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PLURALISM AND TRAINING

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When I published *Jung and the Post-Jungians* in 1985, I commented that it was not easy to find one's way around in the contemporary Jungian world. This was because very little had been written on the various schools of analytical psychology that have grown up. Moreover, Jungians have been encouraged by Jung himself not to think of themselves as belonging to a recognisable discipline in the first place – an attitude of Jung's and a situation which I questioned severely in the book.

The whole book rested on a fundamental paradox – that, by concentrating on debate, dispute and difference, we could get the best possible conception of what analytical psychology as a whole really is. What would define a person as an analytical psychologist is whether he or she reacted actively and emotionally to the debates between the schools.

Of course, any classification into schools is a creative falsehood in that there are unlikely to be many individuals who exactly fit the descriptions. Even more important, there is an imaginative and metaphorical aspect to this business of the schools of analytical psychology and, indeed, of psychoanalysis as well. These imaginative and metaphorical aspects have gradually become more and more interesting and important to me. In fact, I focus on them, amongst other things, in a later book *The Plural Psyche: Personality, Morality and the Father* (1989). The schools of psychoanalysis and analytical psychology can also be envisioned as *separate strands existing in the mind of a single analyst*[1] *and even as having a certain imaginal autonomy therein.* In that case, their strident and polemical debate becomes an unavoidable, urgent, internal matter for each and every one of us.

I have chosen to write on 'Pluralism and Training' partly because this gives a focus from which to share these ideas with the B.A.P.

So – what is 'pluralism'?

Pluralism is an attitude to conflict which tries to reconcile differences without imposing a false resolution on them or losing sight of the

First presented at a scientific meeting of the B.A.P. in 1988

[1]My use of the words 'analyst' and 'analysis' is not intended to mark distinctions with 'psychotherapist' and 'psychotherapy'

unique value of each position. Hence, pluralism is *not* the same as 'multiplicity' or 'diversity'. Rather, pluralism is an attempt to hold unity and diversity in balance – humanity's age-old struggle, in religion, philosophy and politics, to hold the tension between the One and the Many. My use of the term 'pluralism' is also supposed to be different from 'eclecticism' or 'synthesis'. As the paper unfolds, the distinctions should become clearer. Here, at the beginning, I would merely say that the trademark of pluralism is competition and its way of life is bargaining.

We need a psychological working out of the idea of pluralism and, in order to do this, I will make two suggestions.

First, on a personal level, each of us is faced with the pluralistic task of aligning our many internal voices and images of ourselves with our need and wish to speak with one voice and recognise ourselves as integrated beings. So it is an issue of intense feeling. But it is also an issue of thinking – for psychological theory also seeks to see how the various conflicts, complexes, attitudes, functions, self-objects, part-selves, sub-personalities, deintegrates, internal objects, psychic *dramatis personae*, areas of the mind, sub-phases, gods – how all of these relate to the personality as a whole. The extent of the list demonstrates the universality of the problem and its inherent fascination.

My second suggestion is that a pluralistic approach may be of immense help in dealing with issues of unity and diversity as they affect depth psychology, with its massive ideological differences. By 'depth psychology' I mean all psychological endeavours which make use of the concept of the unconscious. The somewhat old-fashioned term (at least in England and America) is useful in an age when both psychoanalysis and analytical psychology are so deeply split. We need a term which refers to the social context of *the whole field*, Freudian, Kleinian, Winnicottian, Jungian, and, at the same time, to *the divisions with the field*. (Of course, we should not forget that depth psychology, the field, is itself composed of individual analysts and therapists.)

The fragmentation and dispute within depth psychology, as each analyst or group of analysts fights for the general acceptance of their viewpoint, seems, on the surface, to be the very opposite of what is usually regarded as pluralism. However, as I said earlier, this competitive aggression is at the heart of any attempt to build up a pluralistic approach. The idea of unconscious compensation (in Jungian terms) or the idea of reaction formation (in Freudian terms) suggest that we should look a little more deeply into the warlike situation. If we do so, then it is possible to see depth psychology as struggling, and as

having always struggled towards pluralism. As Herakleitos put it, 'that which alone is wise both wishes and does not wish to be called Zeus'. What seems like a flight from pluralism may also be a yearning for it and an acceptance at some level of a pluralistic destiny for depth psychology.

A pluralistic attitude can hold the tension between the claims of and tendencies towards unity *and* claims of and tendencies towards diversity. Psychoanalysis or analytical psychology as a cohesive discipline with right and wrong approaches – *and* psychoanalysis or analytical psychology as containing a multiplicity of valid approaches. It would not be pluralistic, as I understand it, to assert that there are many diverse truths but that these are but aspects of one greater Truth. In that religious and elitist approach, entry into the greater Truth, which would do away with all the lesser and seemingly contradictory truths, is reserved for the elect. This is not pluralistic, it is condescendingly casuistic. From a pluralistic standpoint, Truth (with a capital T) and truth have to compete. Sometimes passionate and aggressive expressions of and adherence to the truth can (even should) be the right way to live and function. But sometimes we need a more partial and pragmatic vision, equally passionate and aggressive in its way. Aggression, which is so characteristic of debates between analysts, often contains the deepest needs for contact, dialogue, playback, affirmation.

Now, many analysts and therapists are probably committed to dialogue but the psychological difficulties associated with maintaining a tolerant attitude cannot be minimised. Depth psychologists, being human, will continually fail to be as tolerant as they would like to be. In part, this is because of their passionate devotion to their own psychological approach, to their own particular vision, or 'personal confession'. *But where is a programme to combine passion and tolerance in depth psychology?* We know about and concentrate on the opposites of tolerance – envy, denigration, power, control, and so forth. But we usually pathologise these. My intent is to do something positive and realistic with the incorrigible competitiveness and argumentativeness, mining the envious shit for the tension-rich gold it might contain. Competition that is open, competition that is brought into the open, and into consciousness, competition that is psychologically integrated and valued, could lead to a new tough-minded tolerance.

Through competition with others we may come to know ourselves and our ideas better and more deeply. This is an example of the importance of the mirroring other whose presence glimmers in so many

psychologies – Jung's, Winnicott's, Neumann's, Lacan's, Kohut's. This other is a creative other and needs nurturing. What is more – and I mention this as an example of the realism of pluralism – you cannot annihilate the other who is your opponent. He or she will not go away. The opponent is omnipresent and indestructible. The opponent resists the false way in which we all try to describe him or her. Sure, you can describe your opponent as narcissistic, religiose, transference-bound – but he or she will bounce back, rejecting that distortion and returning to the argument: *la lutta continua.* Like it or not, the dialogue and confrontation go on, as they always have in depth psychology. And, amidst the seemingly ridiculous institutional splits, a kind of exchange is constantly being crafted.

I think that this exchange – and let us recall that Hermes is the god of trade – can be illustrated by reference to Jungian analysis. My view is that, already for quite some time, Jungian analysis has been pluralistic, employing many diverse metaphors such as alchemy, infancy, mythology, but remaining one discernible enterprise. The problem is that our thinking has not caught up with what we are doing or can do. So, if a Jungian analyst seeks to place so-called 'Jungian analysis' and something like object relations in eternal opposition, then our history and our future are passing him or her by. Object relations is a part of Jungian analysis.

My belief is that it is possible to link the monotheistic/integrative/*unus mundus*/elitist concerns of the classical Jung and the classical school with the polytheistic interactive/microscopic/democratic concerns of the post-Jungians –without losing the value and heartfelt truth of both sets of concerns.

Depth psychology is a social phenomenon which, viewed over time, has shown itself able to withstand clashes and splits and generate new ideas out of them. This capacity lies alongside the far better-known tendency for the splits to become institutional and concrete, and hence somewhat unproductive. Depth psychology continues to be desirous of entering a pluralistic state but lacks the ideological and methodological means to do it. It could even be possible that we are all pluralists but the prevailing ideology in the world we live in forces us to deny it. The tendency towards multiplicity and diversity is as strong – and creative – as the search for unity or a striving for hegemony.

As we proceed, we shall see again and again how these two suggestions of mine are really the same suggestion. That is to say, the experience of the One and the Many in relation to one's own psyche and personality, and the argument about the One and the Many in

relation to disputes in the area of psychological theory, are, in a sense, the same thing. This needs some explaining.

We have always tended to keep apart the psyche itself and the social organisation of depth psychology. However, the vicissitudes of depth psychology as a cultural movement, the splits, plots, alliances, gossip and power struggles – all these reveal that, in their professional lives, analysts are participating in a mighty projection of the objective psyche. For, when analysts argue, it is the psyche that is speaking. Differing points of view reflect the multiplicity of the psyche itself. And when analysts recognise what they have in common, often through discussions of clinical experiences, then it is psyche in its monistic, unified vein that is revealed.

My point is that when analysts look at themselves – and they should always be looking at themselves – how they think, feel, behave, organise themselves, they are, perhaps without knowing it, also gazing at and participating in the world of the psyche.

Similarly, the books that analysts write, and candidates and colleagues read, are not what they seem to be. Texts of psychological theory can constitute for us what alchemical texts constituted for Jung. A deconstruction of depth psychology parallels his of alchemy. Just as the alchemists projected the workings of the unconscious into chemical elements and processes, becoming caught up in the pervasive symbolism of it all, so the texts of the depth psychologists, taken as a whole and understood psychologically, may unwittingly provide us with documents of the soul. I think this is a radical re-reading of what books on psychology are about. What was intended to be *about* psyche is *of* psyche. The conscious aim may be to plumb the past for its truths, or to connect past and present, or to reveal the workings of cumulative psychopathology. But what gets revealed, according to this analysis, are the central characteristics of psyche itself. This is where clashes between theories are so useful, because the *actual clash itself* contains the definitive psychic issue, not the specific ideas which are in conflict. Not psychological dialectics, but psyche's discourse given dialectical form. The warring theories and the particular points of conflict speak directly of what is at war in the psyche and of what the points of conflict might be therein.

Now, sometimes it is claimed that differences of opinion could not have such deep implications because they only show differences in the psychological type of the disputants. I agree that some analysts will tend constitutionally, to prefer, see and search for multiplicity and diffusion. Others will be more inclined to favour and to find integration

and unity. But this typological approach contains the seeds of its own contradiction. For, to become truly himself or herself, the depth psychologist cannot 'belong' to one school alone. There is an interdependence with all possible manner of divergence and convergence.

Pluralism is a perspective in which various analysts or the various schools have to take note of each other, without necessarily having unity as a goal, a modular, conversational approach in which different world views meet but do not try to take over each other. As the philosopher Whitehead said, 'a clash of doctrines is not a disaster, it is an opportunity'.

When theories and fantasies of the psyche are in competition, what attitudes are possible? None seems really satisfactory. We can choose betwen theories – but that may lead to blind partisanship and possibly to tyranny. We can synthesise theories – but that may lead to omnipotence and an avoidance of the hard edges of disagreement rather than to transcendence. We can be indifferent to the dispute, but that leads to ennui and a subtle form of 'clinical' inflation in which the relevance of theory is denied. Of course, we could be pluralistic – but that leads to fragmentation and anxiety (as we shall see). It is hard to act upon, this idea of pluralism.

Political thinkers and philosophers have addressed many of the questions we shall try to answer, and we can learn from that. Later, I will use pluralistic political thinking as a metaphor to further our understanding of psychological process and of the social organisation of depth psychology.

Can diversity be analysed so as to reveal its special requirements and guidelines? And can we develop a vision of diversity which makes a place for unity? For, as I have said, pluralism, as I use the term, does not simply mean diversity or multiplicity, not just the Many.

We know from politics that freedom does not guarantee diversity, for freedom can lead to a part of a system expanding to take a tyrannical hold over the whole. If I am free to do or be what I like, this will produce an unequal state of affairs between you and me. To make sure that does not happen, we may be required by political consensus or law to be more equal on some or all respects. But then an inhibition has been placed on my freedom. Exactly the same conundrum faces the depth psychologist today. If I act on, live out, hold dear, fight for my ideas, what am I do to with the differing points of view of which I am aware? I can't just deny that these points of view exist! My freedom to have a particular point of view may lead to an

unhelpful, destructive denigration and abandonment of other people's ideas to the ultimate detriment of my own position.

Equality doesn't guarantee diversity either, for equality may lead to the perils of indifference and boredom stemming from an unreal and infinite tolerance that lacks passion, is flat, bland and mediocre. This ennui can be seen in the attitude some practitioners have towards theoretical differences: that they don't matter when compared with clinical inevitabilities. This myopic, clinical triumphalism overlooks the fact that everything in analytical practice is suffused with theory (and, hopefully, *vice versa*). But if all views are considered to be of equal worth, what is to become of the freedom to feel a special value attaching to one's own view?

So, surprising to analysts perhaps, but not to political theorists, neither the freedom to think nor an egalitarian approach to thought can be said to guarantee diversity in a way that permits a unified view to co-exist with it. Perhaps there is a problem with the way I have formulated things, and so I want to make a most radical suggestion. Instead of advancing pluralism as a desirable state or goal, let us begin instead to *use* it as a *tool* or *instrument* whose purpose is to make sure that diversity does not lead to schism and that differences between particular points of view are not smoothed over. Pluralism can function as an instrument which monitors the mosaic of the psyche rather than as a governing ideal.

Rather than setting pluralism up as a goal or an ideal, we can employ this tool to explore the psyche, or personality development, or what is happening in depth psychology generally, and also as a means to bring a psychological dimension to cultural, political and social debates. For example, I'm interested in the role of the father in the evolution of psychological pluralism in the daughter – her capacity, or lack of it, on the cultural as well as on the identity level, to be many things (wife, lover, mother, daughter, career woman, spiritual voyager) whilst retaining a sense of being an integrated person. She is One woman and Many women at the same time. Similarly, primal scene imagery, in which parental union and separation alternate, also refers to the individual's capacity to deal creatively with conflict and difference, whether this is internal or met in political strife in the external world. When the parents unite, they are One; when they separate, they are Many. The tension between these two parental positions reflects the emotional experiences of intrapsychic conflict and of political dissensions.

This approach can be extended into other areas such as morality

and gender identity. The way I conceive morality is that it incorporates a ceaseless dynamic between a passionately expressed, codified, legally sanctioned certitude, which I call original morality, and a more open, tolerant and flexible style of morality, called moral imagination. These two aspects of morality are equally archetypal and inborn; one doesn't develop into the other. Nor are they always in harmony – quite the reverse. A morality based exclusively on original morality or exclusively on moral imagination would be a useless morality. But the two styles of morality go on competing: sometimes one prevails, sometimes the other, sometimes a bargain is concluded between them and, sometimes, less often than Jungian theories of the *coniunctio oppositorum* would predict, there is a synthesis.

As far as gender identity is concerned, I want to make the following suggestion. In each of us, there are areas of gender certainty and gender confusion. It is important not to see gender certainty as good and gender confusion as bad because excessive unconscious gender certainty leads to inauthentic, empty, stereotypical functioning. Similarly, gender confusion has its creative aspects – in artistic activity, for instance, and even in political and social matters. Gender certainty and gender confusion do not merely combine in health to produce an average position. Rather, each of them goes on in the psyche, in competitive opposition to each other but also linked as components in gender identity. Each is part of the whole we call gender identity (perspective of the One); each has its own psychology and psychopathology (perspective of the Many); they cannot ignore each other and so must compete (pluralistic perspective).

Now – I hope we are in a position to use pluralism as an instrument or tool to help us look at the topic of dispute and disagreement in depth psychology. This subject is, I suggest, of the greatest importance to anyone concerned with the training and formation of the analysts of the future, senior analysts and candidates alike.

A pluralistic approach to depth psychology, as I have explained it, means that a person interested in any particular area of knowledge should seek out the conflict and, above all, the *competition* between practitioners and ideologues in the discipline. The main implication is that even a so-called beginner should try to discover what the contemporary debate is all about. This approach differs fundamentally and profoundly from the conventional, linear style of training and education in depth psychology. There, one is supposed to start 'at the beginning' and when the 'basics' have been mastered and one is 'grounded', exposure to more grown-up disagreements is permitted.

The point I am advancing, backed up by a good deal of teaching experience, is that *starting at the beginning is no guarantee of comprehension.* However, if a person were to focus on the up-to-the-minute ideological conflict then he or she cannot avoid discovering what has gone before; book learning is replaced by a living process. In a way, this is an educational philosophy derived from analysis itself. In an analysis, the focus of interest is where the internal 'debate' is at its most virulent; and in analysis the participants do not follow a linear 'course'.

The debates within psychology give it life. They also serve to define the discipline generally, as I suggested in the post-Jungian book, and act as access routes for those who want to learn. What is important is not so much whether people are right or wrong, though it is vital to have views about that, but whether you know what they are talking about. For it is really rather hard to be completely wrong in depth psychology. Or, as Kafka put it, 'the correct perception of a matter and a complete misunderstanding of the matter do not totally exclude one another'.

I am suggesting that, instead of searching for one guiding theory, we consider several competing theories together and organise our training around such theoretical competition using papers and books written with polemical intent. Actually, if you think about it, that includes a high proportion of the literary output of analysts! What holds these theories together is that the subject – the psyche – holds together; just as for modern sub-atomic physicists, their subject, the universe, holds together. In this viewpoint, passion for one approach is replaced by passion for a plurality of approaches.

Let's consider now some of the problems with pluralism. For all manner of psychological reasons, it is very hard to get worked up about being tolerant, to be a radical centrist in depth psychology, to go in for what has been called 'animated moderation'. Does pluralism condemn us to losing the excitement of breakthrough ideas, which are more likely to be held with a passionate conviction? My view is that such a worry rests on a misunderstanding and an idealisation of the cycle of creativity. So-called 'new' ideas emerge from a pluralistic matrix and are re-absorbed into such a matrix. As Winnicott put it, 'there is no such thing as originality except on the basis of a tradition'. Ideas do not come into being outside of a context; nor does the new necessarily destroy the old but often co-exists with it. So, what looks like inspirational conviction arises from a plural *mise en scène* but it is convenient for the debt not to be acknowledged. And before we hail

the man or woman of vision, let us not forget Yeats's words: 'the worst are full of passionate intensity'. The well-known clinical benefits of having conviction in one's ideas can still be available, but together with open communication and the chance to learn from diversity.

This is not a dry or woolly perspective: passion abides in dialogue and tolerance as much as it does in monologue and fanaticism. The depth psychologist has never been able to work in isolation from others in the same field who have a different viewpoint. That's the conclusion I draw from the history of splits and struggles. People have to fight with one another because they cannot ignore one another. Leaving aside the never settled question of whether any one analytical approach is more 'successful' than the others, the arrogance of isolation was never a viable option. The rows within depth psychology cannot be ignored in a serene, Olympian fashion.

Even those who feel uncomfortable with pluralism, and seek to render it innaccurately as 'eclecticism', need to recall that their own theories arose from a pluralistic matrix and from a competitive diversity of views. For instance, Hillman's archetypal psychology was not a single, time-bound, unchallenged, piercing vision. This was also something Winnicott noted in relation to Melanie Klein. In November 1952 he wrote her a remarkable, long and agonised letter protesting strongly against 'giving the impression that there is a jigsaw of which all the pieces exist'.

So far, I have been trying to establish that pluralism can be seen as an extremely useful metaphorical approach to the interplay of the One and the Many in the psyche and in depth psychology generally. I have also suggested that pluralism is a tool that can keep diversity alive in the face of threats from both tyranny and ennui or boredom. I have tried to show that pluralism enables us to harness the competitive and aggressive energy trapped in theoretical dispute and competition. I have given examples of the hidden pluralism in the father-daughter relationship, primal scene imagery, moral process, and gender identity. My overall position is that depth psychology wants to become, needs to be, and, ironically, already is pluralistic.

This last point – that depth psychology is, secretly and in spite of itself, already pluralistic – needs some expansion. What looks to us like intellectual discovery or new and original ideas are better understood as *descriptions* of the most progressive contemporary practices, or even as *intuitions* about what is already going on beneath the surface. For example, Machiavelli did not write a handbook for princes, containing smart new ideas. Rather he intuited and described

what the most enterprising princes were already doing. Adam Smith's importance is not that he promoted capitalism, but that he described (and hence understood) what the new capitalists were doing. You could say that such writers were bringing something to consciousness and I expect this is true with much of what I write about pluralism. Originality is a kind of delusion!

In spite of all this, pluralism is threatened and under attack from all manner of entrenched interests. I would almost say, thank God that pluralism *is* under attack, for what would pluralism be without its opponents?! There are several branches to this attack which it is possible to identify. First, *holism*, which tends to impose a false unity on our thinking, ignoring diversity. Second, *numinosity*, which forms the unavoidable heart of intolerance, for we become overwhelmingly fascinated by our own ideas and correspondingly threatened by other people's. Third, *hierarchy*, which sets up selected categories as prejudged good things or goals. But the enemy of pluralism upon which I want to focus is *consensus*.

Clearly, for there to be any communication at all, some assumptions have to be permitted and agreed, though consensus can become like airline food –just acceptable to everyone but truly pleasurable to none. However, blandness is not what I perceive as problematic with consensus – for consensus is not really cuddly, cosy, friendly and bland at all. In depth psychology, and perhaps in science as well, personal allegiance and power dynamics play a part. Orthodoxy, heterodoxy and heresy come into being.

This state of affairs can be seen most vividly in relation to training for analysis and psychotherapy and therefore lies at the very root of depth psychology as a social institution. Though the candidate is an adult, a degree of regression seems inherent in the training situation due to the continuing entanglements of the candidate's analysis and supervision/control analysis. It has been claimed that the training posture actually fosters regression in general and persecutory anxiety in particular, and that this is exacerbated by a confusion that often exists in the *trainers'* mind between analysis and training. My concern is different. My concern is that the whole range of careful, thoughtful experiences most analysts have been through in their training might inadvertently have removed the creative sting. I am thinking of syllabi, seminar themes, reading lists, feedback sessions and so forth. The more integrated and professional the training programme, the greater the denial of pluralism.

I think that the denial of pluralism has contributed to the formation

of cult-like bodies within our little world of depth psychology. Being in a cult implies obedience. There may be too much obedience in depth psychology today. There is a serious danger that training programmes will become obedience cults and that this will be rationalised by reference to the advantages of practising on the basis of a system in which one has conviction. It is striking how many of the groups which are active in analytical psychology today either are, or were in the recent past, dominated by leader figures. The leaders may be remarkable people, with a comprehensive vision, which would partially account for the tendency, but I think there is more to it than that. I do not think this pattern results from conscious fostering, but would argue that its effect is to shield the candidate from the stress and anxiety of pluralism. And then the benefits of pluralism are lost as well. The need for strong leader figures has a lot to do with the desire to avoid the anomalous. The leader sorts things out by arranging competing ideas in a hierarchical schema of acceptability, protecting or advancing his own ideas in the process. The desire to avoid anxiety and confusion when confronted with something which feels strange and new strengthens the tendency of groups to select leaders as a combination of leader and safety net.

Now, when I critique consensus like this, I have to answer a difficult question, bound to be posed by the 'eclectics' who depend on consensus: how is our professional world going to be organised and structured at all if we eschew and reject consensus? Surely dialogue between schools is helped along by consensus, not damaged by it?

In answer to this, I say that we should remember that human life is not homogeneous. There are separate spheres of life which are relatively autonomous (perspective of the Many), though also linked (perspective of the One). In the social world, those who rule in one sphere may be ruled in another. By 'rule', I do not mean just the exercise of power but that people enjoy a greater share of whatever is being distributed. For us, what is being distributed is influence, ideological power, and the satisfaction of seeing our own ideas acknowledged and prevailing. Hopefully, everyone has a turn at this sometime, though it cannot be guaranteed. My idea is that, from an experimental point of view, the psyche may be seen as containing relatively autonomous spheres of activity and imagery. Over time, and according to context, each sphere has its dominance. Similarly, from an intellectual point of view, each school of depth psychology (or each theorist) may be seen as relatively autonomous from other schools and its theory as

having its own special strengths and weaknesses. We become henotheists: one god at a time but, in time, many gods.

