-embracing cover-term for all sorts of practice.

ZELDA RAVID

The Analytic Experience: Lectures from the Tavistock

By Neville Symington. London: Free Association Books. 1986. Pp. 347. £8.95.

In his introduction to his book, Neville Symington writes: "I would personally feel very satisfied if, from reading this book, the reader came away with just one new emotional insight; so, following Aquinas, I have been sparing on information." In fact, it would be remarkable indeed should only one new emotional insight be gained from this splendidly sensitive and erudite book, consisting of lectures given at the Tavistock Clinic.

For this reviewer Symington banishes the cobwebs and explodes some myths (to use the writer's own words) that surround much of the theory and practice of psychoanalysis. Under his guidance the experience of analysis, whether for the treater or treated, becomes a living, illuminating quest for the truth and meaning he so vividly describes. He sets out to convey the atmosphere of the analytic experience and does so with reference to the ideas and writings of thinkers throughout the ages, but most of all through his own perceptions and carefully formulated conclusions. Thus the book is, as he says, a very personal account, for his understanding of psychoanalysis is as an emotional, interpersonal relationship and one to which the analyst must inevitably bring his own history. For this analyst, to judge by his writings, warmth and wisdom must be included. Symington covers much ground in these lectures, and does so in a style so conversational and lyrical that one reads and absorbs scarcely aware until later of the import of his thought and his knowledge. He is marvellously good in his use of metaphor to illustrate his arguments, and while he never polemizes he almost invariably persuades.

The lectures are divided into four sections. The first, comprising three lectures, is titled "Setting the Scene". Here he speaks of the truth that lies, hoping to be discovered, "in between the analyst and the patient", and of the meaning that may be found when discrete events become connected and finally experienced as a whole. He makes clear his position regarding the process of psychoanalysis and the congruent growth of a whole person. A split was imposed upon western thinking by Descartes who described a cleavage between an inner and outer world of man. Symington follows the existentialist approach of Heideggar and others who, believing that man and his outside world are a single reality, have tried to repair the damage done to European attitudes by this dichotomy. In this vein he challenges, for example, the weight given to insight by writers such as Hanna

Segal in assuming that change originates from the act of insight. As he points out, insight can be acquired sometimes by reading a book. Real change comes from an encounter between two human beings, between inner and outer world, with all the irrational and well as rational components involved.

The second series of lectures are under the heading of "Freud's Discoveries". In these Symington describes a landscape of thought and belief while establishing clear points of reference in the history and development of psychoanalysis. The influences upon Freud are traced from Darwin through Descartes, the Enlightenment, the Physicalists and the Romantics, and given shape and substance in the ever-evolving development of his theories. Under Symington's guidance there is to be found a renewed understanding of the integration of Freud the Scientist and Freud the Romantic and, through his self-analysis, of the integration of his inner subjective experiences with his studies and indeed his entire social, domestic, and cultural environment: "Nothing could be in a compartment, not touching other things." I have not read an account of Freud's work concerning dreams, instinct theory, transference, structural and topographical models written with greater clarity and empathy, and I use 'empathy' in its dictionary definition as the power to identify oneself mentally with and so fully comprehending, the subject or object of contemplation. Symington is very much present, as throughout the lectures, in these accounts, illustrating with examples from his own clinical experiences and observations, adding his own thoughts and the occasional personal critique. Consider, for example, his belief that there is "evidence for a moral sense in man", a concept for which Freud gives no place. Bion and Winnicott explicitly suggest such a sense and Symington indicates its implication in the writings of Melanie Klein, Fairbairn and Balint to name but a few. A fine understanding of Freud emerges through these pages, and his works are illuminated not only by what he strived for and achieved, but also by the horizons he glimpsed but did not, indeed in view of his mortality could not, attain.

The third group of lectures are concerned with Freud's contemporaries and their works: Abraham, Ernest Jones, Ferenczi and, of course, Jung. It seems to me that Symington elicits from the work of these analysts the most fruitful aspects of their theories, and highlights contributions which, while hitherto acknowledged, perhaps need more piercing illuminations to fall upon them from time to time. He establishes links and similarities between them while not omitting their conflicts: Abraham disagreeing with Jung ostensibly over the aetiology of schizophrenia while the real source of conflict may have been a clash of personalities, Abraham being the "straight guy" and Jung the "emotionally more effervescent"; Abraham's complementarity to Freud while differing in his emphasis upon the

importance of the early relationship of the child to its mother's breast, and his consequent influence upon Melanie Klein. One of Symington's splendid Maverick-like flights through time and history lights upon St. Augustine, in the year AD 397, describing in his Confessions envy of the breast!