It is a case of taking it in turns to be the dominant theorist, accepting that, in some ways and in some situations, the other person has a more utilisable (more 'correct', from a pragmatic viewpoint) theory. Then we may make bilateral agreements to sing each other's song – not the same as agreeing to disagree and different, too, from eclecticism. For eclecticism means singing selected verses only. Eclecticism ignores the contradictions between systems of thought whereas pluralism celebrates their competition. Eclecticism *is* intolerant in that parts of a theory are wrenched from the whole. In a pluralistic approach, the whole theory is used, as faithfully as possible, and together with other theories, until inconsistencies lead to breakdown. Then the breakdown itself becomes the object of study.

To summarise again: I have outlined what I mean by pluralism and suggested that we use it as an instrument. I have suggested what depth psychology can learn from political theory. An ideology and a methodology for training are beginning to emerge. Some problems with pluralism have been discussed and 'consensus' has been attacked.

The general impression I have of depth psychology is that there was a golden age that is now past. The broad outlines of the enterprise are firmly drawn. If that is so, then the fertilising challenge presented by the arrival on the scene of all-inclusive theories, forcing a person to work out his or her response, has been lost. If our generation's job is not to be restricted to 'professionalisation', institutionalisation or historical recovery of the happenings of the earlier days, it is necessary to highlight the one thing we can do that the founding parents and brilliant second-generation consolidators cannot. This is to be *reflexive* in relation to depth psychology, to focus on the psychology of psychology, a deliberate navel-gazing, a healthily narcissistic trip to the fantastic reaches of our discipline; a post-modern psychological outlook, redolent with the assumption that psychology is not 'natural', but made by psychologists. After that, but only after that, we can turn towards the world.

What would a programme for pluralism in depth psychology look like? I have already spoken about this in relation to training. What follows is less practical, more a matter of the spirit of pluralism. Can we allow the flowering of pluralism which depth psychology itself unconsciously desires?

We might begin by trying to envision spontaneity as a genre or particular style of psychological life. This means a person's putting

trust in the gnostic and revelatory capacity of images and experiences, without stressing any presupposition that these are derivatives of an unknowable absolute. It is the spontaneous and autonomous nature of experience and its images which work to support a pluralistic response to them. As an extension of spontaneity, we may need actively to embrace contradictory positions. Not only because opposites can lead to each other eventually, but because contradiction itself produces novel elements. Spontaneity, as a genre, challenges consensus because of this capacity to generate the novel and the unpredictable; it influences other areas besides those at which it is directed.

It is interesting to consider the influence of gender on spontaneity. When we speak of the 'hard' sciences or facts, we are also dealing with the consequences of gender-based child-rearing practices which have relegated softness, irrationality and spontaneity to an inferior ('feminine') standing. In addition, so-called 'masculinity', supposedly objective in its outlook, is an outcrop of the needs of most boys and many girls to assert their differences from their mother. The achievement of personal boundaries and optimal separation from the mother may, for some individuals, tip over into rigidity and an accent on distance and precision – the objective attitude. Depth psychologists who are uncomfortable with transpersonal phenomena (such as mystical experience) because such things cannot be understood from a distance, are, in a sense, 'over-masculinised'. Knowledge that only comes from some kind of merger with what is perceived awakens latent fears of returning to a suffocating symbiosis with the mother.

Coming to the end of this statement of a programme for pluralism, we have to ask ourselves what the moral function of psychological pluralism might be as it struggles to hold the tension between the One and the Many without making them into opposites.

Pluralism is engaged in the discovery of truths as well as in the discovery of Truth. The existence of diverse theories about people complements the psychological diversity within a person and the existence of depth psychology as a unified field complements psychological unity within a person. My concern has been that pluralism should not follow the logic of competition so fully that an ideological position leading to tyranny results, nor allow its embracing of diversity to degenerate into a farrago of seemingly equal truths leading to ennui as much as choas. But if all truths are *not* completely equal, what kind of yardstick might we develop?

I will stick my neck out and say that the *telos* or goal of pluralism, and hence its yardstick, is 'reform'. By reform, I do not mean to make

a distinction with revolution, as in 'liberal reform', but reform as a portmanteau ideogram to include renewal, rebirth, spontaneous *and* well planned evolutions, and imaginative productivity generally. Reform has a moral connotation as well, and that is deliberate on my part.

Pluralism is an approach to the politics of the psyche. Such a politics resembles sexuality in that it simply must be carried on. We do not create them or decide to join in. We just become aware that we are involved as part of the human condition. The moral factor which attends reformist pluralism also has to do with involvement, with engagement. Involvement and engagement in the experience of psyche – and involvement and engagement in the politics of depth psychology which, as I have been arguing, turn out to be the same thing.

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THE NEGATIVE THERAPEUTIC REACTION AND THE NEGATIVE IDENTITY

PHILIP HEWITT

In this paper two concepts in psychoanalysis are being brought together. The first, negative therapeutic reaction is the older and is well documented in the psychoanalytic literature and was described by Freud notably in The Ego and the Id (1912) and also later in Analysis Terminable and Interminable (1937). The other concept of the negative identity I am using here is in the sense intended by Erikson in his paper 'The Problem of Ego Identity' (1968). The reason for bringing these two concepts together is that I was able to usefully connect the two in the work which I had been doing with two patients both of whom were cases of negative therapeutic reaction. I hope to demonstrate that understanding of the negative identity by both therapist and patient enabled certain progress to be made in the therapy.

In Erikson's paper (1968) the thesis is that identity development is as much a result of an institutionalised psychosocial structure as it is the result of a clash of instincts, defences and societal norms.

He posits the theory that throughout development there is a 'dovetailing' between the two systems. This idea Erikson develops schematically through the paper. My interest in the negative identity was that I recognised in a training case and others that very phenomenon in which the patient had assumed an identity which seemed to have functions of separation from and defiance of the parents in order to stave off 'identity diffusion'. For in both cases that I refer to in this paper I saw the assumption of a negative identity had to be a means of rescue of 'the self' from an oppressive psychological experience. In this respect I distinguish the negative identity and the negative therapeutic reaction from the 'True and False Self' phenomenon as described by Winnicott (1960). The distinction is that the false self development occurs where the self accommodates a non-facilitating environment at the expense of a real and true self developing. In the two clinical examples which I use here 'the self's' fought their environment and did not concede a false self as the means of adaptation but absorbed a negative self or negative identity. In fact Winnicott suggests that there are degrees of false self and also true self and to this extent this understanding might be applied to these two cases but the clinical

picture as experienced through the transference is fundamentally different.

In both cases progress was hard to determine. In both cases the prevailing feeling was that the patients might break off therapy at any time and it was therefore a struggle to accept that the patients were at another level 'clinging' to the therapist. Narcissistic resistance or an insufficiently interpreted negative transference did not adequately explain the feelings of despair and frustration experienced in the countertransference. Also in the countertransference it was necessary to obtain an understanding of the role of 'unconcious masochism' in the therapist as well as the patient in order to make more sense of the impasses which were reached. Racker (1968). In other words the patient's attacks on the therapy also find a target in the therapist's unconcious receptivity to the attack which has the potential to undermine the therapy.

It was this which began to facilitate a view of negative therapeutic reaction which 'inform the state of the transference' and therefore become instrumental in understanding and not be relegated to an indicator of negative outcome. Limentani (1981).

In '*The Ego and The Id*' (1923) Freud wrote:

> 'There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of treatment they show signs of discontent and their condition invariably becomes worse. One begins by regarding this as a defiance and as an attempt to prove their superiority to the physician but later one comes to take a deeper and juster view. One becomes convinced not only that such people cannot endure any praise or appreciation but that they react inversely to the progress of the treatment. Every partial solution that ought to result in an improvement or temporary suspension symptoms in the patient for the time being an exacerbation of their illness, they get worse during the treatment instead of getting better. They exhibit what is known as a 'negative therapeutic reaction'.
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> In the end we come to see that what we may be dealing with is what is called a 'moral factor', a sense of guilt which is finding its satisfaction in the illness and refuses to give up the punishment of suffering".

In the above paper and later in *Analysis Terminable and Interminable* Freud stresses the unconcious sense of guilt and laid emphasis on the death instinct. When reading the original text quoted above I was struck by the difference between the objectiveness of the text (which you expect to find) compared with my more subjective experience of feeling responsible for not being able to help the patients. This might be explained in one way by saying that it reflected the limitations of

therapeutic technique, a possibility which always has to be considered. However the evidence is that such patients will and do stretch even the most experienced therapists. Freud himself was pessimistic about treating such patients. Nevertheless James Strachey suggests caution in his note on the 1937 paper. 'The paper as a whole gives an impression of pessimism in regard to the therapeutic efficacy of psycho-analysis'. Joan Riviere, who translated The Ego and The Id, in her paper 'A Contribution to the Analysis of the Negative Therapeutic Reaction' read before the British Society of Psychoanalysis in 1935 as follows; '... he is not however actually as pessimistic as people incline to suppose; and this interested me because it is not intelligible why one reaction should be thought more unanalysable than another. The eighteen pages in The Ego and The Id are in fact part of his contribution towards analysing it...' Riviere (1936). The fact that so much has been written since tends to suggest that therapists have been encouraged to work with such patients rather than be discouraged. Indeed as Limentani (1981) suggests the negative therapeutic reaction makes a unique contribution towards understanding the transference. Nevertheless it is generally agreed that the negative therapeutic reaction is indicative of profound personality difficulties and a patient disposed to obstruct any progress in a treatment.

The primary and most adhesive connection between the negative identity and the negative therapeutic reaction is their shared libidinal attachment to the superego. The connection between the two is also evidenced in that the patients, in my experience, show a characteristic disturbance in their object relations, as suggested earlier in the mother/infant feeding relationship, such as harsh and persecuting introjects which attack a more creative ego functioning. Thus negative identity and the negative therapeutic reaction serve each other in a righteously defended alliance. To illustrate this clinically I will describe the first of two cases.

Mr. A was a 34 year old single man. He came into therapy complaining of depression and a deep sense of failure. He was in fact one of my training cases. The background was that he was the elder of two sons. He described an unhappy childhood with a deep sense of injustice because his parents never understood him and he thought them to be useless. He could not admit to have any positive feelings about them whatsoever. He said that his mother was stupid and his father was only interested in controlling the household with his tempers and silences. The younger brother was said to be a conformist and according to the patient had accepted the family situation. He married,

had two children and settled near the parents' home. Mr. A left home when he was nineteen years old following a violent row with his father. He managed to put himself through college and obtain a master's degree. When he first entered treatment he hadn't been home for seven years. Since being in treatment he had made two fleeting visits back but maintains a phobic attitude to the idea of any direct contact with his family, especially his father.

In the sessions Mr. A was often silent and frequently complained that he was wasting time and getting worse. In time I learned from him that his father's mother had died when his father was an infant. The father was then brought up by his own tyrannical father and a step-mother who later left because it was said that she was so badly treated. Some months after he had told me this he also confided that his father had named him after one of his dead brothers ie. one of the patient's uncles who had in fact been killed in the war. The patient had dealt with this morbid identification mainly by denial, helped by using his second name which as far as I know had no hereditary link. I felt that his telling me of this was an indication of some awareness of an implanted negative or even dead object within him.

When Mr. A wasn't silently witholding he seemed to want to talk mostly about his relationships with women. He also asserted that he had no difficulties sexually but was always misunderstood by his women friends. He seemed to chose women who were generally unavailable for one reason or another. I understood these relationships to represent an unconcious need for emotional succour but his 'negative identity' or 'envious father reaction' precluded this and he enviously attacked these relationships when his narcissistic wants began to impinge upon the reality of the relationship. I saw a pattern which was derived from the envious father attacking the mother/child feeding relationship of which the father had himself been so sorely deprived. From this I could confirm with greater certainty that this patient's difficulties were pre-oedipal and his relationships with women were in the pursuit of a safe feeding relationship with mother.

As treatment progressed I began to feel that there was evidence of a more positive identification with me. Such signs were his acceptence of interpretations or to put it more accurately (ie. negatively) the interpretations were not rejected. On one occasion he had referred to a friend called 'Philip' as being a 'dumbo'. I interpreted this in the transference saying that he might be surprised to find himself in a relationship with a therapist/Philip. He replied, firmly for him, 'No, we have psychology in common'. At the same time this seemed evidence

of the increasingly positive identification with me; I now know it to have been a defence against that very process. The reason for this is that to have made a positive identification would have required the patient to have moved into a depressive position and deal with the object world in a new way. Objects which at another time he had described as 'scum bags'. What I had wanted to see as progress was to be replaced in subsequent sessions with powerful feelings of being unwanted and in particular hate towards the father. Now the process of negative therapeutic reaction was extant and what had happened here is described well by Sohn (1985). When the patient feels helped, 'the new situation is attacked mercilessly, acting out occurs and the original situation of dominance and triumph recurs'. So in sessions following this he began to threaten to terminate therapy saying that my interpretations were 'too Freudian' for him.

The fact that this was a training case was influential in my reluctance to let myself know the tenacity of the patient's need for negation. Perhaps I had fallen into a trap and was like the 'dumbo' parent who was unable to recognise the son's actual individuality (negatively speaking). Holding on to a sense of something positive was a constant feature of my supervision at this time. However I gradually came to know that I was locked into a battle with an acutely sensitive superego which had an ally in the negative identity. Such an alliance would powerfully undermine any threatened progress with an envious repudiation of interpretation.

Eventually after the third summer break the patient did write to me terminating treatment. Within a few weeks he telephoned me asking to return and this was possible but for only one session per week. He made it clear that he would not use the couch (a negative attitude) but by not doing so it turned out that he was able to avoid the persecutory anxiety which had dominated the earlier therapy. In this new situation he was more able to deal with the concrete reality of me and discover what I am not ie. the persecuting envious father. In the same way my own sense of interpretative effectiveness was strengthened because I was not so controlled by the patient's witholding silences which became rare. In the new situation it was possible to help the patient see important patterns and separate out his identifications with an envious father from the more unconscious persecutory anxieties of the negative therapeutic reaction. It is this process which has the potentiality of being ego strengthening. The main evidence for this has been in the patient's dawning appreciation of his absorption of his father's attacks. When he returned to therapy this time there appeared

to be no loss of face but instead there was a sense of wanting to return and renegotiate terms. Mr. A has bought his own house and whilst his relationship with his girlfriend of over two years standing is fraught he is clearly more reflective about his feelings. However to accept this at face value as being solid progress would be to underestimate the negative therapeutic reaction, the amount of unconcious guilt and the negative identity structure. In fact the patient was once again threatening to terminate the therapy at a point when I was not so much as daring to suggest any progress as claiming some understanding in this paper just as he had done when I first presented this case in my qualifying paper.

In the second case Miss B, a young looking 39 year old woman was a post anorexic patient. She had had many years of treatment and including some psychotherapy. As she was no longer seriously acting out by abusing food or taking the huge quantities of laxatives, she was referred outside the hospital setting for therapy. She had a deprived background. She was adopted as a baby but was soon displaced when the adoptive mother gave birth to her own baby girl only months after the adoption. During latency she witnessed her father's death in an industrial accident. She had been sexually abused by an older brother. At 14 she went to boarding school because it is said that she was too difficult to manage at home. On leaving school she was able to pursue a professional career with some success until her symptoms became too serious and she could no longer work. Her social life had been quite disastrous but at the time of her therapy she seemed to have found a supportive social network.

This was a case in which some success could be claimed by the hospital and the patient from the determined efforts of both to overcome her entrenched problems. I experienced the full force of these problems in the first two years of therapy when I often came reeling from a session with her. From the outset the patient mourned the loss of the hospital environment and the opportunity to play the sick role in a concrete way or in other words 'to be nursed by an idealised mother'. In the transference I understood the hospital represented the idealised breast feeding mother whilst I was the hated adoptive mother. I saw this as the reason for her constant and merciless attacks during this two years of therapy. I became for this patient the embodiment of bad food which had to be kept at bay by shouting and screaming through the sessions or by a defiant silence and non-cooperation. In this way the patient was able to keep a sense of control over the persecuting world in which she once again found herself. This is a

world of catastrophic loss and terror of anihilation. However whilst the urge to abuse food and laxatives during this period was never far away she did in fact manage to control it in part by using and abusing her therapist. This was a psychotic process with projections so immobilising that I experienced physical symptoms of stress myself during sessions. I understood this as a concrete representation of projective identification being the patient's acute anxiety about disintegration as she was in such a rage.

Eventually after the sessions had deteriorated so much I thought that Miss B was going to break down completely and a hospital admission would be required. In one crucial session she at last heard me say above her own shouting at me that I was shit, if she thought I was so useless we should plan the time within which to finish therapy. After this she began to calm down and whilst she held on to her accusations of my incompetence it was without the murderousness of the previous sessions. It is easy to tell the difference after being attacked so vehemently for so long. In the six months which followed this whilst working towards a termination there began a more positive evaluation of me as the object which once she could only hate and she began to hear my interpretations of her negative identifications.

> 'It is a reminder that catastrophic reactions sometimes are due to not realising that a phantasy of fusion has been dominating the transference and the patient has felt separate from us. It forces us for instance to examine more carefully what kind of object we are to the patient who may even treat us as a concrete internal object, so much part of themselves. The hardest part will of course be to show them that we are not that object'. (Limentani, 1981).

In my case the 'phantasy of fusion' was being concretely expressed by the patient in her determined wish to be pregnant regardless of any paternal involvement. If she could become pregnant without having any relationship with a man she would. Similarly if she could get better without having a relationship with a therapist she would.

In this case the patient was negating any progress in her life and could not bear to think of the future except in terms of her phantasy of having a baby of her own. Her violent reaction to me was to protect her fragile object world and the phantasy of a once perfect relationship with mother. Thus the loss of her natural mother on adoption was experienced as an object death and an actual loss at a most vulnerable stage of her life and years later she witnessed her adoptive father's death. The persecution which she alleged I was perpetrating on her was that of the adoptive mother who was experienced as unloving and

unwilling to recognise the patient's needs. As Limentani puts it '... to live means that now or sometime in the future they will die and in consequence they opt for survival in preference for a full and contented life'. In other words this patient clung to her negative identity or negative survival for it is this which has the most meaning for her. In the totalistic negative identity Miss B had introjected the persecuting mother identity which could never be satisfied and at the same time is the very object which is hated and feared.

Whilst these two cases are different in many respects the negative therapeutic reaction and the negative identities bring them into relationship. Both Mr. A and Miss B were hostile to progress in the therapy and they both had traumatic experience of object death. In Mr. A's case the traumatic object death was in a 'borrowed sense' namely, the dead uncle after whom he had been named and the loss of the breast which was envied so much by his father. In Miss B's case the object death had occurred on her first adoption when she was a baby and then again when she had witnessed her adoptive father's death and had been sexually assaulted by her brother. In both cases environmental failure prevailed which facilitated further internalisation of negative objects and the present formations of negative identity. I would suggest that in both cases the identification process of introjection and projection ended prematurely during adolescence having already been disrupted during infancy. This Erikson calls a 'foreclosure'. The known precipitating events were that Mr. A actually left home and Miss B was sent to boarding school. 'Identity formation began where the usefulness of identification ended'.

The first step towards offering the patients a more useful therapeutic experience was recognition of my own uncertainty and discouragement as being the very effect which the patient desired to produce. Riviere (1936). As suggested by Limentani and others work through the countertransference becomes all important in these cases. For me it was a question at times of 'survival' in the countertransference, never a question of 'leading a full and contented life'. The second step was the concept of negative identity. In classical theory the negative therapeutic reaction was from an unconcious sense guilt and this was seen as the main obstacle to treatment. The importance of the concept of negative identity is that it enables a further delineation of the unconcious obstacles in the negative therapeutic reaction. Thus the psychological condition of the patient becomes more available when opportunities are presented in therapy for reconstruction using this idea.

Finally it must be accepted that the patient's negative therapeutic

reaction and negative identity have a legitimate existence. Their own negative identities they know. How can they know what is being offered by their psychotherapist? In order to find out they have to question the therapist in primitive fashion as this is the means of discovery open to them and it may often involve destruction. In this process the therapist has to be prepared for the re-awakening of feelings of primitive anger, loss, envy and despair which preceded the negative identity when hope was also still alive.

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HATRED IN THE COUNTER-TRANSFERENCE – THE IMPORTANCE OF NON-RETALIATION

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For a psychotherapeutic experience to be thorough, it has to contain and comprehend primitive hatred in the transference. There is a hierarchy of engagement in the therapeutic encounter, and work with the negative transference and countertransference reaches the deepest levels of the clinical interaction. Feelings of hatred arising in the therapist can seem to be inappropriate and unprofessional, but I should like to suggest that there is a profound and relevant engagement occurring when an apparently pointless and destructive search for the therapist's personal limitations threatens to interfere with the work.

A patient has been in the street outside my house for twenty minutes. His behaviour is sometimes alarming, for he has a habit of going up to the windows of other houses in the street and peering in, or suddenly stopping in his tracks and jerking his head up, so that he is looking at the sky, or the roofs of the houses, a quick, bird-like movement. Usually, about fifteen minutes before the time of his session he takes up a position in my doorway, and seems startled when my previous patient leaves, although this scene has been played out twice a week for some years. At the appointed time, he rings the bell, comes in, and is almost inevitably chewing on the last half of a chocolate bar, which he must have been saving for some time, in order to have something in his mouth to work on as he negotiates the difficulty and anxiety of his entrance and our initial exchanges. This I understand, and have considerable sympathy for. What I find harder to understand, and have much less sympathy for, is the rage that this chewing induces in me as I greet him. He can't wait until the session has started – at least my definition of when the session starts – before informing me that I am in hateful competition with something he has discovered to be more reliable and more available than I am. But if I have successfully recognised that, why do I still feel enraged, over and over again? He has made contact with an intolerant part of my personality that has nothing to do with his therapy. I do not like what he is doing to me, and while I am able to see what is happening, and to think about it, my own feelings about this state of affairs have obviously not been

sufficiently worked through. In this combative encounter, I want to be his only source of comfort, and I feel bothered that I am not.

Does this not belong to his therapy? His experience with me is limited if I cannot tolerate part of the happening between us, but if I *can* tolerate it, while not liking it, we might be able to use it.

'I'm not satisfied with what you said about my dream, yesterday', a young female patient informs me, and adds, 'You're not very good on dreams, are you?' A few minutes later, she reminds me that she had specifically asked to be referred to a Jungian therapist, and had expressed disappointment on more than one occasion regarding my attitude to working with active imagination and some of the exciting archetypal images she brought me. The criticisms had some basis to them. I do prefer to work with the transference, but I felt aggrieved that the considerable benefit she had derived from her six years in therapy did not receive acknowledgement.

My resentment had no place in her treatment, but her capacity to induce it certainly does.

The literature on hatred arising in the therapist is limited, which perhaps reflects our discomfort with the phenomenon.

Fenichel (1939) in *Problems of Analytical Technique* discusses the vicious circle that can be set up by the law of talion. He says: 'Whenever one is blocked in any piece of work to which one is devoted, one always becomes angry.' Racker (1968) points out the opportunity for exploring crucial psychological facts about the patient, but sees irritation in the therapist as a neurotic reaction which interferes with understanding, and a result of the therapist's own insufficient analysis.

Racker considers the paranoid mechanisms which may be activated in the therapist when a resistant patient provokes annoyance, or even intense hatred. The therapist experiences resistance as the hatred the patient feels for him, and Racker emphasizes the objective truth in the feeling, which is not just a product of childhood frustration. Resistance *is* hatred – of feared, frustrating and rejecting internal objects, and the negative projections seek to convince the therapist that he is as bad as the patient's introjected objects. The patient has an ally within the therapist's own personality – the latter's bad introjected objects which hate him and which he hates. Resistance can therefore produce a state of superego persecution in the therapist, and projection of the therapist's bad introjected objects upon the patient. Racker is sympathetic to these difficulties, and advocates a detailed definition of the projections, as they contain crucial psychological information about the patient's personality, ('countertransference reactions of great intensity,

even pathological ones, should also serve as tools'), but is clear that they can be deficiencies to treatment, and require further analysis on the part of the practitioner.

Winnicott, (1949) in *Hate in the Countertransference*, considers the management of negative feelings in therapists – and mothers. He makes us feel less guilty about hating, but sees nothing to celebrate in the experience. Margaret Little (1951) discusses countertransference as a disturbance to understanding and interpretation. She stresses the likelihood of the therapist repeating the behaviour of the patient's parents and to satisfy certain needs of his own, and advocates admitting the hateful feelings to the patient, and then interpreting. She emphasizes that this applies to 'subjective' countertransference reactions, not only to 'objective' ones.

Analytical psychotherapy has more to do with hatred than with love – our love is expressed through our tolerance of the whole person and our response to everything they bring, including their primitive *and current* hatred, and our management of the hateful (and loving) feelings they induce in us. It is at this level that the law of talion (an eye for an eye, a tooth for a tooth) is likely to apply. I suggest that within the temptation to retaliate a central engagement with the deepest level of damage in a patient's personality takes place. The hatred is real, and a talionic response is only to be expected.

A hierarchy of engagement exists in working with patients – we listen to their story, empathise with their suffering, offer to work with their images, and their unresolved, repressed feelings, but fundamentally we undertake to sustain a predisposition – to be attentive, tolerant and interested, and to provide a containing and understanding response to them, which in our terms includes their primitive projections, occasionally offering a formal, articulated account of our view of the experience. Our readiness to work with the negative transference offers a deeper engagement than most 'counselling' relationships, and our understanding and use of negative counter-transference takes us deeper still. Some very damaged patients reach out, through projective identification, for the most vulnerable aspects of their therapist's personality in an attempt to have a 'real' experience with the human being behind the professional 'mask', as they see it in terms of their transference delusion. It is these patients for whom our capacity to tolerate the responses in ourselves to their uncanny and perceptive probing can break into a vicious circle and produce a space for understanding, and thought. Winnicott's elaboration of the importance of maternal preoccupation (1956) and potential space (1971) indicates the necessary

process. By containing the projective identification, a transformation can occur of a meaningless state of pain into something that can be re-internalised and used to generate thought and feeling. By not avoiding the transaction, but without retaliating to the destructive potential, movement can occur from a paranoid-schizoid pattern of thought to a more reflective, subjective state.

'*YOU* WOULDN'T LAST TEN MINUTES!' he screamed at me, the emphasis heavily on 'you', as opposed to himself, a teacher who had to endure hours of torment in front of a monster-horde of fifth-formers, every day. He had half-lifted himself off the couch and contorted his entire body so that he could face towards me. I was to be in no doubt that it was *me* and not an image or a symbolic representation that he was addressing. In my memory he seemed to tower over me for ever, suspended in mid-air by his furious rage. As he fell back on the couch he amended his assertion: '*TWO* MINUTES!' Despite his fury, there was still room for thought.

My first training patient used to cycle across North London at six in the morning, a 40-minute cycle ride, for little apparent purpose other than the opportunity to tell me how useless the psychotherapeutic experience was. Our contract was for two years, but she continued for almost two years longer.

A patient from Essex, who had set out from home one morning in a blizzard, when even central London was halted by snow and abandoned vehicles, rang me from a phone box in Islington, two hours after the time of her appointment, to ask if I had any vacancies later in the day. She then walked from the phone box, where she left her car, spent the day in various Oxford Street department stores, without making any purchases, and finally passed the entire session in a bitter, furious silence. For over a year, she had insisted that her life was fine, her only problem was having to attend her sessions three times a week. All the futility and pointlessness that she had never had a language for, or a listening ear to hear and respond to, was expressed through her hatred for her 'sessions'. Any interpretations that attempted to capture her misery in words, or that referred to her dependence were met with a disparaging, contemptuous shrug, and silence.

In the above examples the hatred is audible and obvious. Some patients are more subtle, and for some it takes place on a level that only becomes apparent in the counter-transference.

A patient I had been seeing for a few weeks was just starting to use the couch. One day she came in, lay down in silence, and suddenly I was overwhelmed with a feeling that I shouldn't have taken her on. I

felt that she needed a more loving relationship, preferably one which contained the possibility of physical contact and comfort. Psychotherapy seemed a wretched thing to offer her, with its rituals and its limitations, its arrogant, time-consuming presumptions. She continued to say nothing, and I had an opportunity to think about my feeling for a few moments. I recalled that during her previous session, when I had been hearing how carelessly her father had treated her, and how much she still longed for his love, I had felt an urgent impulse to telephone him and inform him of the error of his ways. It occurred to me, still in the space of a minute or two at the start of this silent session, that my assistance in helping her sort all this out, and to understand and contain the way in which she communicates her primitive needs was just what she should be doing. In stark contradiction to the feeling I had a few minutes earlier, I was now convinced that she should be working with me, and suddenly I was quite excited at the prospect of the work ahead, and filled with the conviction that I was the best thing in the world that could have happened to her.

'I can't think straight, today,' a patient informs me, 'it's probably because I'm tired, and/or unwell.' Or maybe he has had a dream, but can't remember it. Tantalised, and then irritated, the therapist is being picked up, aroused, and dismissed, a sado-masochistic encounter that seeks to avenge an old, (or a current) wound to self-esteem.

A patient has a minor physical symptom, a backache, a cough, or some digestive discomfort. The symptom is mentioned, and there is a pause, indicating a wish for a response. If a therapist is awake to what is going on, he or she is alerted to a monster beginning to stir in the undergrowth at this point, because a brief dilemma occurs in the mind of the therapist, a hint of trouble to come. It would be human to offer sympathy, unanalytic to give advice. Silence seems unkind, but there isn't much to go on. Most of us have a range of non-committal noises we make on such occasions, and perhaps a slight elaboration is then offered. The patient has consulted his G.P. with the troublesome symptom, and the experience was unhelpful. He was kept waiting, the receptionist was cruel, the doctor was dismissive. A transference interpretation is clearly indicated, partly as there is such a discrepancy between the quality of the offence and the intensity of the complaint, but while the words are forming, some further material arrives. 'The doctor gave me some antibiotics, *but they only made me worse.*' An explosion occurs in the mind of the therapist. '*THEY* made you worse! It's not the tablets that made you worse,' he wants to say. 'You were ill, you know. Couldn't that be the reason you felt worse? The doctor/

the antibiotics (all right, maybe not the receptionist) are supposed to be there to help you. How *can* you be so ungrateful?' Hopefully, long before these sentiments have been expressed, the analytic attitude has stepped in and enabled the healing power of thought to mediate in what might otherwise be an unproductive encounter that has been played out again and again every day of the patient's life thus far.

Some internal, persecuting object, saturated with the pervasive capacity to make our patient feel worse, (and possibly contributing to the original illness) was invested into the 'help' the patient received, and doctor, receptionist, system (and psychotherapist) became his enemy. There was a premonition of trouble, with the hint, early in the exchange, that the patient wanted a 'real' response from the therapist, that a working therapist, ready and willing to analyze, was not what was wanted. Concentrated attention was interfered with by the conscious consideration, in the mind of the therapist, of the response that was being demanded. This is an attack on the therapist's freedom to think, and should have alerted him to what is coming.

A destructive attack on the therapist's capacity to think represents one of the hardest manifestations of hatred to tolerate. One elderly woman completely stops me thinking about her; my thoughts, my peace of mind, my capacity to symbolise are interfered with, and this is exasperating to both of us. Supervision provided the opportunity to start thinking about her, and the meaning of the interaction in terms of the projective identifications taking place. Week after week, as I presented material that produced nothing in me when I was with her, I had the curious experience of a range of empathic and even sympathetic emotional responses coming to life – and the capacity slowly developed in me, (but for a long time only in a senior colleague's consulting room), to see symbolic references to the transference relationship between us that was usual for me with other patients.

Michael Fordham (1947) has elaborated the importance of the process of projection, identification, introjection and reprojection by which the analyst takes into himself the inner pain of the patient, understands and *metabolizes it* and can return it to the patient in a form which can be thought about, talked about, and, for the first time, *suffered.* (Lambert, 1981). This process offers more than containment, and Fordham employs Bion's notion of beta elements, developing through the action of alpha function into alpha elements, the raw material of thought. (Bion, 1967)

Klein emphasizes that in projective identification, unconscious contents are projected 'into' (Klein, 1946), not 'onto' the object, and Bion

develops this idea of projective identification not only as a defence, but as a form of communication in which two personality systems modify each other. Jung's vivid image of the *marriage quaternity* (Jung, 1946) captures, through the alchemical metaphor, the mutual influence of the two personalities on each other.

> 'Projective identification allows an infant, in early development, to emerge from the closed system of his internal psychological world. In the paranoid-schizoid position, the infant has superimposed his internal world on the external one, and is imprisoned until his mother allows herself to be used in a process through which a mother-infant entity is created that is neither infant nor mother, but a product of the two. The projector induces a feeling state in another that corresponds to a state that the projector had been unable to experience for himself. When the recipient allows the induced state to reside within him without immediately attempting to rid himself of these feelings, an experience can occur that had been previously unavailable, and the quality and capacity for emotional communication has been altered.' (Ogden, 1986)

Guntrip describes a final state of regressed libidinal ego damage, the ultimate split into an active sado-masochistic oral ego which continues to maintain internal bad-object relations, and a passive regressed ego which seeks to return to the antenatal state of absolute passive dependent security. (Guntrip, 1983) Winnicott (1971, 1982, 1985) describes the fear-dictated retreat from impingement, continued into an attempt even to escape from *internal* bad objects, a withdrawal of an extreme, radical kind into ultimate regression. Only when we reach and deal with the patient's deepest 'withdrawnness' are we getting at the real roots of his trouble.

When a patient strives to make contact, through projective identification, with a wound in the healer, it is as if a primitive, damaged part of the patient's personality is seeking desperately for a 'real' experience with the 'human being' behind the professional. In the delusion, the belief exists that only when the professional 'mask' can be dispensed with, and the real person can be persuaded to respond, that a healing experience can occur. We designate this transaction as belonging to a psychotic transference, and regard our irritation as being 'neurotic' counter-transference. The therapist feels abused, and retaliation is not unlikely through a talionic withdrawal on our part.

But there is another viewpoint, from where the professional 'mask' has to be seen to be fair game, and although the language of the transaction has been, and can only be, primitive attack, in these terms the behaviour should not be considered sadistic, as it can so easily seem to the recipient. To regard this aspect of the engagement as being

irrelevant or out of bounds would seem to me to block a unique chance of holding and healing.

It is first by reaching the profoundly withdrawn damaged self and re-'living' and relieving its fears, then starting it on the road to rebirth and regrowth, with the discovery and development of all its potentialities, that we offer the opportunity of healing. This kind of patient attempts to make contact with the damaged element in the therapist, and to provoke him sufficiently by relating on this primitive level. These patients seek out *the therapist's* wound and hope that the therapist can overcome his retaliatory response sufficiently to continue to offer the transforming possibility that their persecutory, destructive negativity can be detoxified, or in Jungian language that the archetypal level of their experience can be mediated. The experience might even come to be thought about, its misery heard, its suffering at last worked through, so that finally the damage can have the chance to reach some deep-level security.

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INSIDE OUT
An Exploration of an Adolescent State of Mind

PATRICIA ALLEN

The world of the adolescent is typically an extroverted world, depending largely on reassuring adaptational clues from the environment. (Whitmont 1969)

These words of Whitmont's, from a discussion of Jung's theory of Psychological Types, capture the essential idea of adolescence as a state of movement of the psyche towards the external world of objects. The adolescent in the midst of the chaos which accompanies growth and development, discovers himself in his external world in a similar way to the infant, whose projections of primitive impulses and archetypal patterns rely for mediation on the maternal environment. It is this similarity between the infant, and his need for a containing object, and the adolescent, which is the central theme of this paper.

Speedy and dramatic changes in internal and external life, mirroring those taking place in his body, are the lot of the adolescent. It is a time when emerging adult selfhood clamours for realisation, accompanied by the powerful thrust of potential genital sexuality. It is also a time when the urge to return to childhood and dependence on the external parents, thus avoiding the pain of separation and loss, also plays its part. Before new ways of being can be integrated, the adolescent's relationship to his internal objects must undergo a profound change. Separation from the mother of infancy and childhood, *and* her continuing existence as a containing internal object, must be achieved if the young person is to be able to restore the oedipal parents and their fruitful intercourse inside him. In his paper 'The Oedipus Complex in Adolescence', Gee describes the 'heroic' struggle to give up the wish for the incestuous object, and likens it, after Jung, to the struggle for consciousness. (Gee 1989) In infancy it is the containing mother, described by Bion as using her alpha function to process the raw and primitive beta elements, who is thinking in the service of her baby. (Bion 1963) It is, I believe, the internal containing/thinking mother who enables the adolescent to heal splits, resolve oedipal conflicts and make tolerable the separations and losses which

accompany the heroic journey to the state of adulthood. Robinson in her paper 'Invisible Mending', describes:

> ... two psychic functions both of which have to be present for growth to occur. The hero, visible as the capacity for separation and development of consciousness, can only be active when there is a heroine present in the form of an internal configuration, which can contain; wait; endure; submit to dependence and transform. Heroic enterprises which are not grounded in this way are doomed to fail. For though the maternal object must be left behind, it must also *at the same time* be preserved; and whilst the adolescent must separate, he or she must also be able to tolerate waiting and the limitations of autonomy.
> (Robinson 1989)

These two psychic functions attributed to the hero and heroine have much in common with what we understand to be the dynamic processes of the self. At adolescence the heroic deintegrative process is concerned with the complex re-working of archetypal patterns of experience in the thrust to separate and to resolve oedipal conflicts. It is the containing capacity of the internal object which allows the experience to be processed and transformed, in order for integration and growth to take place. For the infant it is the heroine capacity within the mother which meets with his hero and heroine potential, as together they labour to make sense of powerful and often terrifying experiences. By this I mean that primitive experiences of all kinds are reliant on both the mother's capacity to contain, and the baby's capacity to use the mother as a modifier of experience. The following is an extract from an observation of a baby of ten weeks:

> William, sitting quietly in his chair, passed wind audibly and began to grizzle, moving his head and limbs in an 'agitated' way. Mother stroked his face and made soothing sounds, but he continued to cry. She untied him from the chair and cradled him in her arms, putting her right index finger into his mouth. He sucked for a moment and then seemed to let go. Mother stood him on her lap, supporting under his arms and his sides with her hands. William, wide-eyed, stared silently into her face and then began to cry again. Mother carried him to the couch saying: 'You think you're mother is a cafeteria on legs!' She laid him on a cushion by her right arm. He stopped crying as she lifted her breast forward and put the nipple into his mouth. William's left hand and arm cradled her breast and his right hand rested across his tummy. He sucked and gulped at first, then rested with the nipple in his mouth. Mother told him that he wasn't really hungry, 'just in need of a bit of comfort, perhaps.' William sucked on and off for a few moments, and then his eyelids began to flicker and close. He let the nipple fall out of his mouth and he sighed deeply. Mother crossed her right leg over her left, and William's body sprawled in the angle this made. His head lolled back against her breast, and his right hand lay upon her right hand which held him. His eyes closed and

opened several times, and his legs and feet made little twitching movements. His breathing became deep and regular. Rapid eye movements were noticeable, and after a while, he moved both hands in a circular movement over his tummy and he smiled.

I think that the expulsion of wind had frightened William. His grizzly crying and the agitated movements of his head and limbs, suggest that he felt suddenly 'not held together'. The noise of the flatus being expelled may have made him feel that there was something 'bad' out there. Mother acts immediately, but William insists on what he needs. It seems that only the nipple in his mouth, around which he can organise himself, will comfort him. Soothing noises, stroking, holding, mother's finger as substitute nipple, and eye contact are all soon rejected. Eventually mother understands and somewhat wearily and reluctantly presents the breast. She communicates her understanding verbally to William, telling him that she knows he isn't hungry, just in need of comfort. It is then that we see him allow the nipple to drop from his mouth as his state changes, and he appears relaxed and comforted. The digesting of the comforting breast and nipple experience is indicated by external evidence of an internal process at work: rapid eye movement; feet and legs twitching; and finally William appears to describe a circle, the breast in his tummy and his regained sense of integration, and he smiles as he sleeps.

Fordham writes:

> But a mother does more than act: by holding her baby in her mind, by reflecting about him, especially in a state of maternal reverie, she relates directly to her baby's protomental life and helps in the transformation of beta into alpha elements. It is interactive experiences of this kind that form the basis for the affectively charged mental distinction between good and bad objects, between inside and outside. (Fordham 1985)

For the patient I am writing about who appeared to have become 'stuck' at a major stage of mental growth and development in his young life, adolescence, there was little evidence of an internal configuration which might enable him to mobilise the hero and heroine inside him. Rather he appeared to experience the therapist as an envious, attacking and poisonous breast, which made nonsense of his communications. It was this use of pathological projective identification which was at the core of the therapy relationship, and which prevented him from using the process to assist him in developing a capacity for differentiating good from bad and inside from outside. It was, I think, significant that he sought treatment after he had reached the chronologically appropriate age of adolescence, yet he exhibited many of the conflicts characteristic of this stage of development. It

seemed to me that the bodily changes which he had experienced had put enormous pressure on his whole being to change, grow and develop. He knew that he needed help, but I think that the help he sought was to remain the same, with the psychotic part of his personality intact and in charge.

My experience of Jason in our early sessions was of an engaging personality. He was tall and at that stage reasonably slim, with penetrating blue eyes whose expression changed quickly from 'little boy' frankness to world weary cynicism. Jason himself requested psychotherapy because he had heard about it on a radio phone-in programme. He said that he had been depressed for years, and thought therapy might help him. Before he reached me, he was assessed by a psychologist and a psychiatrist, both of them women, and both finding him an attractive and likeable young man. I think because of his twenty years, his engaging manner and his initial appearance of being self-assured, Jason was referred as an adult patient and not considered for any of the adolescent treatment centres or for child psychotherapy. It became clear to me that his difficulties were essentially those of an adolescent i.e. unresolved conflicts bearing the hallmark of earlier stages of development had coalesced to form a rigid resistance to ever growing up, getting a job, leaving home, and taking his place in the world as an adult. Perhaps the most striking of his 'adolescent' symptoms was his distorted image of his body and sexuality, which was accompanied by a severe eating disorder. Jason declared himself to be ugly, spotty, a figure of ridicule, and the object of inevitable rejection particularly by women. Friendships came to nothing when people found out what he was really like – 'a failure'. He had left school without qualifications, having successfully truanted for his last two years: 'Nobody seemed to notice', he told me with a triumphant grin. He had never worked: 'What is there for me? You want me to be a road sweeper?' He conveyed that he *must* be a failure. People rejected him, they always had and they always would. Psychotherapy must take away the pain.

It seemed that all my early attempts to relate to Jason's catalogue of miseries were doomed if I referred to his 'feelings' or to his 'feelings about himself'. 'It's not my *feeling* about it – it's true', he insisted angrily, accusing me of living in a 'cocoon', of being 'out of touch with the real world'. I came to think that the real world Jason referred to was his inner world which he projected outside himself, while he attempted to live in a cocoon. Exasperated by what he experienced as my inability to understand, he told me that I must go out with him.

We would stand together on the street corner and he would point out the women he found attractive as they passed by, and I would see the kind of men they were with, *then* I would understand reality. I understood this as a desperate attempt to get me to enter into Jason's inner world. Was it in order that I should understand, or was there another purpose? Standing there on the street corner watching these couples go by, I too would know the pain of envy, jealousy, rejection and hopelessness. Or would I? I think that those undoubtedly successful and good looking men, despite the attractive women they escorted, were meant to envy Jason standing there with his therapist/girl friend. This was, I believe, central to Jason's use of the therapy relationship, and of course to the dilemma which adolescence presented. To defend himself against the threat of separation and consciousness, he was attempting to find his lover in the therapist/mother. I believe that much of his paralysis was a defence against his infantile rage, envy and dread of the primal couple.

His destructive feelings towards the parental intercourse were projected on to the external world, which was experienced as scornful, harsh and sadistic; a place where greed and contempt for the weak, the vulnerable and the dependent reigned triumphant. Any reference I made to a baby part of himself was greeted with derision and contempt. Jason told me that he *knew* that his conception had been entirely due to his mother's wish to revive her marriage. His only reason for being was, therefore, to keep father for mother. He had 'failed', and father had left the family when Jason was small. This fantasy appeared to seal Jason's fate. It is only the good parents in good and loving coitus who can make worthwhile babies. He presented an image of a devastated internal couple, and himself as a helpless infant who can only fail to repair and restore them.

Jason said that he had no memories of his father, but he did remember, when he was twelve years old, being told of his father's death. As Jason entered puberty, his absent father died. Sidoli, in her paper 'Separation in Adolescence', stresses the difficulties for the young person on the threshold of adult sexuality. While there is a need for a symbolic death of the parents as powerful and idealised figures, in order that the child can separate and become an adult, if this death is experienced concretely as a result of the murderous infantile rage which omnipotently 'gets rid' of the bad parent, then overwhelming guilt and anxiety may make it impossible for the child to separate. Regression or progression will depend on how these primitive infantile states are re-negotiated at adolescence. (Sidoli 1989) Here Sidoli brings

us back to the function of the containing maternal object. Jason talked of his dead father in admiring terms; he had been a success. However, he also told me that his father had apparently drunk to excess, and had on occasion been violent towards mother. His abandonment of the family had been total, and yet he was described by Jason in terms of his business success, and perhaps more importantly, his success with women. Jason could not, dared not, recognise his rage towards this abandoning father, rather it was turned towards himself. He seemed to be identified with the unacknowledged bad father and the bad baby who did not keep father for mother, but whose destructive impulses sent him away. I think that the following dream depicts Jason's state of projective identification with this bad internal object:

> I had a dream. I kept trying to wake up but fell back into it three times. It was about the Melting Man. I remember him from an advert for a horror movie. I never saw the film. The Melting Man was a kind of monster because he'd run into some radiation, or something like that. The first part was in the forest and he was devouring people and animals. I don't remember the middle bit, and then I was in a house with a couple and the man was being telephoned by the monster who was telling him that he had recovered, and the man was believing him. I was worried and I looked out of the window and saw the monster trying to climb the wall. I knew he was after the couple's baby. I threw something at him and his head came off. But he got it back on again.

The dream from which Jason tried to wake three times, is divided into three parts: the hungry devouring of infancy; the forgotten latency period; and the anxiety of the adolescent, impotent against the power and cunning of the monster. The dream as a whole suggested to me something of Jason's life struggle with the unmediated primitive impulses of early experience. Jason could make no further associations to this dream, and he was not receptive to any thoughts of mine. It was as if he handed it over to me, with its implications of disintegration, madness and death. The parental couple in the dream stood also, I think, for the therapist and the other professionals involved with Jason. We had not understood how mad, bad and powerful was this monster inside him. The monstrous Melting Man was a figure who seemed to represent both the bad father and the murderous infantile impulses of Jason. Radiation suggests an anal attack on father, which turns him into a retaliatory monster who is out to get the baby. The death of the baby, like the death of the parents, is a necessary symbolic happening if the adolescent is to progress to adulthood. However, this death can also be concretely realised, and as Sidoli writes: 'Suicide,

conscious or unconscious is one of the greatest causes of death at adolescence'. (Sidoli 1989)

The threat of suicide was overt and ever present in Jason's material. He said that he wanted to die, had nothing to live for, and dying was the only way to stop his pain. In fantasy his favoured method was to throw himself on to the track in the face of an oncoming tube train. That was, I believe, throwing himself both between and back into his parents in intercourse. His pain would be relieved in a state of non-being, or perhaps pre-being, before the loss of his father when his parents were united, and Jason need feel no guilt. Although I was aware that at any time rage and despair might overwhelm Jason, the fact that he had never at any time, no matter how broken up he appeared to be, made any attempt to kill himself, suggested that some phantasy was present which was the counterpart of his conscious wish for death.