The lecture on "Ferenczi-A Forgotten Innovator" indicates how much there is in this analyst's beliefs and attitudes to recommend him to Symington. Ferenczi laid great emphasis on the communication that goes on between patient and analyst, the need for flexibility in the analyst and his capacity for adaptation and modification of technique. He extended his recommendation for warmth and friendliness to the extent of "even embracing or kissing him or her" (i.e. the patient). Now Symington does not, as far as can be seen, advocate quite such a degree of adaptation, but his own flexibility does raise one question of technique. Occasionally he describes a transaction between himself and a patient in which he uses material from without the analytic situation. It may be a comment about himself, something he has read or an experience of one of his children. I do not question Symington's capacity to use interventions of this nature integratively and constructively, but in hands less skilled than his the patient could perhaps feel them to be intrusive. The lecture on Ernest Jones is concerned with his work on the theory of symbolism, and is beautifully illustrated by the subsequent one in which Symington moves on to examples from his own clinical experiences. The two lectures on Jung, covering his theories and his break with Freud are not only comprehensive but very moving. While the author does not agree with all of Jung's concepts and treatment techniques, he much regrets the schism between the followers of Freud and of Jung: "In each school important elements are lost, and we are in danger of narrow-mindidness and fanaticism."

Finally, nine lectures under the heading "Deeper Understanding" are devoted to the analysts who have worked particularly with patients "who have regressed in treatment to the psychotic area of the mind. Their theories are attempts to conceptualize this area." Those discussed are Fairbairn, Melanie Klein, Bion, Michael Balint and Winnicott. Symington introduces his subject by suggesting some of the sources of anxiety in those of us who attempt to work with psychotics, such as the intense pain and fury of these patients and the felt threat of exposure of the psychotic areas of our own minds. He discusses the nature of psychosis and the confused and frightening world inhabited by those who are mad (Symington comments that the word "mad" is better than "psychotic" as it is more immediately linked with the idea of fury and rage and hatred, for these are always a component of madness). The subsequent lectures are, it seems to me, essential reading for everyone regardless of his or her experience who

approaches the treatment of psychosis through the medium of psychoanalysis or psychoanalytic psychotherapy. The ground covered may not all be new but, as always, the landscape gains breadth and perspective through the author's at once imaginative, incisive and sometimes critical scrutiny.

For anyone who would sit back awhile and take a long and thoughtful look at his work and attitudes; to confirm or adjust some perceptions, perhaps to topple some assumptions; to take time to consider himself in his working and, quite related, personal life, I know of no book more pertinent than this.

MIDGE STUMPFL

Growing Up Observed: Tales from Analysts' Children

By Herbert S. Strean (Ed.) New York: Haworth Press. 1987. Pp. 90. £19.95.

Several months ago, an old friend of mine confessed to me that his teenage daughter suffered from periodic depressions and from unrelenting nightmares. Naturally, I suggested to my friend that his daughter might benefit from some psycho-analytical psychotherapy, and I offered to recommend several trusted colleagues. My friend scoffed at the suggestion and said: "You must be joking. I would never send my kid to an analyst. My next door neighbour is a Freudian shrink, and *he* has completely screwed up all three of his children. I'd never send my girl there."

I suspect that many members of the general public share the impression that psychotherapists are rather introverted and peculiar creatures who spend so much time curing crazy people that they completely neglect their own children. (Indeed, I went to school with the son of an eminent psycho-analyst, and this poor chap was taunted mercilessly because of his extreme shyness and social awkwardness). And I suppose that many members of the psychotherapeutic profession have experienced similar worries as well.

Until recently, nobody had ever undertaken a serious study of the "mental health" of the children of psycho-analysts, but fortunately, Professor Herbert Strean, the Director of the New York Center for Psychoanalytic Training and the author of many distinguished texts on psycho-analytical treatment, has edited a supremely informative and highly readable book on this topic entitled *Growing Up Observed: Tales from Analysts' Children.* (I should note that these essays originally appeared in a special issue of the relatively new journal *Current Issues in Psychoanalytic Practice,* and I commend this excellent periodical to readers).