Jason's only comfort in life seemed to be the large amounts of chocolate he consumed every day. He remembered that chocolate was a feature of his childhood. He hated going to primary school, but mother would meet him with a chocolate treat. He claimed to be addicted to chocolate: 'I'm like an alcoholic getting boose. I go from shop to shop, buying small amounts. I take them home and hide them, then I have to get rid of the wrappers.' Clearly Jason identified his addiction to chocolate with the father whom he had been told drank to excess. In the time that I knew him Jason became more and more overweight. He complained of being constipated. 'Where does it all go?' he asked me. I told him that I thought that he felt that the chocolate was actually stored up inside him, and that he held on to it as a source of comfort. I said that I thought it was his secret store of 'bad' goodness, which could make him feel powerful when usually he felt frightened and vulnerable. Jason made it clear that he considered chocolate far superior to any 'food for thought' I could offer him. He told me that chocolate was always available. It emerged that he used to be constipated as a child, and he remembered shaking with the effort of holding on to his faeces. His family would apparently offer him money to go to the lavatory. Jason told me that he often spent more money in a week on chocolate than he paid me for his therapy sessions. It was clear that one of the uses of this addiction was as a defence against feeding from me, against experiencing himself as dependent and needing the milk of the therapist/mother. In fact, Jason frequently blamed me for his addiction to chocolate, and in doing so he seemed to be making it clear that he could get nothing from me

but the bad poisonous stuff of his own evacuations. He said: 'Psychotherapy is crap, but it's all I can ever have'. The equation of chocolate with faeces is perhaps an obvious one, but the shaking attached to the effort of holding on to faeces in his bottom suggested both excitement, and dread. I believe it was a manifestation of anal masturbation. The faecal penis of the absent father was hard and strong inside him, and under his control until he had to evacuate it. I came to understand Jason's chocolate filled faecal penis was for him not only an omnipotently controlled breast experience, but that other intercourse, the parental intercourse, happening right there inside him. In their book *Adolescence and Developmental Breakdown*, Laufer & Laufer write about what they term the 'central masturbation fantasy'. Based on the work they have done with disturbed adolescents, they suggest that this can be an important element in adolescent psychopathology. The aim is to recreate the relationship with the gratifying (breast) mother, but of course at this stage of development it is experienced within a different context, a different body; one with physically mature genitals. (Laufer & Laufer 1984)

It seemed that Jason was retaining and thus controlling *both* the baby breast intercourse and the parental intercourse; his faeces equated with the nipple and father's penis, and his bottom with his mouth and mother's vagina. As such it was a bodily enactment of coupling from which no nourishment could be gained, and no baby Jason could be born to destroy and to be abandoned. I believe that it was this phantasy which was projected into the therapy relationship, and that it was the counterpart of his wish to kill himself. An omnipotently controlled intercourse from which no nourishment can be gained, and from which no baby can be born was both a desperate and triumphant attack on the therapist/parents, and a murderous attack on his emerging adult self. He could not return to infancy, nor could he move forward through adolescence to adulthood; he was paralysed. Any move towards relinquishing control over the 'parental intercourse' enacted in the therapy relationship would have faced Jason with his feelings of powerlessness and the destructive phantasies which he had so violently projected into the 'harsh and rejecting' external world. As I have made clear earlier, I believe that the adolescent re-working of oedipal conflicts is dependent on the relationship with the containing maternal object. The intercourse between Jason and the therapist/breast was one in which massive projective identification predominated. It frequently seemed that I could say nothing which was felt to be of use – it was all 'crap'. No good experience could be allowed by Jason; it

would be evidence of good outside himself and outside his control. To need, to want and to experience himself as dependent on a good external object was, it seemed, more terrifying than the prospect of a paralysed 'half life' lived as a victim of the 'bad' all around him.

This paralysis was frequently experienced by the therapist, particularly when attempts to communicate my understanding of his state to Jason were met by threats of violence. On one occasion he got up from his sitting position on the couch and grasped the arms of my chair. Towering over me, he leaned his face as close to mine as he could, without actually touching me. He told me that he was going to hit me, but he knew he couldn't hurt me. I was, of course, frightened. There was a look of intense hatred in his eyes, but I was aware of a fleeting impression that he was about to kiss me on the mouth. I think that Jason's experience was of himself as a desperate and powerless infant, hitting out at a huge and uncomprehending mother, while mine was of myself as a mother who was part of a violent primal scene. The difficulty I experienced in thinking and communicating my thoughts to Jason, was I believe a measure of just how powerful these projections were. He had a highly developed capacity for, as it were, moving the goal posts, so that an interpretation aimed at communicating understanding of one statement, suddenly became evidence of my total inability to understand anything at all. I experienced myself as a child, confused and often frightened, whose thoughts and feelings had no meaning.

Earlier I looked at an interaction between William and his mother, in which both appeared to be working hard at resolving a situation which might have led to a prolonged experience of feelings of disintegration. William, supported by mother's immediate attention, appeared to be able to tolerate the period of frustration before he got what he needed, the comfort of the breast, and the nipple in his mouth around which he could bring himself together. It was also important that mother communicated verbally her understanding that his need was for comfort rather than food. William could struggle and wait as he communicated his distress and his need to mother, and was then able to find a good experience. For Jason however, the space between internal and external reality appeared to give rise to intolerable feelings. He seemed compelled to create externally all that was so terrifying and filled him with dread in his inner world. He had to experience the therapist as a mother who uncomprehendingly returned to him all the primitive and unmediated elements of his own evacuations. Psychotherapy must be crap, but it was all he could ever have. I came to

understand Jason's position as one so precarious, and so close to catastrophe, that his only way of functioning was not only to maintain a constant state of evacuation, but to have absolute control over that evacuation i.e. he must do everything in his power to maintain his state 'inside out'.

As a child Jason had retained a faecal mass in his anus and shook with excitement and dread, and I have suggested that his unconscious phantasy accompanying this behaviour was of a triumphant controlling of both the baby/nipple intercourse, and the parental intercourse for which he held himself responsible. The developmental task which adolescence presented to Jason was dependent on a capacity to both tolerate and introject a modifying containing object which was not of his making and which was not under his control. The task was dependent on both the hero and heroine capacities in himself. In the therapy relationship with me, both the baby and adolescent parts of Jason remained, as it were, 'stuck' in a primitive and potentially catastrophic state, in which movement, change and consciousness threatened disintegration and death.

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OEDIPUS – AN ANCIENT MYTH FOR MODERN TIMES

STEPHEN GROSS

In this paper I shall move from an overview of the Oedipus Complex as conceived by Freud to a concentration on its incest as opposed to its parricide aspect and then finally and specifically to a consideration of the father/daughter incest with which we, in contemporary British society at least, have become increasingly preoccupied in the last few years, particularly in the post Cleveland era. (Admittedly the issue is wider than father/daughter incest, but it does I believe encapsulate the wider issue of child sexual abuse, and in any case most feminist theorists now regard the criterion for incest to include all types of sexual conduct.) My purpose will be to shed some light on the powerful fascination with incest which has gripped civilization, certainly European, throughout its recorded history.

The story of Oedipus has its origins in the myths of the Mycenean period of 1400 to 1100 BC so that it can be said to have assumed at least a 3,000 year presence in the collective European mind.

Oedipus which in translation means 'swollen foot' was mentioned in Homer's Odyssey around 800 BC as the son of Laius King of Thebes, who unknowingly married his mother (thus establishing the 'incest' aspect of the myth) who when the truth was revealed hanged herself whilst he continued to reign in Thebes.

In the Iliad, written around the same time, it is stated by Homer that Oedipus was eventually killed in battle and buried with full military honours. There is no mention of the oracle which prophecies the crimes of Oedipus which is a central feature of the myth as we know it.

It was the lost epic Thebais which served as the source for the later view of Oedipus as polluted outcast burdened by his guilt and also for the working out of the curse on the house of Labdacus.

The point at which Thebes is assailed by plague which the oracle states can only be removed if the murderer of Laius (Oedipus' father and thereby establishing the myth's parricide aspect) is driven out of the country is where Sophocles' *King Oedipus*, written around 425 BC, has its beginning. It is this version of the story that was to influence and inspire such writers as Shelley, Yeats and Eliot, in the Elder Statesman. It has served as the model for Seneca's tragedy, which in

its turn inspired Corneille. Other artists of the twentieth century, including Cocteau, Stravinsky, Gide, Pasolini and Ted Hughes, have all created or adapted versions of this theme. And it was the Sophocles version that was to provide Freud at the turn of the century with the essential ideas for his hugely celebrated and equally maligned Oedipus Complex.

The actual term Oedipus Complex does not make its first appearance in Freud's writing until 1910 but it was clear that the concept was by that time already accepted in psycho-analytic usage. In fact as early as 1897 Freud had written to his friend Wilhelm Fliess 'We can understand the riveting power of Oedipus Rex because the Greek legend seizes on a compulsion which everyone recognises because he feels its existence in himself'. Here we witness Freud spontaneously referring to a myth which transcends the history and vicissitudes of the individual's life experience. However, it would appear that Freud's actual discovery of the Oedipus Complex was made during his own self analysis, that is to say he was to claim a universal psychological phenomenon transcending both historical epoch and socio-cultural groupings apparently on the basis of a purely subjective experience. This would hardly of course pass the test of strict scientific method. From what we know of Freud's own family life he held professed deeply ambivalent feelings towards the dominant figure of his father, a typical Jewish paterfamilias of his time, whereas his reciprocal devotion to his doting mother never allowed him, despite his celebrated self analysis, to acknowledge his own incestuous feelings, which must, I think, ultimately account not only for the supremacy of the father in his Oedipal theories but for the phallo-centricity of his entire psychology. At the same time we must also recognise the full blown patriarchy which provided the socio-cultural context for his life and work in Vienna. However, despite these seemingly purely subjective sources Freud was later to corroborate his claims with historical evidence in the highly contentious *Totem & Taboo* (1912–13). In fact many anthropologists including Lévy Bruhl and Thelia Feldman regarded mother incest as the great universal taboo, the most dreaded among all primitive societies and everywhere compounded with dire pollution. In our present time the renowned Claude Lévi-Strauss writes that the prohibition against incest is the universal law and the minimum condition of the 'differentiation of culture from nature' whilst Jacques Lacan states that the incest taboo brings into play a proscriptive device which bars the way to naturally sought satisfaction and forms an indissoluble link between wish (that is incest) and law (proscription).

Incest with the mother was, so it seems, not merely a jealously guarded feature of Freud's own unconscious longings but was regarded by a number of more serious students of primitive societies as indeed the very psychological foundation on which human culture and law is based, when natural man becomes cultural man.

Because of the essential phallocentric nature of Freud's thinking he explicates the Oedipus Complex primarily from the perspective of the male child with his deep ambivalence towards the father and his incestuous desire for the mother. He did however proceed to talk of the Electra Complex, a term coined by Jung, as the female counterpart of the Oedipus Complex, in which the female child becomes fixated on the father whilst experiencing great jealousy towards the mother. Electra too comes down to us from the Greek legends as the daughter of Agamemnon and Clytemnestra and for the classical tragedies she is one of the central figures in the dramas of murder and revenge. She too has been the subject of the work of many artists over the centuries who in more recent times have included Hoffmansthal, Richard Strauss and Eugene O'Neill. However, Freud never developed this concept and was soon to dismiss it completely as invalid.

The myth of Oedipus was first discovered only in its simple and positive version but Freud averred that this was simply a schematisation when set against the complexity of actual experience where a boy has not merely an ambivalent attitude towards his father and an affectionate object choice towards his mother, but at the same time he also behaves like a girl and displays an affectionate feminine attitude towards his father and a corresponding jealousy and hostility towards his mother. In each case the two coexist in a dialectical relation to each other. In this context the Oedipus Complex connotes the child's situation in the triangle. Other important factors in this triangular relationship will be the unconscious desires of both parents, seduction and the relation between the parents as well as the subject and his instincts. A number of authors maintain that a purely dualistic structure that is mother and child precedes the triangular relation of the Oedipus Complex (peaking between years 3 and 5) whereas the Kleinian school does not treat any phase as pre-Oedipal. For them the Complex comes into play with the so-called depressive position, that is as soon as the child starts relating to the whole person (at around the fourth month).

According to Freud, if the ego has not achieved much more than repression of the Complex at the onset of the latency period (that is from 5 or 6 to the onset of puberty), ideally achieving its abolition

and destruction, then it will persist in an unconscious state in the id and will later manifest its pathological effects.

In the young boy, according to Freud, it is the threat of castration by the father which is the determining factor in the renunciation of the incestuous object. With the young girl the renunciation of the penis is not tolerated without some attempt at compensation. She slips from the penis to a baby, her Oedipus Complex culminating in a desire, long retained, to receive a baby from her father as a gift, to bear him a child.

Freud's major attempt to corroborate his theory of the Oedipus Complex with historical and anthropological evidence was his book *Totem and Taboo*, first published in 1912. In this work, composed of four inter-related essays, he attempts an explanation of the origin of the totemic system by presenting it as a unique historical event in which the primal father, who by threatening his sons with castration, reserves for himself the exclusive sexual rights over the women of the horde and was in turn slain by them out of their jealousy-inspired urge to usurp his power as well as his possessions. Stricken as they then become by their guilt at the killing of the father and by their new unmediated sexual access to their own women, they erected the totem as symbol in animal form of the slain father and of the identity and continuity of the clan. The two most fundamental and important taboo prohibitions of totemism were then to ensure against the killing of the totem animal, that is, the killing of the father and the other was against sexual intercourse with members of the opposite sex of the totem clan, which confirmed Freud in his conviction that patricide and incest are the two oldest and most powerful of human desires. The wish to violate these taboos, he maintained, persists within the unconscious and that those who obey them, that is most of mankind, hold a deep ambivalence to that which is prohibited. This, as we have seen, constitutes the essential propositions of his Oedipus Complex, coinciding as they do with the crimes of Oedipus.

Freud was never able to resign himself to treating the sexual phantasies of his patients as simply the outgrowth of the spontaneous sex life of a child, he was forever searching behind the fantasy for its grounding in reality and came to regard primal phantasies which included seduction, the primal scene as well as castration as mnemic residues transmitted hereditarily from actual experiences in the history of the human species. He was to acknowledge belatedly that with the seduction phantasies of his patients he had stumbled upon the Oedipus Complex, as it was a short step from the seduction of the little girl by

her father to the Oedipal love of the girl for her father. Significantly, the themes recognised in primal phantasies, the primal scene, castration and seduction all relate to origins: the primal scene to the origin of the subject, seduction to the emergence of sexuality, and castration to the origin of the distinctions between the sexes.

It is, perhaps inevitable that we might wish to speculate on the personal psychological origins of such seminal ideas of both Freud and Jung. Freud's theory of the Oedipus Complex was hardly likely to escape such scrutiny. One of his most gifted followers and associates, the Hungarian-born Sandor Ferenczi, was to argue that Freud's own fear of death had shown that Freud the son had wished to murder his own father and that this in turn had induced him to develop his theory of Oedipus the parricide. He went on to claim that Freud's concentration on the father-son relationship which so dominated his thinking, had lured him into exaggerations. Such a concentration had forced Freud's sexual theory into a 'one-sided androphile direction', obliging him to sacrifice the interest of women to that of men and to idealise the mother. He conjectured further that Freud himself having witnessed the primal scene, may very well have constructed a theory in which the father castrates the son, out of his own wish to castrate his father, the potent one, as a reaction to his own humiliation.

In fact, Freud's entire emphasis on the role of the father and on the period of patriarchy succeeds in revealing a fact of overwhelming significance to our own time. This is that in the period of patriarchy, to which his ideas refer, and out of which they have emerged, the father-daughter relationship was excluded from the incest prohibition, so that the father as egotistic law-maker, committed to protecting his own personal property and possessions, established a law by which he preserved his wife for himself from sexual appropriation by other members of the clan, whilst at the same time licensing himself to sexually possess his own daughter should he so desire.

It was Carl Jung, Freud's one-time heir apparent, who was later to become his greatest theoretical adversary who first challenged his master's belief, in a letter to Freud written in May 1912, on the primacy of the incest desire. Jung claimed that there existed in primitive man a large amount of free floating anxiety which led to the creation of taboo ceremonies which included among other things the incest taboo. Incest, according to Jung, was forbidden not because it is desired but because free floating anxiety regressively reactivates infantile feelings and phantasies and turns them into a ceremony of atonement as though incest had been or might have been desired. The salient fact

was the regressive movement of libido (or psychic energy) and not the mother. According to Jung, it appeared highly likely that primitive man never passed through an era of incest but rather *the first manifestation of incestuous desire was the prohibition itself.* Whereas Freud held that anxiety originated in the prohibition of incest, Jung was claiming that the prohibition of incest originated in anxiety.

Jung went on to develop ideas on incest markedly different from those of Freud: a difference reflecting the fundamental opposition between these two giants. Freud's approach was literal, instinctual and causative, whilst Jung's was metaphorical, psychological and teleological, that is, asking what is its purpose. Jung did not view the incest impulse from a literal perspective but saw the incest phantasy as a complex metaphor for a path of psychological growth and development. When, according to Jung, a child expresses incest feelings or phantasies he/she is unconsciously attempting to add enriching layers of experience to his/her personality by close emotional contact with the parent. The sexual aspect of the impulse ensures that the encounter is deep and meaningful. The taboo prevents physical expression. When an adult regresses in an incestuous manner he/she can be seen as attempting to recharge their batteries in order to regenerate themselves both spiritually and psychologically. For the child or adult fixated incestuously on one person, the sexual element is a symbolic entry into a desired inner state. The two bodies which might engage in the sex act represent different parts of the psyche which are not yet integrated. Intercourse marks such integration and the baby which might result symbolises growth and regeneration.

Now just as we found Freud vulnerable to accusations of the denials of his own incestuous feelings towards his mother by subjugating the mother to a peripheral and somewhat idealised role in his Oedipal theory, giving centre stage to the all-powerful father, so Jung perhaps is equally vulnerable to similar accusations in his transfiguring of the literal sensuality of incest into a spiritualised and metaphoric form. How might we respond to such ideas which may be flawed, perhaps at their very heart, because the thinkers concerned for all their unquestionable brilliance and originality, could not acknowledge the disturbing truths of their own psychic reality?

Andrew Samuels has attempted to build upon Jung's model of incest by introducing or perhaps more aptly returning to it the literal erotic component which Jung felt necessary to exclude. Samuels maintains that Jung's model can be applied most fruitfully to the daughter's relationship with the father, whereby she has to experience a deep

connection to her father that contains what he calls an erotic tone. If, he continues, this symbolically eroticised relationship fails to take place, then the father cannot initiate the daughter into a deeper psychology, for she will be too distant from their relationship for it to have a profound effect on her. The father, he claims, could not be more different from the daughter. He is male and of another generation which gives him a potential for stimulating an expansion and deepening of her personality. At the same time he is of the same family as his daughter and this makes him 'safe' as far as the physical acting out is concerned. Cases of actual incest result when the symbolic nature of these interactions is bypassed. It is equally damaging, he avers, rather surprisingly I feel, to the psycho-sexual development of the daughter if erotic withdrawal or even indifference occurs on the part of the father. Such erotic expression is easier for the mother because of her early physical contact with the child and accompanying excitement but for the father with his daughter he may find such experience too much to bear and so repress his erotic feelings perhaps displaying mockery of her sexuality or by imposing too rigid a boundary upon it. He recognises too, that there is a much greater cultural inhibition on the father demonstrating emotional expressiveness.

Samuels, bringing the incest theme right into the centre of contemporary family life, believes that clinicians must begin to think of an optimally erotic relation between father and daughter and that there must be a change in the family towards the father's greater physical involvement. Incestuous desire, he goes on, has the function of providing the fuel for the means by which we get close to other people and hence grow. Eventually, in the so-called healthy family, the daughter and her father must renounce their admitted longings for each other, and such renunciation is itself an affirmation of the daughter's erotic viability. This quite crucial idea is also held by the Freudian analyst Searles who views the acknowledgement of attraction between father and daughter or between mother and son, followed by a renunciation by both as at least as important a factor in the resolution of the Oedipus Complex as identification with the same sex parent. The good enough father functions for his daughter by offering her an alternative image of femininity to the maternal. An image of herself as an erotic being is the liberating factor from the imaginary confinement to one possibility only, that is maternity.

How satisfactory and persuasive are Samuels' ideas? When I first encountered them I was much impressed; now however I am far from convinced. Certainly what he has succeeded in doing is to draw our

attention away from the Freudian preoccupation with the mother/son incestuous dyad, to the erotic nature of the father/daughter relationship which in turn has highlighted a major focus of our currently burgeoning awareness of child sexual abuse. In doing so he gives vital recognition to the inescapibility of the erotic component and to the possibility of its value to the psychological development of the daughter. However, I feel that at the heart of his ideas lies the spectre of an insidious sexism, which could well facilitate the entry of a potentially destructive and inappropriate erotic dimension to the father/daughter relationship through, as it were, the back door.

Samuels seems unable to decide whether the erotic as opposed to the incestuous component is symbolic or literal, and anyway, in this particular instance, how he can effectively distinguish one from the other on a symbolic level of operation. Certainly we can see how incest might be given a symbolic significance and there can be little question of its undesirability as a literal expression of the relationship but either the erotic exists as an affect in both father and daughter and he certainly wants us to believe that it does, and surely it does, or he is referring to something else which functions symbolically as if it were erotic. If purely symbolic it would of course be far easier to manage and could readily serve those beneficial objectives for the daughter that he prizes so highly. But the erotic does exist and though we may wish that in the father/daughter relationship it be put to use only for the daughter's psychological good, it is by its very nature far more likely to serve the enhancement of the father's sexual gratification at his daughter's expense, or at least of his power and control over her, as both female and child. His view of the alternative image of femininity, as facilitated by the father, that is, of an erotic being as opposed to maternity, is surely sexist in the extreme. It is once again a blatant example of the male defining and prescribing a suitable image of the female and in this instance it is of her as an erotic being. Surely the purpose or at least the result of this will be to continue to satisfy man's long-held needs for sexual gratification by exploiting the woman. It also perpetuates the power relationship between the sexes. This time it is the father's sexuality on which the daughter must come to depend for her future psychological well-being. And why is it, if Samuels is as committed to the elimination of sexism and gender conservatism as he claims elsewhere in his writings, does he not consider how the mother's erotic connection with her son might not offer him an alternative image of masculinity to that of sexual and economic achiever? It would

then appear that the ideas that Samuels puts forward are no more than entrenched masculine reaction in deceptively enlightened clothing.

This being the case, where do we now find ourselves having followed the fate of the myth of the Oedipus myth for over 3,000 years? One place at least to which this road has led us is our own contemporary society where the daily disclosure of both current and past child sexual abuse is truly quite shocking.

My own belief is that the essential Oedipal structure of our unconscious as described by Freud, in which the child experiences a rivalry with the same sex parent for the sexual possession of the other parent is likely to be the case, at least in societies governed by a patriarchal system. Under such a system where men have almost total control of the institutional and ideological structures, envy, hostility and fear are certain to flourish throughout that society, most especially within the family where one of its most violent and destructive manifestations is the sexual abuse of the child.

There is no single nor straightforward solution to this frightful phenomenon, the causes of which lie deep and manifold within the very heart of our social life, but returning to Samuels, I do believe that one quite inescapable need to which we must attend is the expansion and development of our long established gender images and definitions, so that our notions and eventually our lived experience of what it means to be either a man or a woman is radically altered and that such a change is merely part of a continuous exploration of gender possibility. Only perhaps in this way might the power and the allurement of the Oedipus within us be made to loosen its hold.

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THE MULTIPLE ROLE OF DREAMS IN ANALYSIS*

MARY LISTER

Introduction

I hope to show in this paper how, when we work with patients, dreams illuminate the transference and countertransference, point to the person's complexes or, in Freudian terminology, fixation points, communicate to the analyst the person's state of mind at the time, indicate prognosis and so much more. In my view, dreams have an irreplaceable position in what James Hillman might call the age of the Logos. They are evidence of symbolic life and the mind at play and, fundamentally, they offer the analyst the opportunity to witness the dialogue between a person's conscious life and unconscious or inner world. Jung wrote that unconscious meaning can never be fully 'described' but only 'circumscribed'. (Jung, 1940). In my work, I seek to provide for a patient a facilitating environment where what Masud Khan has described as 'Those quiet and somewhat paradoxical vicissitudes of the self between the clamour and the silence can occur'. He goes on to say that these are 'assembled through a mutuality of playing dialogue between the analyst and the patient in an atmosphere of trust and unknowing'. (Khan, 1976). With all the feeling, thinking, body messages etc. in the analytic room, there is still a temptation to believe the omnipotent fantasy that one does know everything about the person. The position of the dream, its mystery, its beauty, its trickery, its elusive qualities help me to maintain without much effort the position of unknowing which I think is vital to our work. I conclude this introduction with Michael Fordham's words, 'When the analyst's ego is trained to relax its control, then another centre can be sensed and symbolised, which Jung has called the self. To it the ego can relate as a part to the whole, ... as part of the whole the ego can allow for the activity of an unconscious that it cannot understand but that is, as it were, understood by the self ...' (Fordham, 1962).