Professor Strean solicited many exciting manuscripts from the children and even the grandchildren of psycho-analysts in which these Freudian offspring describe their personal experiences. The age range of the contributors is simply extraordinary; some of the writers are quite old now, but others are very *young children.* I am often rather delinquent about submitting articles in time for publication, and so I am extremely impressed that seven-year-old Amy Louise Sande-Friedman and seven-year-old Jessica Barson both managed to complete their pieces before the deadline. Miss Barson and Miss Sande-Friedman may well be the youngest people every to have written for the psycho-analytical literature.

Some of the chapters have been authored by the children or grandchildren of the earliest psycho-analytical pioneers, and the volume begins with the memoirs of Francesca Alexander (the daughter of the great Franz Alexander) and those of Ernst Federn (the son of the legendary Paul Federn); and these are followed by a short communication from Alfred Adler's granddaughter Margot Adler who queries: "As I turn forty (last week) I'm reconsidering my career and wondering if it's not too late to became a therapist." (p. 29). Professor Strean has also included a warm and engaging article written by this own son, Billy Strean, a university student. When Billy had to describe his father's occupation to his mates at nursery school, he told them, "My father fixes feelings" (p. 39).

The vast majority of the psycho-analytical progeny seem rather content and well balanced, and most respect and appreciate the work that their parents do; in fact, some of the older writers identified quite closely with their therapist-parent and became clinicians themselves. Virtually all of the children have developed a marked capacity for concern, and this is quite admirable. For instance, eleven-year-old David Kaley recalls that: "I saw one of my classmates looking sad during recess. I asked her what the matter was and she told me that one of her friends wouldn't let her play in her game. I gave her my advice, imitating, I thought, my mother." (p. 65). Furthermore, all of the writers have a deep respect for the world of feelings, and this should never be underestimated.

Of course the children do express their reservations about their parent's profession. Several of the youngsters noted that their parent(s) spends a great deal of time in the office, and this can be construed as a sign of neglect. Vanessa Clementano complains that her mother's psychology books take up one third of the house, and that her mother bores her father by reading Freud to him at night. Others have commented on the potential intrusiveness of the analyst-parent. I have great respect for Herbert Strean, the editor, for having included the following comment written by his son: "Although it was great to have a skilled listener who was able to analyze my difficulties, I suffered from premature interpretations. Because my father

knew me so well and was confident of his analysis, I was not afforded the luxury of his patients, who might have been able to come to some of their own conclusions." (p. 41). I presume that Dr. Strean wanted to share this insight with all of us, namely, that we must listen first and analyse later.

The editor admits that he has in no way provided us with a comprehensive or scientific survey of the psychological well-being of these children; the data is anecdotal and impressionistic. Yet it suggests that the children of therapists benefit greatly from the sensitivity and the insight of their parents; and this is encouraging. It would be a very great tragedy indeed if those of us who have devoted our lives to helping others proved feeble when confronted with the difficulties of our own children.

But let me defer once again to the editor's son, Billy Strean, who strikes me as a young philosopher. His remarks seem consonant with the observations of his colleagues, and he writes so elegantly. Billy Strean states: "Although there are aspects of having had a therapist for a father that I am bothered by, for the most part I am grateful for the experience and I feel I have learned a tremendous amount. While problems exist, both dad and Sigmund will be happy that being a Freudian's offspring has enhanced my ability to love and work." (p. 41).

BRETT KAHR

Learning Process in Psychoanalytic Supervision: Complexities and Challenges A Case Illustration

By Paul A. Dewald, M.D. with a contribution by Mary M. Dick, M.D. Madison, Connecticut: International Universities Press. 1987. Pp. 478. £38.00.

The use of tape recordings in psychoanalytic sessions in order to study methodology and the development of the analytic process over time has been eschewed by analysts as breach of confidence and distorting of the material, to the frustration of researchers who would desire access to 'raw data' in their attempts to validate psychoanalytic treatment. What may be the next best thing, tape recordings of supervision sessions, can elucidate the unfolding of the analysis, the impact of technique on changes in the patient, as well as the development of the supervisory learning process

involving changes in the candidate and the supervisor over time, as has been displayed by Dewald in this illuminating volume.

The book begins with a review by Dr. Dewald of the recent literature on supervision and an overview of the phases which supervision undergoes. The patient is introduced in a chapter which includes an initial history taken by a clinic social worker, the report of the evaluation session by a psychoanalyst, followed by the student's first six-month report and the supervisor's eight periodic progress reports to the training body over the course of the five year analysis. Tape recordings were taken of two successive supervisory sessions at random intervals, varying from several months to one year. The majority of the book consists of chapters of the transcripts of the tape recordings of these 18 sessions, after each of which is a section on comments by the supervisor. At the end, there is a contribution from the trainee reflecting on the study and the last chapter is a synthesis and summary by Dewald.

According to Dewald, there are three types of supervisors:

1) those who see their main task as one of observing and working with the student's intuitive response to and affective interaction with the patient, placing emphasis on the counter-transference;

2) those who encourage trainee initiative and independent learning by experience, tending to be rather silent and sparse in their interventions, and

3) those who see themselves as teachers, emphasizing not only affective responses but cognitive understanding of technique and theory. These supervisors are more active and directive, demonstrating what can or should be done in a given situation.

Dr. Dewald is of the third type, highly experienced and clear as a teacher and sensitive in picking up patterns from the presented material to which he offers conceptualizations and suggestions in regard to technique. In the early stages, Dewald is quite active in response to the relatively unstructured presentations of the trainee, establishing with her a non-authoritarian "learning alliance" which he stresses as vital to the supervisory process, within which the student can feel free to question, to discuss mistakes, to enter with enthusiasm into the process of discovery. Dewald is flexible to the learning needs of the trainee at all levels, and as the process evolves, he becomes less active and more a creative partner to the emerging issues.

The student presents rich, detailed session material which progressively becomes easier to read as the core issues become clarified. One can track her learning experience, observing her growing sophistication and skill as she begins to learn how to make transference interpretations, to understand her patient in depth and to tolerate the strong feelings of the full-blown transference neurosis.

The patient was an entirely felicitous choice as a training case, a 23 year old woman, beginning a career in design, who was personally engaging, overly involved with her father, and who presented as her two main problems over-eating and unsuccessful relationships with men. The patient took easily to analysis and as defenses loosened, primitive, regressed fantasies and feelings revealed a central trauma around a painful uretheral stricture and its treatment at age 4 which had taken on the unconscious significance of castration and of punishment for masturbation with fantasies of father. This trauma was projected forward and backward onto other developmental stages, manifesting variously as wishes for a penis, body-as-phallus, castration impulses toward men and 'vagina dentatis' accompanied by temporary vaginismus, to name a few of its forms. It is impossible to summarize this complex and fascinating analysis in a review format, so the reader must be left to imagine how the pattern of stricture, pain and release was repeated in the flow of associations, in work patterns, in the transference as anger toward a helpless mother, in the defensive ego organization of holding back as long as possible and then releasing all in one go as a defense against pain. The patient provided a good example for the candidate's education of a biological pattern that reflects in psychological patterns in manifold ways with far-reaching consequences.

The re-enactment of the urethral trauma in the psychoanalytic setting and the uncovering of the pathogenic fantasy systems were monitored in the transference and counter-transference, providing convincing psychoanalytic explanations for the trainee and an optimal therapeutic experience for the patient. There is a particularly good coverage of the ending phases of the analysis.

Dewald is a classical analyst with an approach to interpretation of 'defense before content'. Within this framework he is effective in helping the trainee to increase fantasy interactions and to move between the position of deep empathy which increases regression and the objective position of interpretation enabling ego integrations to be made. In the section of Supervisors Comments at the end of each chapter, Dewald extensively, and in rather too much detail, reviews the session, giving a theoretical account of the progress of the analysis, the defences, conflicts, fixations of the patient and the progress of the learning alliance. His comments allow the reader a view into his rationale for supervisory interventions and the conscious way in which he exposes the trainee to the thinking process of the analyst which is most valuable. He candidly analyzes his own errors in supervision, for example when he takes flight into a theoretical excursion for which the trainee is unready, analyzing this as a defense against issues of his own around separation and loss. There is an interesting session in which supervisor and trainee disagree and where Dewald attempts to

persuade the trainee of the correctness of his own views, which he afterwards criticizes as poor teaching technique. This is analyzed as an intrusion into the supervisory session of anxieties about a visit to the St Louis Institute, of which Dewald is Medical Director, by inspectors from the American Psychoanalaytic Association, who were coming to assess the teaching program; in other words, there was unconscious anxiety about student progress displaced from the inspection visit. Thus, Dewald exhibits the analyst's continuing process of self-analysis.