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It is not unusual for a person to say that they do not dream and also for dreams not to figure in someone's therapy for months and sometimes years. In *The privacy of the self*, Masud Khan discussed what he calls 'dream space' and a patient's capacity to act out in his dreams. (Khan, 1974). When a person does not bring dreams and seems too frightened to experience dreaming, it suggests to me that the person's consciousness feels swamped by unconscious processes and threatened by the waves of powerful, archetypal, forces which have not been sufficiently modified in childhood by good-enough parental figures. The fact that a patient does not bring dreams can also of course be a manifestation of a negative transference experience e.g. the therapist may be feared as an envious robbing figure who will take away the good things that are hidden inside.

Nevertheless, when a patient does not bring me dreams or reports having nightmares, I recognise this as illustrating a basic fear of dreams and the unconscious. Therefore, the first task is to help the patient do what James Hillman has called 'befriending the dream'. (Singer, 1972). When such a person eventually brings a dream or dream fragment of a frightening nature, rather than offering an interpretation, I receive the dream as a communication and by my emotional response, that is for example by not panicking, we begin to detoxify the fearful experiences in the internal world of the patient and thereby make them less powerful. The following are two case illustrations of such an intervention.

Case Illustration A

Geoff is 40. He works in the computer field. When he was a small child his mother left him with his father and siblings. Geoff's father kept all letters and presents sent by his mother and Geoff did not see her again until he was a teenager. After his mother left, the family was cared for by his paternal grandmother. His father suffered from bouts of depression and used to beat the children. Geoff looked upon his grandmother as the one reliable figure in his life. In his late teens, she became physically ill and would wake up in the middle of the night and accuse him of leaving the room dirty when in fact she had soiled herself. Not long after this she died and Geoff recalled not crying at her funeral. He came into therapy several years later after he had been made redundant and two years after his father's death.

Geoff had been coming to see me for eighteen months before he brought the following dream. Geoff dreamt on the night prior to the session that he was at his grandmother's funeral. She was like an Egyptian mummy and to begin with her head was off. He was very distressed in the dream. He said he had had a number of dreams about her recently and in one she had come alive again. It was characteristic of Geoff to be anxious lest, having told me such a dream, I would think that he was 'odd'. My role was to respond to the dream as an important communication which did not make me reject him. I did not offer interpretation, invite Geoff to associate or question him that much about the setting for example as I felt that this would encourage his logical, thinking side to remain in domination. However, the dream offered me a commentary on what was going on in the therapy at the time. He had come with an idealised picture of his grandmother who was to be the 'good mother' as opposed to his bad, abandoning mother. I was also expected to be this good mother and had been held anxiously in that place for some months. In addition, this idealised person had been an image of himself that he felt compelled to be, rather than allowing his true self to emerge. The dying in the dream paralleled therefore the change that was going on for him in his perspective of his grandmother, myself and ultimately himself.

I also thought at the time that the head being disconnected from the body of the corpse reflected Geoff's tendency to overuse his brain and the need for him to be in connection with his body. Of course the dream also illustrates the angry, murderous feelings that he had begun to be in touch with in the sessions.

Case Illustration B

Jim sought therapy as he had a reoccurrence of severely disabling obsessional rituals. He had previously had what we think now was a course of Cognitive therapy. He too is in the computer field and has a particularly sharp mind for problem solving. He first came to therapy twice a week and then reduced to once a week when his obsessional symptoms subsided. He would bring fragments of dreams which he would be embarrassed to recount. At first he just told me that he had dreamt about chopping up bodies and that there was a lot of blood everywhere. As time progressed, the dreams were brought in full and

his destructive feelings towards himself and others became clearer as the dreams became peopled by real people in his life. From the start he would bring the dream fragments around the times of our breaks and it was important to make explicit his fear of his destructive feelings but it was not helpful until a later stage to link these to me, and to reconstruct from the past his destructive feelings towards key people in his life.

I think it is interesting that with Jim a theme similar to that of Geoff's dream emerged i.e. in one of his later dreams Jim and his wife ended up bashing someone's head in. Perhaps this shows something of a collective nature in this age of the computers where the individual experiences so much, literally, in his head. I think that the basis of this is also that of the infant's experience. Here, when the mother is unable for whatever reason to digest and give back the baby's mental distress in a more manageable form, the baby is forced to do it himself. Wilfred Bion first pinpointed the importance of this mothering function and Michael Fordham later also underlined its integral value in the development of the individual. (Fordham, 1985). Donald Meltzer has taken this idea one step forward in linking it to considering why some people do not have the capacity to dream. (Meltzer, 1984). Similarly, it is the analyst's task to hold and contain the projections which feel unbearable to the patient until there is enough mental space for him to tolerate more. This occurred with Jim who began in time to experience more space in his dreams so that there was room for whole people and also a watching self or dream ego to be aware of what was going on in them.

The dialogue begins

When the person begins to feel free to bring dreams and to dream, the dialogue can begin between his unconscious and conscious mind. Then, as a rule, Jungians look to the dream to see how the unconscious mind is compensating for a conscious attitude or way of life.

Initial dreams

The first dream that the patient brings to therapy can sum up in a nutshell the patient's psychic predicament and the likely prognosis. Jung always stressed the importance of the initial dream and gave us

a salutary reminder of how it involves two people, the patient and analyst, when he said '... We know from the analytical experience that the initial dreams of patients at the beginning of an analysis are of especial interest, not least because they often bring out a critical evaluation of the doctor's personality which previously he would have asked for in vain'. (Jung, 1956).

I have found that the first dream often expresses the person's fears about coming into therapy and the resistances that I believe the psyche has used protectively up until then which will be needed to be worked through before engagement in therapy and dependence is allowed. It is not always possible to work through the defences against dependency and this first dream may well predict that the person will not stay in therapy despite their apparent motivation.

Edward Whitmont and Sylvia Perera give a very straightforward example of the fears expressed in an initial dream. (Whitmont and Perera, 1989). 'A woman brought in an initial dream: "I am sitting in a dentist's chair and refuse to open my mouth for fear of being hurt" '. The authors point to how the image in the dream shows her fear and resistance to the analytic process. The patient was asked to associate and she said that 'All dentists are sadists' and thus highlighted the fear of sadism which I think is already evident in the dream image. The following are two examples of initial dreams brought to me in therapy.

Case Illustration C

Nigel is a man in his late 30s who sought help because he became depressed after he was passed over for promotion at work. He was referred to me by a colleague whose assessment was that Nigel hid behind a Winnicottian false self. Nigel was an attractively imaginative person and my immediate countertransference reaction was that I was keen to take him on. Nigel expressed conscious ambivalence from the start, blaming financial restraints.

The dream

Nigel dreamt the night before his second session in therapy that he wanted a car space at work. His boss said that he could have it as long as he gave a lecture. Nigel said that this was the worst thing he could be asked to do as he could not cope with public speaking. He

ran out of work and thought about giving up work. He woke up feeling bad. Later in the session, Nigel said that fertilisers were involved in the dream somehow. In transpiring sessions I learnt that Nigel's father was in the fertilising business.

This dream aptly describes the costs Nigel felt there would be for him in coming to therapy and seeking a space and identity for himself. It involved a public performance in which he would feel humiliated. There are also hints of a castrating father therapist which I could make more sense of as Nigel's story unfolded. I am choosing not to go into more detail about his story now but it came as no surprise that Nigel left therapy after only four months. I did not attempt too vigorously to persuade Nigel to stay as I think it is important to respect the patient's decision on how much they feel able to go through their particular pain in the process of individuation.

Case Illustration D

David is a man in his late thirties who came to me because he was shy and unable to maintain intimate relationships. He described himself as being unable to express his feelings in a close relationship and that he would become silent and withdrawn.

The dream

David dreamt that he was in therapy on a train and sitting on the floor cross-legged. There were a number of people there and he felt singled out and self-conscious. I was there but he cannot remember seeing me. I gave him a round blue thing which he later described upon questioning as a button or piece of glass. I told him to wash it in some special fluid. He washed it and found the fluid was only water. He woke up upset.

To my mind, this dream illustrates David's possible path in therapy. He was in a train i.e. a collective vehicle which he was not driving himself. He at first felt self-conscious and in the end disappointed by me. I think that the round blue thing represented himself, a self of which he had a very fragile sense at the beginning of his therapy. In subsequent dreams this 'blue thing' developed into a blue monster child. These later dreams coincided with David's greater ability to face and assimilate his shadow side.

Having said that the initial dream tells us all, I do not mean that we grasp it all at the beginning, if at all. Subsequent dreams will repeat and develop certain themes as in the case of the blue round thing later becoming a monster child. However, it is often only with hindsight that the message can be seen clearly. James Hall (Hall, 1983) writes that it is important in interpreting dreams never to feel that the dream has been exhausted. I quote; 'At best one can find a useful current meaning to the dreams, but even this may be modified in the light of subsequent dreams'. (Hall, 1983). Indeed, it is often possible to identify a sequence of dreams which appear to show the subject working through a particular dilemma. Jung described how a sequence of dreams develops the motifs in a spiral pattern. (Jung, 1943).

I think that one of Jung's major contributions to the study of psychology is his insistence that a symbol is not something that one can neatly package. Thus, in David's dream, although the blue round thing sounded to me so much like a Mandala or self representation, it is the image of the blue round thing which stays alive in my mind and thereby, I believe, is used dynamically in the therapy.

Jung said about symbols, 'A term or image is symbolic when it means more than it denotes or expresses. It has a wider "unconscious" aspect – an aspect that can never be precisely defined or fully explained. This peculiarity is due to the fact that, in exploring the symbol, the mind is finally led towards ideas of a transcendent nature where our reason must capitulate.' (Jung, 1961A). I think that the work of Melanie Klein and her followers about a person's capacity to symbolise, and Winnicott's emphasis on the need for play in therapy are very much in keeping with Jung's attitude to symbols. I therefore endeavour to create the possibility for such play between myself and my patient.

Case Illustration E

Joe brought me a dream about a tiger coming into the room to attack him. He had had an experience of a highly intrusive mother. In response Joe had sexualised his aggressive feelings, split them off and acted them out by homosexual acts. Joe told me that he had had recurring dreams in his life about such an animal attacking him. I am not quoting the dream in full here as I wish only to illustrate my use of the symbol of the tiger.

Marie-Louise von Franz said in '*The way of the dream*'; 'If a person

represses or suppresses instinctive emotional responses, a hostile animal may occur in the dreams'. (Von Franz, 1988). I saw the tiger in Joe's dream as somehow representing his instinctual responses, but at the time his internal experience and his experience in the transference was the fear of attack. We therefore used the image of the tiger over a long period of time in his analysis. At first it was his mother, then me, then his internal mother and only lastly a part of him. I find that the Kleinian concept of Projective Identification which is intellectually such a complex concept can be realised through the use of images or symbols in this way.

The internal drama and the analytical process

The meat of our analytical work is to help the patient re-experience past experiences which hinder him in the present, to help him recognise aspects of himself of which he is not conscious and therefore to be more in a position to make choices about life decisions.

As therapists we are interested in the patient's complexes. Jung initially saw dreams as 'a channel for the complexes to be acted out'. (Jung, 1906). The residue of the previous day, things in the therapy room, body feelings during the night etc., are all taken up and used to recreate a drama for the self. Years later, Masud Khan also suggested that 'The dreaming experience is an entirety which actualises the self in an unknowable way'. (Khan, 1976). As I pointed out earlier, Khan had the notion that we as therapists make it possible for the patient to have the space for the self to have a voice. Some people already have a greater capacity to dream as they have less fear of their unconscious processes. On the whole, as the therapy progresses and as a result of the patient's growing trust in the therapist's ability to hold him, the possibility of what Khan terms 'dream space' can occur and then a kind of internal acting out or drama ensues.

Dreams aptly demonstrate a picture of the person's inner world, his relation to others, himself and the therapist. A dream can both complement what one is aware of in the transference but also compensate for a conscious attitude held by the patient or by the therapist. The patient's dreams and the therapist's own dreams which include the patient, can also show up the inevitable blind spots in the therapist's countertransference. The patient's complexes are likely to be interwoven with the transference and countertransference experiences in the therapy and similar projections in other relationships. I therefore

usually see the figures in a person's dream as being potentially both objective and subjective. The objective interpretation of a dream is when the person appearing in it is seen as the person in real life. The subjective interpretation is when the person represents a figure in the patient's inner world and therefore part of himself. In the following case I would like to give you an instance of when the patient's conscious transference towards me was compensated for by her experience of me in her dream.

Case Illustration F

Vanessa sought help for the effects of her childhood experiences of being sexually abused. We had begun to explore together the many angry, hurt, guilty and shameful feelings she had had. Vanessa did not consciously experience angry feelings towards me in the transference either as representing the abuser who got close to her and then betrayed her or as the parents who went out to work when she was a child and left her unprotected and craving for affection. When she brought this dream she had been in therapy for eighteen months and had regularly brought dreams already respecting what they have to communicate.

The dream

Vanessa dreamt over the weekend that she went up a steep hill to a house for her session on a Monday. There was a lot of frivolity in the room and I was there and not there. There were four other clients there. She turned up again the next day, which was not a day she would normally come to therapy, and I was on my way out. I wore a grey coat and a cream scarf and there was a man in the background. Vanessa said that the coat was like one of her mother's and felt that she herself tended to be frivolous rather than facing her feelings. I have a grey coat and cream scarf which always hang on a stand outside my consulting room.

This dream came at a time when outside the sessions Vanessa was for the first time in touch with her sad and hurtful feelings about the abuse. I worked with her about the representation of me in the dream as disinterested and distant and also with myself about what I was bringing to the therapy which aggravated her sense of isolation.

I think the dream's use of the scarf and coat images bring together

her mother and me as a composite figure thus illustrating Freud's finding of how dreams condense material. Thus, I could become the 'bad mother' when she left the room. Through this dream it was possible for Vanessa to hear her unconscious experience of me as this bad mother which compensated for her conscious positive attitude towards me. I saw the man in the background as potentially being the abuser or Vanessa's father. It did not feel appropriate however to interpret and include the work around her father in the sessions close to the dream as at that time the pre-oedipal issues of Vanessa's need for the care of her baby self predominated.

Kenneth Lambert amongst others has illustrated how dreams can be used in the therapy by the patient in a number of ways. He proposed that a patient can bring dreams as an act of compliance, or as a diversion for the analyst from the real problem or to swamp the analyst with dreams for fear of being robbed. (Lambert, 1979). The way dreams are brought to therapy give an added understanding of the transference and the patient. They can be gifts of reparation, creative babies or anal babies which the person just shits out in relief. An example of how they complement the transference in this way is Joe, the patient I talked of before, who dreamt of tigers attacking him. He brought dreams as he knew this would please me but secretly resented doing so. This mirrored a conflict he experienced with his parents, wishing very much to do what they wanted for their approval but resenting have to do so.

Psychic fragility

I also have found that dreams make a statement about the psychic fragility of the person and can indicate when for example, I as the therapist am becoming a too frightening, archetypal, threatening figure. The next case illustration is of someone whom I encouraged to come twice a week. I think that in these times when people are not always aware of whether they seek counselling, therapy or analysis that we as therapists need to be mindful of what the particular psyche can tolerate.

Case Illustration G

Ray is a man in his early twenties who came to me having suffered for some time from bouts of depression which occurred at the same

time every year. He thought there had been a history of mental illness in his family on his mother's side. He was well educated and enjoyed playing symbolically but presented an inner world which felt chaotic to him. After a few months of once a week therapy, I suggested that he try for a period to come twice a week. He came twice a week for a month or so and then Ray reported this dream just before he decided that he could no longer afford to come twice a week.

The dream

Ray dreamt that he was on a local housing estate with his girlfriend. He was wary in his waking life of going on this estate as it has a reputation of being rough. Towards the end of the dream, Ray and his girlfriend went to bed in a flat on this estate. A rat ran across the floor and he threw his toothbrush at it. The rat got smaller but then there were more of them. His girlfriend told him to turn the light out and they would go away. He did so but they did not go away, changing instead into voodoo dolls with plaster faces.

Ray's dream communicated to me the terror of what we were uncovering and his feeling of being unable to deal with it. I can remember when we were discussing his inability to continue paying for the second session, the vividness of the dream came to my mind and his relief when we agreed to reduce back to once a week.

In the following instance the message of the dream heralded a psychotic breakdown which I was unable to avert.

Case Illustration H

Emma was in her late twenties when she came to therapy. There was a history of mental illness on her mother's side of the family. We think that her mother broke down when she was 30. Emma had been, for a number of years after her mother's death, obliged to look after her younger siblings. She was finding her opposing feelings about her loyalty to the children and her need for her own life too intolerable to face consciously for long. Emma had this dream soon after her own thirtieth birthday.

The dream

She dreamt that someone was in her house and was going to kidnap the children. She thought that the person had already kidnapped her

best friend and perhaps her brother. She had woken up in the dream and knew that someone was in the house as all the lights had been turned off. Her sister was sleeping in the spare room as she had in fact done the night before in real life as a treat. Emma was pleased that this would confuse the intruder. She was going towards the intruder with her step-father behind her when she realised that she or he had a knife. She thought that the intruder was a member of the I.R.A. She woke up feeling very frightened.

At the time of the dream we were able to explore the idea of the intruder being me but Emma felt that it was more likely to be herself. Indeed she had recently had an argument with her best friend who figures at the beginning of the dream, and was not talking to her. Her feelings of resentment against her brother and sister and the jealousy for them as rivals had had to be repressed. However, Emma's ego strength was not up to this conflict, nor could she experience her intense feelings of love and hatred towards her mother. As I said above, this dream heralded a psychotic breakdown which was of an affective kind. It is interesting to note that in both Ray and Emma's dreams the lights had been turned off. I would understand these to denote the light of the conscious mind. In addition, at a subjective level of interpretation this dream shows Emma's state of being under siege in her internal world.

Interpretation, archetypal and personal

The task of interpretation is a thorny one and a matter of much debate. I do not think there are any short cuts and I agree with a comment made by Marie-Louise von Franz who has analysed thousands of dreams, that the tools of interpretation cannot be taught. The skill, in my view, comes from an imaginative attitude which is open to anything and primarily from practice and experience. Rabbi Hisda has been quoted as saying that a dream uninterpreted is 'Like a letter unread'. (Meier, 1989).

Freud described dream interpretation as 'The royal road to the unconscious activities of the mind'. (Freud, 1900). Jung said 'One could even say that the interpretation of dreams enriches consciousness to such an extent that it relearns the forgotten language of the instincts'. (Jung, 1961A). Both men have studied dreams in the context of the many studies of dreams before them which stretch back to ancient civilisations. Freud saw dreams as part of the primary process of

thinking. He highlighted how highly condensed dream material is and stressed the value of free association. He thought that dreams have a latent and a manifest content and that the latent was more important. At the time of writing '*The Interpretation of Dreams*' in the early 1900s, he saw this latent content as expressing infantile wishes stemming from the sexual instinct. Jung differed from Freud who saw dreams as primarily expressing wish fulfilment and who viewed material as being derivative from the sexual instinct. In contrast, Jung valued both the manifest and latent contents, seeing dreams as a psychic reality or 'fact'.

The therapist's capacities to listen to dreams and to interpret them are integral to any therapy. I think that the process of interpretation should be as mutual as possible but there will be times when the therapist does not share her understanding of the dream right away and the understanding in itself will still have effect. In commenting about dream analysis in the context of his difference with Freud over Freud's interpretation of his dream when they were travelling together to America, Jung said 'Dream analysis on this level is less a technique than a dialectical process between two personalities. If it is handled as a technique, the peculiarity of the subject as an individual is excluded and the therapeutic problem is reduced to the simple question: who will dominate whom?' (Jung, 1961A).

Jungians have consistently made use of the structure of classical drama to analyse dreams. There are four stages: firstly the setting, the time and the people involved; secondly the exposition and weaving of the plot; thirdly the culmination; and lastly the solution and conclusion. I find that this method of examining dreams gives an invaluable starting point. It provides a conceptual boundary within which can be explored the symbolic, infantile and child material and the archetypal patterns. Many writers have gone into detail about the importance of the setting e.g. in David's dream which I mentioned above, he was in a train and this indicated to me that he was in a collective mode of transport and therefore not feeling in control of his own destiny. The time and setting often indicate the area of life that the person is concerned with at the time for example when the setting is secondary school. The culmination and solution stages can show the person's ability to deal with the inner scenario and *the question of* whether his attitude and affect is appropriate.

Much of the interpretation I do is on a personal level but I am ever conscious of the recurrence of archetypal images which often have a

peculiar or numinous quality. Whitmont and Perera call this a 'fairy tale' quality.

Case Illustration I

Maggie came to therapy in her late thirties. She had suffered from gynaecological problems for years and finally had had a hysterectomy. Her mother was a domineering and forceful personality. Her father was experienced by Maggie as passive and ineffectual. The following dream illustrates her search for the father figure in therapy in order to develop a clearer sense of herself and in particular her sense of herself as a woman.

The dream

Maggie told me this dream had two parts. In the first part she was in a room at the top of a house. She could see the stars and colourful shapes. A woman was there drawing the curtains. The woman stopped and said 'look at that star, it's your father'. There was a rush of wind. She was invited to go forward to look and although frightened, she did so. In the second part of the dream she was in a restaurant. There were two men at a table. One was a shadowy figure. They were inviting her to join them. She refused because, although she really wanted to join them, she was afraid. She woke up feeling very lonely.

These dreams express a number of things and in particular her ambivalence about engaging in therapy at the time. My point in including it here is that it illustrates how the archetypal image of the father in the star offers her psyche the opportunity to develop her sense of self while the father in life presented such a shadowy figure. It is also likely from my experience in the countertransference that Maggie as the little girl did experience her father as a star for a time but only, as is the oedipal pattern, to be disappointed by him.

Von Franz highlights the star as the symbol of the dreamer's unique destiny. She has said 'Because following your own star means isolation, not knowing where to go, having to find out a completely new way for yourself instead of just going on the trodden path everybody runs along. That's why there has always been a tendency in humans to project their uniqueness and the greatness of their own inner self onto outer personalities. It is much easier to admire a great personality and

become a pupil or follower of a guru or religious prophet ... than following your own star.' (Von Franz, 1989). I think Maggie's dream echoes this human fear of the isolation of following one's own destiny and the path of individuation.

Patient or dream

In the last 40 years there has been a reaction in London to what is seen as the classical Jungian's over-emphasis on dream interpretation and the amplification of the archetypal patterns because it was felt that the transference and infant and child issues were missed. Indeed the extreme of this view was that the analyst, attracted by the themes in the dreams, would be led far away from the patient by the consideration of mythology or fairytales to Mount Olympus or Nordic lands. To the other extreme, a dream can be so reductively interpreted in the light of personal wish fulfilment and infantile phantasies that the dynamic of the dream can be totally stifled. In my view perhaps there has been a tendency to lose sight of the wisdom of the dream because of the attraction of the highly important contributions to Jungian thinking of Klein's findings. I am advocating a middle path between these two extremes of reduction and amplification. Moreover, I think that the influence of myths and mythology on dream interpretation renders the mind more open to the unexpected and symbolic and therefore can only be advantageous as long as it is in the spirit of service to the patient. Meier, who co-founded the Jungian Institute in Zürich, gives an interesting illustration of amplification in his book '*The meaning and significance of dreams*'. There he shows how the amplification of one of his patient's dreams illuminates the healing process that is taking place in the patient's unconscious. (Meier, 1989).

Although Jung recognised the importance of free association to dreams in his early writing seeing that, as I have said before, dreams lead us to the person's complexes, he later advocated concentrating on the dream itself: 'There can be no doubt that dreams often arise from an emotional disturbance in which the habitual complexes are involved. The habitual complexes are the tender spots of the psyche, which react most quickly to a problematical external situation. But I began to suspect that dreams might have another more interesting fucntion. The fact that they eventually lead back to the complexes is not the specific merit of dreams.' (Jung, 1961A). Jung then goes on to stress the need for us to concentrate on the dream itself which gives

us all the information of the person's present psychic dilemma although it will include the complexes which have their roots in the past. He stresses also the purposeful nature and teological quality i.e. the forward thrust of a dream and therefore its role in suggesting the future. I would suggest that the essence of a dream's creative capacity is its transformative potential. It is thus the active wisdom and symbolic quality of the dream that I concentrate on whilst keeping the patient's context always in mind. So, in my previous case illustrations, it is David's blue round thing, Joe's tiger, Vanessa's cream scarf and grey coat and Maggie's star which remain in my mind as dynamic pointers rather than solely translating them into what I believe they mean and thereby packaging them and perhaps making them inert.

James Hillman characteristically provoked a debate in the Jungian world when he placed dreams totally within the realms of Mythos. In '*The Dream and the Underworld*', he writes 'Through dream-work we shift the perspective from the heroic basis of consciousness to the poetic basis of consciousness recognising that every reality of whatever sort is first of all a fantasy image of the psyche'. (Hillman, 1979). Hillman's notion that the soul exists outside the human being and that we are attempting to establish reconnection with the cosmic soul is an attractive one and reminiscent of Jung's dream of the yogi. Although I think this takes us a long way from the usual nitty gritty of the consulting room it would be a pity not to include Jung's dream.

The dream

'I had dreamed once before of the problem of the self and the ego. In that earlier dream I was on a hiking trip. I was walking along a little road through a hilly landscape; the sun was shining and I had a wide view in all directions. Then I came to a small wayside chapel. The door was ajar and I went in. To my surprise there was no image of the Virgin on the altar, and no crucifix either, but only a wonderful flower arrangement. But then I saw that on the floor in front of the altar, facing me, sat a yogi – in lotus posture, in deep meditation. When I looked at him more closely, I realised that he had my face. I started in profound fright and awoke with the thought "Aha, so he is the one who is meditating me. He has a dream and I am it". I knew that when he awakened, I would no longer be.' (Jung, 1961B).

Kenneth Lambert, a former leading member of the Society of Analytical Psychology, emphasised that the analyst's primary task is to

analyse the patient not the dreams. I concur so much with what he wrote that I conclude this section with his view of the multiple role of dreams: he wrote '... dreams can often be understood by patient and analyst to sum up in a remarkable way the psychological situation of the dreamer – his blocks, his dynamisms, perhaps the direction to be taken in his life. Above all, perhaps, they not only express archetypal themes and patterns in terms of images and internal objects, but also can introduce the dreamer to the beginning of an experience of emotional intensity hitherto only latent or not allowed to come into consciousness. They thus play an important part in the realisation of the self.' (Lambert, 1979).

Summary

In this paper, I have attempted to demonstrate how, through the influence of various Jungian, Freudian and other analytical standpoints, one can adopt a synthesis of approaches to the role of dreams in analysis. Thus dreams have a multiple role. They are about complexes but not only complexes, they show the internal world and the object relations in it, they are both about personal issues and collective, archetypal issues. Dreams compensate for conscious attitudes in the present and sweep the psyche forward to its future destiny. They are fundamentally about the mind at play. Informing the analysis along the way with all its ups and downs, they are our signposts and hazard lights. However, they are always somehow just out of our grasp.

I conclude with Jung's words: 'The dream is a little hidden door in the innermost and secret recesses of the soul, opening into that cosmic night which was the psyche long before there was any ego-consciousness, and which will remain psyche no matter how far our ego-consciousness extends'. (Jung, 1933).

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THE PSYCHOSOMATIC CONTROVERSY – A LIFE AND DEATH STRUGGLE

DIANA RICHARDS

Introduction

This paper addresses theoretical developments and treatment implications in the controversial field of psychosomatics. The original version of this paper was presented at the second conference on this subject organised by City University Counselling Service in 1990. It begins with a summary of the three main presentations to the 1989 conference.

A number of questions are then posed in order to understand better both the meaning of the term, psychosomatics, and some of the clinical issues. Links between the historical development of the psychosomatic movement and of psychoanalysis are discussed, together with some of the significant recent literature relating to biopsychosocial and psychoanalytic approaches.

The 1990 conference was entitled 'Psychosomatics – Medicine, Metaphor, Myth or Madness?'. As the title suggests, it is a complex, difficult and often confusing subject, about which views vary considerably and knowledge and understanding is limited. It is, however, an issue we are all likely to encounter in our clinical work and one which we struggle with – or maybe avoid – because it seems so hard to address, both conceptually and clinically in a meaningful and acceptable way to our patients.

A G.P. perspective

Irene Weinreb gave the first paper at the '89 conference on the role of the G.P. in Student Health, through which we were allowed to see some of the wide range of skills of the primary care specialist and given an insight into the relationship between the G.P. and her patient. Importantly, the fact that the first presentation was from a physician's perspective served to remind us of the need both to take somatic symptoms seriously and to ensure that they are not viewed simplisticly as 'purely psychological', – thus requiring no medical involvement.

Indeed this has been the subject of some controversy in the psychosomatic field, when some psychological approaches in the past appeared to dismiss the need for medical consultation, with consequently increased risk to the patient's health. This, of course, is also an issue in reverse, when patients may be subjected – or subject themselves – to endless physical explorations and interventions, when psychological help is clearly needed. Dr Weinreb's paper highlighted the need for multi-disciplinary collaboration in working with patients with psychosomatic symptomology. Attention was also drawn to the fact that the patient's anxiety may be projected in a number of directions and that the different helping agencies need to be aware of one another's involvement and of who is dealing with the patient's problem. Reference was made to a number of factors which may cause students anxiety and which, for some, may precipitate somatic symptoms.

A number of students may just have left home for the first time; they may have accommodation and financial problems; they are having to establish new friendships and may fall in love for the first time, and become involved in sexual relationships. Their academic progress may prove difficult, injuring their self esteem, and they may have to struggle with a realisation that compromise career objectives are necessary. Foreign students may face particular difficulties as a result of the changes they encounter – a subject dealt with in depth in Alex Coren's paper. We were also reminded that students, like many patients, have a fear of psychological symptoms and are resistant to the idea of somatisation, fearing a prejudical effect on their careers. Through clinical vignettes, we were shown the careful, sensitive and yet containing way in which Dr Weinreb approached these patients, realising that she may be experienced by them as a transitional object or a parental figure.

Psychotherapy with foreign students

In his paper, 'Treating foreign students: Psychotherapy or Imperialism' Alex Coren discussed, in a very open and thought-provoking way, some of the difficulties involved in counselling overseas students who present with somatic symptoms. He invited us to share in some of the painful, perplexing and challenging issues, which arise in working with patients who have a totally different cultural background from that of the host community and the therapist. He highlighted the language/communication problems involved, not only that English is not the

first language of many of these students, but that they communicated their suffering, stress, conflicts and affects in language which appeared foreign to our ethnocentric models and values. He was struck by the absence of affect in these patients and noted that psyche-soma links were completely denied. Their health problems seemed totally preoccupying, providing, through the symptom, a means of binding all other anxieties. Could it be that they could only communicate through body language? Did the overseas students' compliance to the British educational system result in the bodily symptom? Did it represent an uncomfortable compromise between Western education and their own cultural values – which were recognised as having an important continuing influence, despite the apparent acceptance of Western ideas and values. It is important for therapists to consider how affects are expressed in this person's culture. Through fascinating clinical illustrations, he demonstrated the uncomfortable clinical dilemmas, the marked differences in patients' experiences and value systems, and their struggles with their own and their family's expectations of successful achievement of their academic goals.

His paper evoked many important questions, both about the experiences that overseas students and immigrants have in Britain and about our understanding of, and ways of working with, patients from other countries who are experiencing stress and symptoms. I suspect that these may possibly include some covert racist attitudes. Alex Coren concluded that 'any form of migration is intrinsically stressful and that the symptom is an understandable and not unusual product of it'. He became convinced of the need to respect and explore the culture of origin.

Theoretical issues

In the final paper, Colin James began by discussing some of the literature pertaining to psychosomatics and the developing understanding of its causation. Beginning with Freud and Breuer's work described in Studies on Hysteria, he then referred to Engel's differentation of conversion symptoms and hypochondriasis from somatisation. He reminded us of Susan Isaac's work on 'The nature and function of phantasy', showing that the earliest phantasies derive from bodily sensations and are about bodies and parts of bodies. He spoke about some psychoanalysts' work with psychosomatising patients being unsuccessful, perhaps because of the fact that the symptoms were seen

as symbols, whereas 'the body has different rules'. The symptom is a sign and not a symbol. He quoted Joyce McDougall and her view that in psychosomatosis the mind is bypassed. After referring to Segal's 'The development of the capacity for symbol formation', and Deutsch's work on the nature of the conversion process, he spoke of the view of the psychosomatists in the 1930's and 1940's. They understood peptic ulcer, bronchial asthma, essential hypertension, thyrotoxicosis, ulcerative colitis, rheumatoid arthritis and neurodermatitis to be the psychosomatic illnesses – which became known as the 'Big 7'.

Colin James went on to say that a much wider view is now held by many, involving aspects of the early mother/infant relationship, especially issues of separation and individuation. He discussed these matters further and their links with the development of Object Relations Theory and work with psychotic and borderline patients. He spoke of the interfaces between the normal, borderline, psychoneurotic, psychosomatic and psychotic, and the psychotic ideation which may underlie psychosomatic symptoms. After referring to the work of McDougall and the French analysts, on the borders between the perverse and the psychotic, and to Bion's views on the function of the mental apparatus, he went on to discuss more fully Graeme Taylor's position, as described in 'Psychosomatic medicine and contemporary psychoanalysis'. The predisposition to psychosomatic illness is to do with pre-neurotic, pre-oedipal conflicts. Psychosomatic homeostasis depends on good object relations, and a psychosomatic disorder involves a serious deficit in internal object relationships. There is severe pathology involving aggression, the object being unable to survive the infant's attack. Winnicott was quoted. The function of the object as part of the baby has to be destroyed. Colin James understood such disorders to be more than defences, rather a whole system change. Whatever it is that is bypassing the mind is very painful – maybe psychotic.

Questions without easy answers

I would now like to discuss some of the questions, issues and clinical implications arising from the study of psychosomatics. In my thinking about these matters, I have found Graeme Taylor's views, in his book, 'Psychosomatic medicine and contemporary psychoanalysis', and, in particular, Joyce McDougall's views, as expressed in 'Theatres of the Body' most interesting and thought-provoking.

These are some of the questions which I found myself asking:

What do people mean by psychosomatic illness?

How narrowly or broadly should we understand this concept?

How 'normal' or 'abnormal' is it to somatise?

What psychological/emotional processes are involved?

What approaches, and from whom, are most useful in helping these patients?

Can psychoanalytic psychotherapy make a relevant contribution – or are these patients unable to benefit from this approach?

It was not easy to find a clear definition of psychosomatic illness in the psychoanalytic literature, much of which seemed to demonstrate the difference in perspectives between authors, or gave an impression that there were generally understood agreements about what was or was not psychosomatic. This did not seem to be the case. Lapalanche and Pontalis do not include an entry under psychosomatics at all. Fenichel refers to the term only briefly in his chapter on 'Organ Neuroses', finding it an unhelpful term which 'has the disadvantage of suggesting a dualism that does not exist', and goes on to say that every disease is psychosomatic, in that no somatic disease is entirely free from psychic influence.

It was something of a relief, therefore, to find in Rycroft's useful little dictionary (A Critical Dictionary of Psychoanalysis) a working definition to start with. I quote: 'Illnesses and symptoms are designated 'psychosomatic' if (a) the symptoms are accompanied by demonstrable physiological disturbances of function, and (b) the symptoms and the illness as a whole can be interpreted as a manifestation of the patient's personality, conflicts, life-history etc. Condition (a) distinguishes from neurosis, particularly conversion hysteria. Condition (b) distinguishes from organic disease pure and simple. Delimitation of the field of psychosomatic illness is bedevilled by two factors: the ease with which condition (b) can be fulfilled by enthusiastic speculation, and the possibility that constitutional factors may predispose to specific types of both mental and physical illness.'

Historical developments

It seems that the lack of clarity regarding the definition of psychosomatic illness has to do with the ways in which theoretical positions have

changed and developed over the course of this century, in the light of a range of contributions and research from different disciplines.

Following his work with Breuer, described in Studies on Hysteria, in 1905, Freud made clear his belief that the health of the body could be affected by mental states. However further psychoanalytic interest in physically ill patients was more active some 20 years later, which led to the founding of the American Psychosomatic Society in the 1940's. These early psychosomatists came to focus their interest mainly on the 'classical psychosomatic diseases' – the 'Big 7' or 'Chicago seven', referred to earlier. Unfortunately, their enthusiasm did not lead to the hoped-for cures for these illnesses through psychoanalytic treatment, and a long period of disillusionment with psychoanalytic approaches in the field of psychosomatic medicine followed. Indeed many biologically-orientated psychosomatists today still dismiss the relevance of psychoanalytic contributions to this field.

However, whilst some of the thinking based solely on instinct theory and instinctual conflicts may seem of limited value in extending our understanding of psychosomatics, the ideas stemming from Winnicott's writings about the psyche-soma and the development of the Object Relations Theory offer a more helpful conceptual framework.

During the 1970's, work in the field of psychosomatics identified the influence of psychobiological mechanisms and emotional/social factors which led, in the 1980's, to the use of a 'biopsychosocial model of disease' in psychosomatic medicine, which, as Taylor describes, 'considers the complex interplay between, biological, psychological and social factors in all diseases'.

The term psychosomatic seems to be applied more widely these days, than to the seven 'classical' diseases only, although hysterical conversion phenomena and hypochondriasis are generally excluded. Rycroft's definition remains helpful, I find, in that it is neither over-inclusive nor too restrictive, in terms of what we may recognise clinically as psychosomatic.

In the 60's in France, and the 70's in America, analysts reported specific characteristics they had observed in their physically ill patients. The French analysts described what they called 'operatory thinking' (pensee operatoire) denoting an unimaginative, concrete, utilitarian way of thinking. Later, the Americans spoke of a 'marked difficulty in verbally expressing or describing their feelings and an absence or striking diminution of fantasy', in contrast to psychoneurotic patients. Patients with classical psychosomatic diseases seemed to have a specific disturbance in affective and symbolic functions, leading to sterile or

colourless communications. The term 'Alexithymia' was used to denote this disturbance.

These important observations paved the way for further study of this disturbance in symbolic capacity and its underlying mental processes. For some, it showed that psychoanalytic approaches, with their reliance on symbolic communication and understanding, were contra-indicated with such patients. Others, such as Taylor and McDougall, in their different ways, looked, for further understanding, to very early developmental processes. These involved the mother/infant relationship, viewed from Object Relations perspectives. Both also make reference to the important work of Margaret Mahler and her colleagues about separation/individuation processes described in 'The Psychological Birth of the Human Infant'.

McDougall, who was working with some patients who suffered from very serious and life-threatening psychosomatic illnesses, spoke of psychic deprivation and Taylor, of psychic deficits. McDougall felt that some of these patients had no words to describe their emotional state, finding themselves unable to distinguish between, for example, depression, anxiety, anger or hunger. She observed, under the 'camouflage of pseudonormality', perceptions of psychic and physical warnings were not denied or repressed in these patients, but ejected from or bypassing consciousness altogether. Something very serious had gone wrong at a preverbal, preneurotic stage in the separation/individuation process between these patients and their mothers, leaving them unable to deal with inexpressable pains and psychotic fears except in such extreme and dangerous ways.

Issues for ourselves and our patients

Returning to my questions, I find they do not have simple answers, but tend to raise more issues and questions to explore, reminding me again of the complexity of this subject and the incomplete state of our understanding. Perhaps some of its interest for us has to do with the way it raises issues about human-ness and about ourselves, as well as our patients. We all get ill and we all die. Also, as McDougall says, we are all capable of somatising our emotional distress.

More and more in my clinical work, I am becoming aware of my patients being involved in a fundamental internal conflict, which can seem like a life-and-death struggle, between a destructive, psychotic self (or aspect of self) and a sane, wishing-for-life-and-enrichment,

self. Sometimes the one seems to be in the driving seat, sometimes the other.

When analysing patients' destructive, crazy thoughts and feelings, I often find powerful propaganda about internal rules and beliefs, which must be adhered to. Their sabotaging function is to prevent change and understanding which might lead to change, thus maintaining the status quo. Along with other, more or less subtle, critical propaganda, they endeavour to maintain a fundamentally negative or unrealistic view of the patient's self and capabilities. Whilst these rules and beliefs involve and may be based on this misunderstanding, distortion or lies, they masquerade as truthful and often life-saving. Perhaps psychosomatic symptoms which, as McDougall points out, can lead to death but also represent a wish to survive, are an expression of this splitting and distortion. However, a struggle, between such different aspects of the self, does not seem only to be found in a few very disturbed patients, but appears to be the rule, rather than the exception. I notice it in the people I know, who seem not to be seriously mentally or physically ill, and in myself. Perhaps it expresses a fundamental conflict between life and death in all of us. It is likely that this destructive and dangerous self derives many of its ideas and beliefs from early experiences in the carer/baby relationship, when the mothering was not always 'good enough', together with fantasy elaboration or more primitive survival strategies to deal with intolerable anxieties.

This brings me back to the questions. Thinking in terms of normality or abnormality implies a split between two extremes, which like most splits, is unrealistic, unhelpful and possibly dangerous. Perhaps we can wonder instead about how common psychosomatic manifestations are, and how they can be understood in relation to a dynamic continuum between relative health and seriously disturbing illness. This then, in turn, raises again the questions about underlying processes and how they arise, and the psychosomatic debate.

Recent contributions to the Psychosomatic debate

The psychosomatists' research led them to describe a 'psychosomatic personality'. Such people utilise operatory thinking – a pragmatic and affectless way of relating to the self and others – and demonstrate alexithymia – having no words to describe their emotional states. This raises controversial questions about alexithymic patients' capacity for symbolisation, whether the apparent absence of symbolisation is per-

manent and unalterable and consequent questions about the appropriateness of psychoanalytic treatment.

Graeme Taylor makes an important contribution to bridging the conceptual and therapeutic gaps between the biologically and behaviourally-orientated psychosomatists' views and contemporary psychoanalytic understanding. He discusses research into bioregulatory functions which has led to recent concepts of biopsychosocial regulators of health, and the biopsychosocial approach to physically ill patients, advocated by many psychosomatists nowadays. He found that Kohut's theories about self-objects, and their clinical application in psychoanalytic self psychology, increased his understanding of and ability to help psychosomatic patients. He has a more eclectic approach than many psychoanalytic therapists, where indicated also using medication, or behavioural approaches, seeing the latter as emphasising the need to increase the patient's self-regulatory capacities. However in discussing some of these therapies – such as relaxation training or biofeedback – he adds his psychoanalytic understanding of the treatment situation and relationship with the therapist.

Taylor's ideas relate to very early disruptions or distortions in the mother/child relationship, which can result in the *absence of a caring internal object*, deriving from satisfactory mother/child experiences. Whilst everyone needs to regulate complex physiological and biochemical processes to stay physically healthy, research evidence indicates that everyone uses social interactions and self-object attachments as external accessory regulators to a greater or lesser extent. Thus, social support and the influence of environmental events, such as the loss of an important person, are significant.

Taylor writes:

> 'Contemporary psychoanalysis, through its understanding of early mental life and the internal object world, helps to explain the greater reliance of some people on external regulators and, as a result, their greater vulnerability to disease. The conceptual frameworks of self-psychology and object relations theory provide ways of intervening psychoanalytically and/or behaviourally to alter patients internal and external object relations, thereby increasing their resistance to disease'.

McDougall reminds us that the 'Chicago seven' illnesses are often still thought to be devoid of any symbolic meaning. Whilst she has observed manifestations of alexithymia and operatory thinking in some of her psychosomatic patients, she now understands sudden psychosomatic 'explosions' in her patients as an archaic (pre-verbal) form of hysteria, involving archaic forms of symbolisation. She also comments that

many of her psychosomatising patients did not demonstrate alexithymia and operatory thinking, even though a number of them had severe and life-threatening psychosomatic illnesses. She sees the underlying problems for the patients to be due to a pathological symbiotic relationship in childhood, involving disruptions in early mother/infant communications – 'a mismatch with tragic consequences'. This may be due to constitutional factors in the infant, but also to the mother's responses to the baby in which she may, due to her own problems or catastrophic external events, forcefully impose upon the baby what she wants it to feel or need. This mismatch can lead to the *absence of an internal caretaker*, with whom to identify and a split image of the mother. Mother may be experienced as either idealised and unattainable or death-dealing.

Identification with this death-dealing mother, rather than with a soothing maternal object, will lead the patient to behave in a similar way towards his own child-self. Such people rely heavily on the world of others and may turn to addictive substances to repair the sense of damage. There is a lack of ability to distinguish between the self and the object, and separation and difference are feared, as threatening loss of fusional oneness. She sees the alexithymia as warding off deep-seated, psychotic-type anxieties – indeed she notes similarities between psychosomatosis and psychosis in some respects.

McDougall also speaks of patients who have a psychosomatic vulnerability. Some patients, who demonstrate features similar to Winnicott's concept of the False Self, may be more likely than others, under stress, to regress to infantile ways of psychic functioning. The associated primitive forms of relationship between mind and body can then result in somatic manifestations.

Implications for treatment

This leads us on to think about degrees of severity in psychosomatic illness and treatment implications. Everyone is capable of somatising, and becomes ill at times – some more than others – and perhaps it is only a minority who had sufficiently good-enough experiences in early childhood, to protect them from some regression to infantile modes of functioning under stress. Somewhere in all our inner worlds it seems, a life or death struggle goes on, involving primitive splits and distortions.

Engel, however, points to the buffering function between mind and

body, performed by neurotic organisations, which may protect the patient against somatic 'explosion'. Many of our patients may have this facility, although it may mask more serious problems, associated with primitive psychic structures, like psychosomatosis, which may be revealed if the protective function breaks down. In such circumstances, we are faced with very complex and challenging clinical issues, and we need to have due regard for the contribution our medical colleagues can make.

As McDougall states 'Psychoanalysis (or, I would suggest, psychoanalytic psychotherapy) is not necessarily the treatment of choice for all psychological or psychosomatic disorders'. A careful assessment is required in order to establish a potential patient's suitability for such treatment. Some severely psychosomatic patients, who require highly skilled intervention, may be most helpfully treated by a very skilled analyst, with particular experience in the psychosomatic field. Others may be unable to use psychoanalytic interventions, but could benefit from other approaches. Many such patients, however, with appropriate motivation and capacity to understand their difficulties will, I suggest, benefit from psychoanalytic approaches as our understanding of psychosomatics develops.

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BOOK REVIEWS

About Children and Children-No-Longer. Collected Papers 1942–80 by Paula Heimann.

Edited by Margret Tonnesmann. New Library of Psychoanalysis. (1989) £15.99 P/b. 368 pp.

'My hope is', writes Paula Heimann in her paper '*Further Observations on the analyst's Cognitive Process*', 'that my comments and interpretations will enable my patient to experience the psychoanalytic process as illuminating and inspiring and that his own creative activities will be facilitated'. She fulfils this hope for her readers. These papers are very clear and illuminate many concepts which I knew about already, as well as introducing new ones, sometimes quite fully developed and sometimes scarcely more than hinted at, leaving scope for thought to continue.

As Margret Tonnesmann points out in the introduction, Paula Heimann 'emphasised right from the beginning the independence of the ego (conceived as the self) its strengthening, its widening and the enlargement of its perceptive functioning, as the task of psychoanalytic treatment. The analyst is seen as the patient's supplementary ego, the 'good enough' mother who enables the child to develop his own capacities. This firm belief in the patient's abilities and his need to be free to use them makes this a hopeful book. Nothing is promised, conflicts are never removed; but increasing the patient's capacity to perceive his emotional experiences by transference interpretations frees him to unravel his emotional entanglements. This unravelling includes a softening of the superego which, typically, the author insists cannot be done by introjection of the analyst which would be a by-passing of the issue. The patient must be helped to struggle creatively with ideas and with artistic, intellectual and practical problems; he thus replaces a cruel and restricting intrapsychic figure.