The authors are to be applauded for this bold project, especially Mary Dick for opening to view the supervision of her first case. In her contribution at the end, she reflects on her changing transference to Dewald, and relates the point at which she discovers Winnicott's concept of the false self which she carefully introduces into the sessions, expecting but not getting his disapproval. This moment marks a turning point for both the analysis and the supervisory process, after which both become more authentic. This section highlights the difficulty that all students face in forging analytic identities in the presence of differing theoretical and political view points, particularly if they too are "allergic to dogma", as self-proclaimed by Mary Dick.

This volume will be of value to supervisors, students, researchers and those inyolved in psychoanalytic education. This reviewer found herself comparing what would have been her own supervisory comments on the case material with the ones offered by Dewald, which proved an interesting exercise. The complex intermeshing of the supervisory triad is well-depicted in this book, as is the excitement and pleasure of psychoanalytic discovery as a creative enterprise shared by student, supervisor and patient.

JEAN ARUNDALE

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NOTES ON CONTRIBUTORS

Patricia ALLEN	Associate Member B.A.P. Psychotherapist in private practice.
Jean ARUNDALE	Full Member and training therapist B.A.P. Tutor in Psychotherapy, Guy's Hospital. Psychotherapist in private practice.
Joan BURNETT	Full Member and Training Therapist B.A.P. Psychotherapist in full time private practice.
Glenys JAMES	Associate Member B.A.P. Member, Severnside Institute for Psychotherapy. Works part-time in private practice in Bath, and part-time in the Department of Child Psychiatry, University College Hospital, London.
Susan JOHNSON	Part-time Psychotherapist at London Youth Advisory Centre. Part-time Psychotherapist in private practice.
Brett KAHR	Clinical Psychologist. He is former Research Officer at Littlemore Hospital in Oxford, and the former Director of the Oxford Psycho-Analytical Forum. Since 1985 he has been the host of *Fifty Minutes*, the award winning American television programme on psycho-analysis.
Berenice KRIKLER	Principal Clinical Psychologist at the Portman Clinic. Psychotherapist in private practice.
Robert MORLEY	Full Member B.A.P. Formerly Staff Member I.M.S. Director of the Family Welfare Association. Psychotherapist in private practice. Publications: 'Sleeping Beauty as a Marital Myth' (1974), *Intimate Strangers* (1984), 'Conjugal Dreams' (with E. Morley, 1987).
Michael PARSONS	Associate Member of the British Psychoanalytical Society.
Zelda RAVID	Full Member B.A.P. Previously P.S.W. in Adult Psychiatric Hospitals, Hill End Adolescent Unit and Brent Child & Family Centre. Now psychotherapist in private practice.
Sarah SHAMNI	Psychotherapist in private practice. Formerly Senior Clinical Psychologist, Portman Clinic.

Hester SOLOMON	Training Therapist and Supervisor B.A.P. Chair, Jungian Training Committee; Co-Vice-Chair B.A.P. Council. Psychotherapist in private practice.
Midge STUMPFL	Full Member B.A.P. Psychotherapist in private practice.
Denise YELDHAM	Consultant Psychiatrist with a special interest in psychotherapy (NHS). Part-time private practice (psychotherapy).

NOTES FOR CONTRIBUTORS

Papers, particularly from members of the Association, are welcomed and should be sent to the Editor, Mrs Denise Taylor, at 78a Compayne Gardens, London NW6 3RU and Books for review to Book Reviews Editor, Mrs Judy Cooper, 131 Broadhurst Gardens, London NW6 3BJ.

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REFERENCES

References within articles should indicate the surname of the author followed by the date of publication in brackets, e.g.(Khan, 1972).

For all works cited in the text there should be an entry in the list of References at the end of the paper, arranged in alphabetical order by name of author.

When referring to articles include authors' names and initials, date of publication in brackets, the full title of the article, the title of the journal, the volume number and the first and last pages, e.g.

James, H.M. (1960) Premature ego development: some observations upon disturbances in the first three months of life. *International Journal of Psycho-Analysis,* 41: 288-295.

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In order to be certain that the reference is correct it should be re-checked against an original source.

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