The advantage of reading all these papers together is that it gives the reader a chance not only to trace the author's development and change, which is facilitated by Margret Tonnesmann's chronological arrangement, but also to get an overall view of the essence of Paula Heimann and her faith in the potential scope for the liberated ego which can be so damagingly limited by the narcissistic parent or analyst.

Just as Paula Heimann considered the historical and genetic background of her patients as vitally significant, so has Margret Tonnesmann thought it important to place these papers in the context of a biographical memoir by Pearl King. The editor's introduction describes the author's development away from the bosom of Melanie Klein to a new self based on freely chosen identifications with her original Freudian training and other 'collective alternates', such as object relations theory and ego psychology. Aspects of Klein are also kept.

'The infant whom we meet in the analytic session is not identical with the original infant'. Although Paula Heimann does not want to undervalue what we can learn about babies through psychoanalysis, she also thinks that the contributions of non-analytic researchers as well as poets and authors are essential to our understanding. She sees the actual experience of physical handling, with its emotional counterpart, in very early babyhood, as vitally important and the basis of somatic memories which become converted into psychological facts.

Real life cannot be discounted and equally significant are hereditary attributes which, although they may be diminished or stultified by the infant's emotional perspective, should not be underestimated. Paula Heimann has much to say about the importance of talent in her papers on sublimation. She sees the ego according to Freud's later views of it; not just as a product of the id or the result of identifications but as containing genetic qualities of its own, independent of emotional experience. Such qualities may be used to develop the personality and provide satisfaction through artistic creation or to help counteract the effects of deprivation by the use of Greenson's 'collective alternates'; which are alternative identifications used to supplement those available in the original objects and thus to enlarge the ego. The invaluable ability to use the environment in this way, however, presupposes 'a capacity for undisturbed self-assertion'; a healthy narcissism without which an individual cannot put his abilities to good use.

Balint talks of rage becoming regret; Paula Heimann emphasises the importance of moments of 'sadness, remorse and quiet love, not paranoid hatred or self pity,' when the patient recovers his lost original objects. The objects are felt to be an essential part of himself and his integrated ego can now function optimally. Here the author steps away from Klein to a belief in Abraham's concept of the pre-ambivalent object which can be rediscovered. The author's gradual weaning from Melanie Klein is fascinatingly illustrated in this book. Some of the early papers which she wrote as a contribution to the 'Controversial Discussions' (Freud/Klein 1941–5) have not been included because she

regarded them as a statement of Kleinian thought rather than her own. The most important of her early original contributions was her well known paper on Counter-transference written in 1949.

One of Paula Heimann's most significant changes comes with her giving up of the Kleinian view of the Life and Death instincts. In a paper written in 1942 'Notes on the Theory of the Life and Death Instincts', she follows the view that impulses arise from instincts. She takes cruelty as a specific example. This, she says, arises as a result of some instinctual disaster, when the death instinct overwhelms the life instinct and the only way the individual can save himself from destruction is by deflecting it onto an outside object. Her ideas however, progressed. In 1975 she wrote in 'Parapraxis; Failure or Achievement?', 'It is an error, which I too made years ago, to think that Not-Me equates with the recognition of another person, a Not-Self. What it denotes is merely the omnipotent negation of pain, employing the mechanism of negative hallucination. This is possible thanks to the reality of the maternal figure'.

Here she diverges from Klein back to Freud's belief in primary narcissism (or Mahler's 'normal autism'), at the same time recognising the importance of the mother's role in establishing the infant's early belief in himself. It was with these concepts in mind that she decided in her paper 'Evolutionary Leaps and the Origins of Cruelty' written in 1964 that the postulation of a death instinct was unnecessary. When an infant's defensive hallucinations are not endorsed by the mother's attentions, the child feels something akin to the death of himself. The impulse to be cruel arises from revengeful wishes towards a mother experienced as cruel.

Paula Heimann's acceptance of the idea of primary narcissism became for her a source of illumination and inspiration such as she hoped to provide for her patients. In 'Notes on the Anal Stage' 1961, she wrote 'Freud's statement that narcissism is to some extent retained throughout life can be understood as a comment on the imperfections of human nature. It can also however, be understood to refer to narcissism as something other than a mere manifestation of primitive asocial selfishness. Here is food for thought'. She came to believe that narcissism was not only a vital necessity for a child struggling to establish his independence at the anal stage but also a pre-requisite for satisfactory sublimation and for a healthy capacity to relate freely to other people. A fully functioning ego depends on a capacity for narcissistic self-absorption; turning away from the analyst in the transference should not always be construed as a hostile gesture but some-

times as a benign and essential bid for independence and self-enhancement. The author gives an example of a patient who recited a poem in a session. Again diverging from the classical Kleinian view, she emphasises that these are times when the analyst needs to stand by and let the patient work by himself; another such time might be when the patient finds himself in touch with his original objects.

Narcissism is also sometimes an important component in sublimation which Paula Heimann sees as an enormously useful process for expanding the ego and its achievements. This may take place in a session when a wish for gratification may be converted into an interest in the analytic process; reflection can (be seen) in her terms as a form of sublimation. Sublimation fails or is only partially successful when the ego is unable to make a free choice because of entanglements with inner objects which it needs to repair or restore. A clinical example of a woman who compulsively painted Victorian families illustrates this state of affairs; it was only after she had freed herself from her guilt and persecution that she could use her talent to paint in order to fulfil herself. Similarly it may be only when the patient has liberated himself from the need to place the analyst in a particular position that he can be free to reflect.

Paula Heimann thought that the clue to the operation of neurotic residuals in the analyst was a tendency to get away from the analytic situation. By this she meant, for instance, describing counter-transference feelings or other matters pertaining to the analyst in a way which is not necessary to the analysis. This pseudo and narcissistic 'honesty' is clearly different from the attention to reality to which the author adheres in so many aspects of her work and 'to which all psychic progress and opportunities for happiness are tied'. In her 1978 paper 'On the Necessity for the Analyst to be Natural with his Patient' she writes with a confidence which speaks of years of experience and which can only be read with refreshing relief. To refrain from giving a hot drink to a patient blue with cold, she says, might be more obstructive to the analysis than the risks involved in doing so. She equates such spontaneous behaviour with intuitive interpretations distinguishable by experience from naive or wild impulsiveness. A neutral analyst who suppresses counter-transference feelings and cannot behave naturally is only, she believes, a short distance from the neuter.

The author further stresses the importance of being natural in her final paper written in 1979 'Children and Children-No-Longer'. 'Playing is learning and learning can be joyful', she writes. 'I also hold that a valid lecture need not be pompous or heavy'. In this paper she does

play with words and ideas and the reader feels invited to join in. There is also however, a didactic element, not pompous or heavy, but perhaps conveying there was little time left to make sure that children are not deprived of 'primary joy' by the prosaic approach of those who are children-no-longer.

I have found considerable joy in reading this book.

ANNE TYNDALE

Dream, Phantasy and Art

By Hanna Segal. The New Library of Psychoanalysis and Routledge, London. (1991) £10.99 P/b. 120 pp.

Hanna Segal has given us a most important and illuminating book in *Dream, Phantasy and Art*. She has managed in a mere 109 pages of text to refer not only back to Freud's discoveries and to link his thinking to that of Klein, Bion, Rosenfeld, Money-Kyrle, Susan Isaacs and her own, but also to the possible future where Spillius, the editor of this work, is still working on the depressive position. There is ample case material to illustrate each idea. The whole, although densely packed with thought and fact, flows in a seemingly effortless manner, so at home is she with her material. There is some new thinking but the book is primarily a reworking and re-focussing of past work so that it is a vehicle of clarification rather than innovation. There is even the occasional suggestion on technique.

The importance of understanding the manifestations of the unconscious is the underlying theme of the whole book. *Psychic work* is needed to transform the deepest levels of the unconscious into dreams, child's play, or any art form or aesthetic experience. It is also needed to comprehend the full meaning of these phenomena.

Segal discusses phantasy, claiming that while Freud saw it as a late phenomenon in mental life, Klein gave full weight to the ubiquity and dynamic power of unconscious phantasy: the younger the child, the more dominant its unconscious life.

It is through symbolism that unconscious phantasy is expressed, whether in symptoms, dreams, ordinary relationships, everyday activity or art. Segal continues her analysis by showing how Klein equated intellectual inhibitions in children with an inhibition of symbolic function, anxiety and guilt arising from aggression being amongst

the prime movers to symbol formation. Successful artists, in particular, combine an enormous capacity for symbolic 'use of the material to express their unconscious phantasies with a most acute sense of the real characteristics of the material they use'. The difficulty in communicating with psychotic people is that words are felt to be concrete objects or actions, barring their capacity to symbolise.

In her chapter titled 'Mental Space and Elements of Symbolism', Segal holds that there is an equivalence between Bion's 'Beta' elements and her own 'concrete symbolic equations'. Beta elements are raw, concretely felt experiences which can be dealt with only by expulsion. If a mother is tolerant and understanding, able to bear anxiety, Beta elements are converted into 'Alpha' elements and re-introjected by the baby. Comparing 'mental space' with Winnicott's concept of 'potential' or 'transitional' space, Segal says that Winnicott's space lies between mother and child, becoming the space in which transitional phenomena develop unless they are exposed to intrusions by the mother. For Bion, it is an internal mental space formed by the introjection of a breast capable of containing the infant's projective identifications and of giving them meaning. When there are good relationships between the container and the contained, it gives rise to a third object engendered by the way that those two objects share a third.

Segal's discussion of art is particularly interesting because it opens new ground. She asserts that Freud's preoccupation with eliciting the unconscious conflicts and phantasies embodied in a work of art led to new insights. For example, the idea of splitting the personality into many characters came from *The Brothers Karamazov*. But Freud only touched on the actual problem of clarifying the nature of *artistic creativity* and the *aesthetic experience*. In fact, he minimised the significance of the latter by comparing it with fore-pleasure in sex. At this point in her exegesis, Segal introduces the arguments of the artist, Roger Fry, and the critic, Clive Bell, about the primacy of *form* over content: aesthetic pleasure comes from the recognition of 'inevitable sequences' of the kind encountered in a succession of musical notes in a line. For Segal, a work of art is an expression of the artist working through conflicts. In that guise, unconscious symbolism is crucial. She maintains that form, be it musical, visual or verbal, can move us deeply because it symbolically embodies an unconscious meaning. Further, referring to Rodin's observation that the artist strives for truth, she defines that truth as primarily psychic, a balance of the ugly and the beautiful. A day dreamer may avoid conflict by a phantasy of wish-fulfillment and a denial of external and psychic realities, but artists

seek to locate their conflict and resolve it in their creativity. In this sense, the artistic impulse is specifically related to the depressive position. Artists need to re-create the harmonious internal world that they feel in their depths they have destroyed. Art then represents a reparative attempt at the resolution of conflict. There is no art without aggression. Segal cites many literary examples and Patrick White's *The Vivisector* in particular. In that book, White turns to the theme of destroying and re-creating again and again.

Dream, Phantasy and Art derives its power from an explanation and synthesis of very different ideas. I hope that I have conveyed enough to show how important and admirable it is. It should be read widely.

ZELDA RAVID

The Protective Shell in Children and Adults

By Frances Tustin. London, Karnac Books. (1990) £15.95 P/b. 241 pp.

As most readers of this Journal will be aware, Frances Tustin is a leading clinician and research worker in the field of the psychoanalytic treatment of autism. Her new volume is an attempt to further develop the ideas put forward in her previous books, especially her last (Autistic Barriers in Neurotic Patients, 1987). The present volume concentrates on the notion of autistic functioning, in both clinically autistic children and in adult 'neurotic' patients, as a protective shell which both 'cures' the individual of traumatic primitive anxieties but also acts as a barrier to emotional development.

If this complex and demanding book – which is best read in conjunction with 'Autistic Barriers in Neurotic Patients' – can be distilled into a central idea or thesis, then it is this: that autism occurs in an infant as a reaction to a sudden and traumatic separation from the feeding mother, with whom there had been an abnormal experience of fusion; this separation is felt as causing a bodily mutilation when the 'tongue-nipple continuity' is broken, leaving a sense of a gaping wound in the body and a 'black hole' in the emerging self. A hard shell or 'second skin' is then necessary to protect the infant from spilling out in an uncontained way and in a way that endangers a sense of 'going on being', but this protective shell comes to be used increasingly as a replacement for mother and her external care, and thus actively inter-

feres with the normal processes of emotional development through object relating. The space that suddenly appears between infant and mother when the 'tongue-nipple continuity' is broken is also experienced as being filled with predatory rivals – evoked by the author's images of 'a mouthful of sucklings' or 'a swarm of stinging rivals' – who threaten to squeeze the infant out of existence. The peer group – other children – are experienced in this way by the autistic child, whose protective shell serves as a barrier to ever having to feel part of such a peer group.

The nature and composition of the protective shell is best described by Tustin in the following passage:

> 'The impact of bodily separateness seems to have caused the loosely integrated child to startle with fright and rage. This is experienced as being turgid with poisonous substances experienced as "grit". This pressure is relieved by the explosive projection of "lava" or "death-juice"... . A security cloak made from extruded body stuff is felt to be thrown around the "busted" object, which then becomes part of the loose structure of which the child feels composed. The "busted" object yields no hope of integration, and as a terror mounts it erupts again, with the same results. A deathly terror is hidden as the core of a nightmare object. He feels he retreats from this by entering a body prefabricated by himself. It is a cyclical manoeuvre to stop the rot.' (pp. 141–142).

Such extraordinarily vivid writing displays Tustin's remarkable capacity to both understand and describe these very primitive and very disturbing anxieties.

Detailed clinical material is presented from the therapy of two autistic children and one adult 'neurotic' patient treated by the author, and clinical evidence is also gathered from other clinicians who have corresponded with her about their work, and from the few recent papers published in the literature on autistic functioning. This reader is not a child psychotherapist and is therefore in no position to evaluate the clinical work with child patients which Tustin describes, but I found it compelling and convincing. She freely admits that she has treated only a small number of autistic children in depth (though supervised the treatment of many others), but I feel it is refreshing to find an acknowledgment that, for all of us, as practising psychotherapists, our 'research findings' are by definition based on the detailed knowledge of only a very small number of patients.

Though the book suffers from a certain repetitiveness in the enunciation of its main ideas, and is stronger in its descriptions of work with autistic children than with adult 'neurotic' patients, it must be borne in mind that this is pioneering work, taking psychoanalytic thought

into hitherto uncharted areas of the mind. Tustin connects the development of her thinking to three crucially important papers in the psychoanalytic literature — by Bick (1968), Winnicott (1974), and Sydney Klein (1980) – but otherwise her work is very much her own, and she writes about it with vividness and immediacy. One of her autistic patients, John, whose sessions are presented in detail, is able to say, after a helpful interpretation. 'You're a sensible Tustin.' We all have much to learn from her.

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NOEL HESS

Between Freud and Klein. The psychoanalytic quest for knowledge and truth.

Adam Limentani. Free Association Books. (1989) £30.00 H/b. 276 pp.

This book situates itself within the independent tradition of the British School of Psychoanalysis and is a compilation of Limentani's clinical and theoretical papers over the past twenty five years. The author shares with the reader insights and reflections which stem from years of experience. As there is no central theme running through this volume, we are grateful to the author for introducing the book in the beginning, with an aptly titled paper 'between Freud and Klein' which in a sense is autobiographical and serves the purpose of locating the background and evolution of his thinking. His professional life developed in the midst of the controversies between M. Klein and A. Freud and his work is inspired by the middle group now offically called the independent group within the British School of Psychoanalysis.

Throughout the various topics examined in these pages and at each stage in the reading, Limentani offers us a careful and reflective review

of the prevailing psychoanalytic ideas pertaining to the issues studied, including a constructive and critical attempt to integrate concepts from different orientations. He then points to areas of conflicts between different schools of thought and finally, through the presentation of his own clinical material, he makes his own original contributions.

Limentani's ideas always emerge through the process of review, scientific observation, deduction and creative imagination. His style is very accessible to the reader as he is capable of conveying difficult and complicated themes in a simple and clear way.

One cannot fail but to be impressed by the breadth of both the perspective and issues examined in this book. His papers relating to psychoanalysis range from topics as diverse as the negative therapeutic reaction, acting-out, to the question of analyzability. His papers on psychotherapy encompass various themes including sexual perversions, delinquency, and drug dependence. There are some further papers which could be loosely described as papers on applied psychoanalysis where he discusses issues such as aspects of human violence and the myth of Orpheus.

The papers are presented chronologically rather than according to theme in order to reflect the author's evolution of his thinking over time. Although I personally would have preferred a thematic order to facilitate a sense of continuity from a conceptual point of view, this is however of no grave consequence to our understanding of the material.

It will be possible to give only the most cursory outline of the major themes contained in the various papers.

In his 1966 paper 'A re-evaluation of acting out in relation to working through', often presenting very original categorization of the clinical functions of acting out, Limentani makes the strong case that there is no one single explanation for it and shows through live examples how it can be turned into a useful therapeutic guide and tool. Later on, in his 1981 paper 'On the positive aspects of the negative therapeutic reaction', Limentani develops his thinking further. Here, he gives us a very comprehensive and instructive developmental view of the phenomena of the negative reaction to therapeutic efforts and one cannot help but be impressed by the author's sensitivity and faith in the human experience. In some ways, I think he approximates Bion's ideas relating to the container-contained paradigm and of reverie. Limentani uses simple and moving language without resorting to specialized wording to explain the most difficult phenomena that we all encounter in our practices. This is very refreshing for the reader.

In two papers written in the early 70's he makes a major contribution

to the thinking of, selection for and training in psychoanalysis. He deals with the two ends of the continuum: the finding of suitable patients for candidates and the relationship of the training analyst to the whole ethos and norms/values of the training institution.

In the first paper he examines six factors in detail which contribute to the difficulties of selection and which need to be critically examined and evaluated to help the selective task. These factors are: a) the widening of psychoanalysis, which includes a greater knowledge of borderline and psychotic states. b) the use of pure diagnostic categories in the assessment, c) the use of symptomatology for criteria for suitability, d) the interview and its value and impact, e) theoretical views and how they diverge as to what constitutes analyzability, and f) the role of the evaluator which includes his/her own values, biases, prejudices and of course, countertransference aspects. Limentani offers us in these works the wealth of experience accumulated through the many years he was involved in the London Clinic of Psychoanalysis and also as president of the International Psychoanalytical Association with candor, intellectual honesty and he is generous with examples which are enlightening and stimulating.

He finishes the topic with suggestions for further study and a postscript written in 1988 where he feels that the evaluation and predictability of analysis is still a contentious issue and difficult to validate in spite of advances in knowledge and experience. He concludes that outcome is ultimately dependent on a combination of factors arising from both analyst and patient. Limentani, I think correctly, feels that it is, in the final analysis, the simultaneous link between emotional responses in analyst and patient and their verbalisations which will be of the utmost therapeutic value.

In the second paper, the author centres his attention on the difficulties of differentiating a therapeutic from a didactic analysis and he concludes that the training analyst should not have a direct say on the educational progress on the candidates in training in order to try to minimise unwelcome interferences of the training on the candidate's and vice versa. In both papers, Limentani offers us again a useful and well researched background of information based on data gathered from international surveys. His effort is to integrate and seek a global view from a multitude of inputs and to open up new areas of questioning.

His ideas about sexual deviations and a comprehensive review of the psychodynamics of case material from the Portman clinic, where Limentani carried out psychotherapy of patients with sexual deviations

over many years, are disseminated in about half of the papers in this volume. What one gains in reading these papers is inspiration to examine and re-examine all our conventional ideas about sexuality when confronted with phenomena which most of us probably do not encounter in our daily practices.

The chapters on bisexuality, homosexuality, transsexualism and perversions are major clinical contributions of this thought provoking volume, providing a strong basis to locate and conceptualize sexual deviations in our nosology. Limentani examines the links and differences between latent bisexuality and homosexuality and actual behaviour and tries quite successfully to present a typology of different personality structures underlying these conditions. Invariably, he confirms that clinical bisexuality reflects borderline character structures. So does a certain type of homosexuality where it is mainly employed as a defensive character structure against primitive anxieties of annihilation. Thus, sexual deviations are not considered to be a type in themselves but a syndrome which, like eating disorders or phobias, can reflect different severities of psychopathological character structure and therefore their treatability or intractibility to treatment will vary.

These classifications are very instructive and useful to help practitioners, particuarly those of us who are involved in the assessment of patient's suitability for psychoanalytic or psychoanalytic psychotherapeutic treatment. For example, he distinguishes three groups of homosexual patients: one, with a neurotic structure with severe oedipal problems offering optimistic prognosis; then, a second group which is much more borderline where homosexuality is mainly a defensive system, and the prognosis is less optimistic and yet another group, presented by people who find themselves in situations such as in prison or under external influences who practise homosexuality but who are not 'ill'.

In his paper on transsexualism, Dr. Limentani reviews psychoanalytic approaches to the understanding of this condition. He challenges the traditional view that it is only a defense against homosexual wishes which threaten the very sense of self of the individual. He regards it as 'the transsexual syndrome'. According to his own clinical work, which he presents in great detail vividly and compellingly, one is puzzled by the lack of castration anxiety in the transsexual which is central to the fetishist and transvestite or lack of repressed hostility as it exists in the male homosexual. The transsexual, for Limentani, is not psychotic. He maintains transsexualism is the precursor in some cases of transvestism and of homosexuality. He regards it as a 'person-

ality and characterological disaster.' He states that beneath their unhappiness, lies the most profound disturbances in object relations and it is separation anxiety or fear of annihilation which is at the basis for the appearance of the transsexual syndrome.

In a paper, written in 1984, he deals further with a related subject and he uncovers and develops the concept of the 'vagina-man', as the counterpart to the more generally discussed 'phallic-woman'. Limentani argues that once again in these cases, fear of castration is avoided. There is profound envy on a part-object level and an unconscious phantasy feeding the desire to be a woman, of possessing a phantasized vagina. Limentani hopes his description and analysis of these 'character types' will help clarify the concept of bisexuality.

Limentani further shares with us his experiences as a psychotherapist dealing with delinquency. In a 1981 paper he deals with the progress of a case of childhood delinquency towards neurosis passing through different phases in psychotherapy over a period of twenty years. This is a very moving and detailed account which involves a frank examination of the therapist in relation to the treatment of a delinquent girl. There is much to be learnt from the author's detailed account of this psychotherapy and of his own feelings in the process. Limentanti has particular ways of conceptualising psychological phenomena, as for instance, he speaks of the 'girl's modes of self-cure' referring to different ways of minimizing pain but also at various attempts by the psyche to heal. He raises the concept of cure which is such a relative one and, the question that comes to one's mind is: does the concept of cure have a place in our epistemology? Is it to heal pain or avoid it, or to find better mechanisms to deal with pain? I think we all agree it is the latter. Limentani's ideas stimulate our phenomenological thinking. For instance, in his paper on the study of perversions in 1986, he shares with us his work with what he calls treatable and untreatable cases. Here we find a real contribution to the examination of transference and countertransference in the psychoanalytic treatment of sexual deviations. There is no doubt that this paper constitutes a very important basis for the further study of the dynamics of sexual deviation.

The two questions Limentani asks and tries to deal with in this paper are: 'is it possible that by protecting their distorted reality sense, perverts succeed in protecting some hard core of ego disturbance which threatens the whole of their being, rather than purely being (the perversions) not being given up because it is pleasurable'? The other question posed is 'how the cloud of unreality affects the therapist-patient relationship, since the therapist represents the enemy to the

defeated'. The battle is between truth and distortion (perversion of the truth). Limentani impresses the reader with a useful examination of the background literature and tells us the results are disappointing in explaining the psychopathology of sexual deviations and then proceeds to give us a very comprehensive analysis of its phenomenology, its psychopathology and its treatment. He demonstrates how the study of sexual deviations has undergone a revolution through changes in theories related to phallic primacy, penis envy and increasing awareness of disturbed object relations in early infancy influencing its assessment and treatment.

He gives us a very full and vivid account of a psychoanalysis of a case of female perversion, illustrating the problems encountered during treatment. He examines the prognosis of different types of perversions and discusses in a very detailed and original manner 'the perverse transference'. He explains the importance of distinguishing between perverse behavior which is rooted in oral and anal sadism from perverted acts which are always limited to a sexual aim, directed at facilitating genital orgasm. Limantani quotes Glasser frequently to describe the core problem encountered in such patients of merger-engulfment and the eroticized defences active in these patients. One of the main points that emerges from this paper, is that the therapist has to rely very heavily on his/her countertransference as is the case with most narcissistic phenomena and that it is not just the negative therapeutic reaction which can be extremely frustrating and exasperating for the therapist but also the perverse use of the relationship.

I found only a couple of chapters to be slightly and comparatively less satisfying. His paper 'On some aspects of human violence', for example, appears to have been written for a more eclectic audience. It tended to be too generalized and a final paper in the book, entitled 'Variations on some Freudian Themes' is light hearted and general and as such could have been included at the beginning of the book perhaps within the introductory material.

Apart from these minor comments on the form of the book, Limentani's writing is clear, accessible and its content is well researched. I enjoyed the book and I was very impressed by the author's amplitude of thinking. It reminded me how important it is to take different theories and frameworks into account in order to understand the complexity of phenomena we all deal with in our own work. This book is not about answers but about observing and asking questions, both basic and complex. It is not a textbook, but rather an intimate relationship with the author's quest for truth and understanding. Mr.

Limentanti has given us a very valuable addition to our psychoanalytic library.

RICARDO STRAMER

The Maturational Processes and the Facilitating Environment

By D.W. Winnicott. London, The Institute of Psycho-analysis and Karnac Books. (1990) Paperback reprint of 1965 edition. £14.95. 295 pp.

Readers may be interested to know that my former analyst, the late Masud Khan, once told me that when the eminent Kleinian analyst Mrs Joan Riviere (Donald Winnicott's second analyst) discovered that Winnicott planned to publish a book with the word 'Environment' in the title, she became most distressed and demanded that he remove it.

Such was the Kleinian climate of the time and all the more courageous was Winnicott's unrelenting insistence that growth occurs between mother and child and all behaviour is shaped by thoughts and feelings from the mother.

For Winnicott, the human individual was an unknowable isolate who could personalise and know himself only through the other (originally mother). Thus Winnicott idealises mothers but also puts the burden of an infant's mental health firmly on her shoulders. However, the act of separation means taking on individual responsibility and in a Winnicottian analysis one should be careful that the emphasis does not lie in *blaming* mother/the environment but more in the notion that *recognising* the other's lacks can help to free one.

It is exciting that this book has been reprinted. It is the cornerstone of Winnicott's work, very dense and a real classic. It is his best statement both on child development and his views on psychoanalytic theory and technique.

Everybody will have their own favourites amongst the papers but mine is undoubtedly 'The Capacity to be Alone' (1958). I find the idea of being alone in the presence of mother very useful in my clinical work. In my opinion this capacity is the hallmark of mental health. To have internalised this particular aspect of mother and early bonding is the springboard of all sustained creative endeavour. It also forms the core of the analytic encounter which is based on a patient's capacity to be alone. The analysand is basically talking to himself and dis-

covering for himself and we, as therapists, are there to keep him company and make him feel safer.

As Masud Khan once said 'We all have our own Winnicott'. This is a book to be enjoyed in the spirit of Winnicott. Let readers buy it and dip into it. One can really play with the ideas and return to them again and again. Winnicott has written a tremendous amount and various collections of his papers have been appearing since his death twenty years ago. None measure up to this book and it is good that there is now a paperback reprint of this timeless classic.

JUDY COOPER

The Provision of Primary Experience
Winnicottian Work with Children and Adolescents

By Barbara Docker-Drysdale. Free Association Books, London. (1990) £29.50 H/b; £12.95 P/b. 212 pp.

In this book, consisting of a collection of essays, Barbara Docker-Drysdale describes her work at the Mulberry Bush School and at the Cotswold Community, a former Approved School which was transformed into a Therapeutic Community for adolescent boys, in itself a daunting task. In both settings, as former Director of the first and presently as Consultant Psychotherapist in the second, she has based her work upon that of D. W. Winnicott with whom she was closely associated for many years.

We may be sailing towards troubled waters when we apply psychoanalytic concepts to group living, but the need to differentiate interpretation in the consulting room from that within a community is a difficulty Mrs. Docker-Drysdale has tackled with impressive success. The relevance of applying Winnicott's 'Provision of Primary Experience to the understanding of children and adolescents cannot, for this reviewer, be disputed. These young people have undergone a severe breakdown in what should have been the provision of primary experience and thus integration has failed to take place. To compensate for this potentially fatal early lack is what Mrs. Docker-Drysdale and her colleagues have tried, with remarkable success, to do.

To work with very disturbed children and adolescents in a residential setting holds the potential for great rewards but also for damage to both adults and the children in their care. The experience can be a

seductive one taking place in a hot-house atmosphere where workers may become overly involved and thrown off balance by the communications of residents. On the other hand it can develop in them imaginative thought and action, self-discipline, sound judgement, and a keen awareness of self and others. Mrs. Docker-Drysdale is acutely aware of the need for staff to have a strong sense of their own selves and she has clearly been sensitive and effective in helping them to work therapeutically for the children rather than for themselves, thus avoiding a pitfall faced by all workers in such residential settings.

In describing her work at the Mulberry Bush her consummate skill and creativity in holding the children and, with infinite patience, recreating the 'good enough' care so necessary for healthy growth is apparent and quite remarkable. These 'frozen' children slowly unfreeze and achieve integration. She illustrates the application of her theories with vignettes that are both colourful and moving; I remember 'Susan' who for a whole year was totally dependent on her. She asked for a fried egg late every night; her manner of eating it (i.e. the breast) slowly changed until it lost its obsessiveness and became relaxed and healthy.

Faced with such evidence of effective care and treatment, it seems almost churlish to question any aspect of Mrs. Docker-Drysdale's work. However, I was left with one or two difficulties which are, in fact, reflections upon Winnicott's work. There is the matter of boundaries: She took some of these very disturbed children into her own home where they required virtually round the clock attention. I have to wonder about the effect upon her own family life and the reaction of her own children to another child to whose needs she responded at all hours of the day and night. Again, she describes a shopping trip with a small boy whose behaviour in the street severely impeded her own needs and plans. She accommodated this, understanding his need. But even a small child must have boundary lines drawn and should not feel that he can successfully manipulate the adults who love and care for him.

At the Cotswold Community she was, it seems to me, particularly effective in her understanding of the interaction between workers and children or, to be precise, adolescents. I would have liked a little more discussion about management although, as Isabel Menzies Lyth comments in her Foreword to the book, much of this is indicated between the lines. The ability of the staff in this Therapeutic Community to help these very disturbed boys to recognise feelings and to learn to reflect; to enable them to safely regress and thence to grow, is outstanding. They make constructive and imaginative use of transitional objects

such as soft toys (I particular liked the Society for the Protection of Unhappy Monsters) and her accounts are, once again, both dramatic and touching. What seems to be missing, however, is discussion about sexuality. A fifteen-year old boy may regress emotionally to earliest childhood, but his body remains that of an adolescent with the sexual impulses and anxieties this suggests in addition to the distress and distortions of unintegrated boys.

I found this book completely absorbing and Barbara Docker-Drysdale's achievement extraordinary. These papers should be read by everyone who works with disturbed children particularly, but not necessarily, within a residential setting.

MIDGE STUMPFL

Further Learning from the Patient. The Analytic Space and Process.

By Patrick Casement. Tavistock, Routledge. (1990) £25 H/b. £9.99 P/b. 197 pp.

In this follow-up to his successful book, *On Learning From the Patient*, Patrick Casement concentrates on what occurs between the analyst and the patient conceptualizing some of the tasks which we as therapists perform, making us aware of what we often take for granted. He illustrates the points he raises through a wealth of clinical examples and at the same time, new key concepts are developed by the author in the course of his exposé. The book reads essentially like a clinical textbook locating itself within the independent tradition of the British school of psychoanalysis. The author's aim is not to give a full theoretical framework but to show how our work oscillates constantly between theory and practice. Casement is a phenomenologist who invites the reader to observe, take note, disentangle some of the threads which make up the triad between the patient, the analyst/therapist, and the analytic task and discover afresh what happens in the analytic encounter.

Casement's central preoccupation is with the issues of analytic space and analytic process. In order to enable the latter to develop, the former needs to be provided. His main concern is about preserving the analytic space where development can take place but which can be disturbed by the patient's or the analyst's/therapist's emotional claims on that space thus creating a block in the analytic process.

The book comprises ten chapters, allowing the reader to follow the development of the author's thinking clearly and with interest. In his first chapter, 'Beyond Dogma' as a form of introduction to the book, Casement explains the principal influences behind his approach to technique and describes how dogmatic certainty always constricts an analyst's capacity to think imaginatively. He examines transference and countertransference in an open and stimulating way, and discusses the important distinction between 'personal countertransference' and 'diagnostic response' which in turn leads him to examine the phenomenon of projective identification. In the second chapter 'Interpretation: Fresh Insight or Cliché' Casement shows, in line with Bion and Winnicott, the importance of being able to tolerate 'not knowing' to permit real insight to emerge. This can be discovered only when the patient is emotionally ready in a secure and safe environment. Again, he stresses the need for the analyst to preserve the analytic space by remaining open to the experience, suggesting that clichéd thinking on the part of the therapist often indicates insecurity about clinical understanding.

Throughout the book Casement emphasizes the need for the therapist to follow the patient's lead. This central aspect is beautifully illustrated in chapter three 'A Child Leads the Way'. Here Casement, in a detailed account of a psychotherapeutic treatment of a six and a half year old girl, shows how he had to learn to follow the girl's unconscious search for her sexuality to be acknowledged and contained.

Furthering his discussion on the need to differentiate between personal countertransference and diagnostic response, he proceeds to illustrate the use of internal supervision to arrive at the right intervention with the patient. He examines the difference between the internal supervisor and the internalized supervisor (the latter being less integrated and 'superegoish', whereas the former is a more autonomous ego-syntonic reflective function). Chapter four, 'Countertransference and Interpretation' is dedicated to the presentation of an analytic case aimed at highlighting various issues which arise when interpreting from the countertransference, in particular the issue of the right timing of the interpretation in order to maximize it's effectiveness.

In chapter five, 'Experience of Trauma in the Transference', the author emphasizes the need for the patient to find the right balance between re-experiencing, in the transference, past trauma and at the same time experiencing the analyst/therapist as helpful in his real capacity as a therapeutic agent. Although it is the therapist's role to

provide a facilitating environment where this delicate balance can take place Casement warns us that 'sometimes the transference experience can be so like the past as to become in itself traumatic' (p. 75). He provides us with vivid examples to show how this can be avoided by listening to the patient's unconscious lead.

In 'The Meeting of Needs in Psychoanlasis', the author clarifies his analytic approach differentiating it from Alexander's 'corrective emotional experience' by emphasizing that 'the meeting of needs is not provided by the therapist but it is found by the patient'. (p. 107). Here he shows how the patient needs to experience the analyst/therapist as a primary object in the transference who can survive before he/she can use the analyst as a helpful figure. Casement strongly believes that the analyst/therapist will perform his/her task best by adhering to the analytic function in order primarily to facilitate the patient's finding of what he/she is unconsciously seeking.

A central concept in his work, namely that of 'unconscious hope' is described in chapter seven. He defines it as the inner belief or hope in the patient that needs which are unconsciously sought will be met. It is a moving chapter and Casement illustrates how unconscious hope can be recognized even in destructive types of behaviour as well as in severe pathological states. The author reminds us that at 'no time is unconscious hope more vital than when a patient is putting an analyst through the roughest of times'. (p. 124).

In the next two chapters entitled 'Inner and Outer Realities' and 'Trial Identification and Technique', Casement examines the analyst's/therapist's own part in the analytic process and the need to recognize the effects upon the patient of the analyst's ways of working and interpreting. Again through example, he demonstrates the various ways in which ignoring the real impact of the analyst on the patient can be as detrimental as overlooking the real effects of failures in the early environment of the patient.

In his final chapter 'Analytic Space and Process', Casement synthesizes his exposé. Basically, he reminds us that in order for an analysis to progress, it is necessary to maintain sufficient analytic space. That is, the area in the analytic encounter which reflects the psychological possibility for the patient to find him or herself. In this endeavour, he concludes that 'the analytic process is not created by the analyst. It has a dynamic of its own, a direction that expresses unconscious hope of the unconscious search of the patient, and often it seems to contain unconscious wisdom'. (p. 159).

Casement writes in a clear, entertaining and jargon free way,

enabling the reader to follow profound and complex phenomena with interest. He takes enormous care to illustrate all the ideas presented, like a scientist demonstrating every step involved in a theorem. I found the author's description (through clear examples) of how the transference develops and shifts very useful. He shares with us his inner supervisory thoughts about what is going on with a particular patient and thus gives us the benefit of his insight and experience. For example, he points out the danger of the therapist becoming in objective reality, too much like a key figure in the patient's inner world. This can lead to an impasse when for instance the analyst/therapist becomes too critical, too persecutory or sometimes too 'unholding' by being too soft or not firm enough, vis à vis the patient's tendency to avoid pain and difficulties in the analysis. The reader literally learns from the patient in a sense alongside the author. There is no doubt that this book helps the reader build a framework of self or internal supervision.

Like playing an instrument, he equates our work to that of an artist who has to practice different passages in order to refine his awareness of the piece. In this respect, through trial identification, the therapist considers the patient's possible reactions to an intervention and thus 'refines' his/her technique as to when, and how much and what to interpret if at all; to preserve the fundamental analytic space and allow the process to run its course. Like its predecessor, there is a refreshing outlook in this book which stimulates the reader to look at the 'whole picture' of the analytic process, rather than, as is quite often the case, in a piecemeal and narrow fashion.

The book is, however, not without its limitations. At times it appears to repeat its central message perhaps a bit too narrowly and thus defeat its own basic tenet, namely to be open to different views. There is a tendency to leave out the role of instinctive destructiveness in Casement's discourse. It would seem that Casement does not tackle sufficiently the anti-developmental tendencies in some patients, particularly the very disturbed ones, and some theoreticians would argue that unconscious hope at times is not just a wish for growth and development but at times a wish to remain merged with the primary object, avoiding mental pain, or even worse, the desire to eliminate any form of meaning in a destructive mnaner. I would have liked to see a section devoted to these issues. The book's strengths lie in having an effective clinical focus rather than in terms of its theoretical rigor. In effect, the reader, depending on his/her theoretical orientation might not always agree with some of the author's conclusions regarding particular cases,

but is invited to examine and hypothesize around the observations made.

In conclusion, this book, like its predecessor, is an excellent clinical textbook for trainees and experienced analysts/psychotherapists alike. The author shares with the reader generously and intelligently the benefits of his experience and knowledge, stimulating the reader's sense of questioning and self examination. A very valuable sequel.

RICARDO STRAMER

Love's Executioner and Other Tales of Psychotherapy

By Irvin D. Yalom. Penguin Books. (1991) £6.99 P/b. 270 pp.

'I do not like to work with patients who are in love ... the good therapist fights darkness and seeks illumination, while romantic love is sustained by mystery and crumbles upon inspection. I hate to be love's executioner'. This illuminating first sentence in Dr Yalom's 'ten tales of psychotherapy' sets the scene very well for a book that is always riveting, provocative and in turns, tender, wise, funny and sad. He is an original innovative therapist whom it would be hard, and I feel, a waste of time, to try to *pigeon-hole*. He says of himself, when frustrated in his work with a patient 'how I long at such junctures for the certainty that orthodoxy offers ...' Dr Yalom talks of his 'existential perspective' and is at pains in his prologue to outline his belief in the need to recognise and struggle with what he calls 'existence pain.'

His primary clinical assumption is that basic anxiety emerges from a person's endeavours, conscious and unconscious, to cope with the harsh facts of life, the 'givens' of existence. The four most relevant to psychotherapy, are, Yalom argues: the inevitability of death; freedom to make our lives as we will; our ultimate aloneness; and the absence of any obvious meaning to life. His aim, he says, in these ten tales is to demonstrate that it is possible 'to confront the truths of existence and harness their power in the service of personal change and growth'.

I imagine there will be few psychoanalytic psychotherapists who will not take issue with some of his beliefs and certainly his techniques. I would also predict that very few, too, who pick up this book will be able to put it down very easily. He is an enchanting writer. He thinks aloud, very endearingly, chiding himself on one occasion 'Bad technique! A beginner's error'! He is also able to share with his reader, his

excitement and wonder at what he is discovering. '*The therapeutic act, not the therapeutic word*'! 'I was so stimulated by this idea that I could hardly wait until the hour was over so I could think more about it'.

The ten patients he describes are all ones who might well give a therapist pause before deciding to work with them. There is Thelma, a seventy year old woman, chronically depressed (with a history of twenty years of psychiatric treatment) who, eight years previously, had a brief, intense love affair with her therapist.

Another patient, dying of terminal cancer, was in individual therapy with Dr Yalom, but also in group therapy with a colleague who found his macho fantasies so grotesque that she described him as the most despicable human being she had ever met. Yet the work with Carlos is one of the most moving accounts in this book, examining whether it is appropriate to strive for 'ambitious' therapy in those who are terminally ill. 'When I visited him in the hospital', Yalom concludes, 'he was so weak he could scarcely move, but he raised his head, squeezed my hand and whispered, 'Thank you. Thank you for saving my life.'

The fascinating titles of each of the tales sum up the essence of the story. 'Fat Lady' for example; 'Three Unopened Letters'; and 'Therapeutic Monogamy' an intriguing account of work with a patient with an extreme split personality.

All the patients were seen individually; some on a time limited basis owing to a planned sabbatical in eighteen months' time. Nevertheless Dr Yalom's expertise with groups is continually drawn on. One patient will put him in mind of someone he saw in a group and he reflects, aloud as it were, about this.

His own interest in literature and philosophy is apparent and shared unobtrusively with the reader so that thoughts from Hemingway, Proust, Flaubert, Spinoza, Nietzsche all help to enrich this text.

In no sense whatever is Dr Yalom a 'blank screen' therapist. Nor does he appear to be troubled with doubts about therapeutic neutrality, far less therapeutic aims and goals. He candidly recalls how, 'stricken with empathy and grief, I became what Hemingway has referred to as a 'wet-thinking Jewish Psychiatrist'.'

I found this book profoundly unsettling and intensely thought provoking. It is written, I believe, with complete candour and integrity. It is not about psychoanalytic psychotherapy in any purist sense, but I am sure it is about his own search for truth. Unbidden, a powerful phrase from the film 'Dead Poets' Society' came into my mind. The revolutionary tutor, Keating says, jumping onto the table in the class-

room: 'Just when you think you know something, you have to look at it in a different way'.

This is what 'Love's Executioner' most powerfully invites us to do.

PAMELA MANN

Witnessing Psychoanalysis (From Vienna back to Vienna via Buchenwald and the USA)

Ernst Federn. Karnac. (1990) £15.95 P/b. 308 pp.

'Read it during your Christmas break' said our book review editor encouragingly, 'You can keep the book, you know'. The author's name unknown to me in bold white print above a strong and colourful reproduction of a painting by Tsingos. And then I saw the sub-title 'From Vienna to Vienna via Buchenwald and the USA' and my heart sank. I did not want to read or think about Buchenwald so I put the book down for several days. Next, the quick flick through from back to front while the awful chapter headings flashed passed; 'The endurance of torture', 'Some clinical remarks on the psychopathology of genocide,' 'On the psychology of mass murderers.' I reached the safety of the introduction by Riccardo Steiner which begins by quoting the author. 'While I myself was too young to know Freud, he, of course met me when I was a child. I believe that in fact I fulfill the role of a living link between the pioneering days of psychoanalysis and the present.' It was Steiner who persuaded Federn to publish this collection of his papers written over a period of forty years and chosen to be of particular interest to both the historian and the psychoanalyst.

Federn's selection of the eighteen papers which make up this book follow a somewhat biographical line and are grouped under four headings. (1) On Social Psychology, (2) On the Psychology of Terror and Violence, (3) On Psychoanalytic Psychotherapy and (4) On the History of Psychoanalysis. Not for nothing is the final chapter called 'About King Laius and Oedipus' for in it Ernst Federn explores the intense rivalries and loyalties within his own family, particularly in relation to his father, Paul. For this is a book about fathers and sons, loyalties and betrayals, torturers and the tortured, power, politics and ideologies. I looked in vain for references to women until I read the dedication 'To Hilda, to whom I owe my survival.'

Federn tells us that by the age of fourteen he had decided to devote

his life to the betterment of mankind. He was deeply influenced by his father the eminent psychoanalyst Paul Federn who, in a letter to his son had described himself as 'the mastersergeant in the psychoanalytic army,' and who for many years organised the Psychological Wednesday Society formed around Freud in 1902. Already a deeply committed socialist, Ernst Federn had by the age of eighteen begun his work on combining the ideas of Marx with those of Freud, and a paper he wrote lead to his arrest by the political police in 1936. He subsequently spent seven years in Dachau and Buchenwald. It is clear that the decisive event of his life was his experience in the concentration camps and the help he received there from his psychoanalytic knowledge. He recounts his extraordinary and moving meeting with Bettelheim when both men found themselves in a human chain passing bricks between them.

In 1948 he settled in the USA where he trained in psychiatric social work and psychoanalysis. He returned to Vienna in 1972 where he works as a lecturer, writer and supervisor.

Federn is outraged at what he sees as a distorted account of the early history of the psychoanalytic movement and his father's unacknowledged place in it. He is determined to set the record straight and makes a furious attack on Ernest Jones for writing a biography of Freud so full of 'errors, omissions and misrepresentations,' accusing Jones of being' utterly unsuitable by origin and character for the task before him – a narcissistic personality – not capable of empathy with the mixture of modesty and self-confidence that was unique in Freud.'

Some of the papers are quite slight, and concepts such as 'Mental Hygiene' rather outmoded, but whether Federn is tackling drug-abuse in teenagers, the management of aggressive children in residential care or the psychopathology of torturers, what comes across to the reader is his tremendous compassion and a commitment to applying the insights gained from psychoanalysis to some of the most horrifying events and personalities of the twentieth century.

The chapter titled 'On the psychology of mass murderers' is a collection of letters between the author and Robert Wälder on issues like the relationships between psychoanalysis, its values and politics, and political ideologies such as Marxism and Nazism. Both men obviously enjoy their intellectual wrestling match, while the reader cannot fail to be impressed by their grasp of history, philosophy, politics and psychoanalysis. Wälder seems to tire before Federn and hints at this when he writes, 'I should like to suggest to you strongly the reading of a few books which it seems to me may not be familiar

to you.' The put-down ignored, Federn writes back a long and brilliant letter in the course of which he writes, 'I too will be frank here and see an irrational bias in your need to prove Marx wrong'. Courteous to the end but not prepared to pull his punches even to a man he so clearly admires.

In a paper originally published in 1967 entitled 'How Freudian are the Freudians?' Federn challenges the American Psychoanalytic Society's right to call itself Freudian when it disagrees with Freud's unequivocal conviction that psychoanalysis is not part of medicine. His argument is supported by a previously unpublished letter from Freud to Paul Federn on this subject. In the same chapter he disposes of Klein, Jung and Adler in one brief paragraph, and makes it clear that a belief in the Oedipal complex as the core of all neuroses must be considered as the one criterion that distinguishes Freud from all other psychological schools.

This statement of faith may put some people off this book but I hope it will not because so many of the papers in this collection are particularly relevant today as the war rages in the Middle East and we may need reminding that our neutrality as therapists does not entail a denial of the complexity and the issues of the reality we are living in. Although at the outset I positively did not want to read this book, I am now very glad I have. I have got to know someone who, though sometimes maddening comes across as warm and interesting to be with and passionately committed to applying psychoanalysis to the problems of society and history. As Steiner says in his introduction, 'The kind of living witness Federn presents and the way he theorises about and practices psychoanalysis confirms that it greatly helps to be and remain a 'person', even in the most limiting of circumstances'.

PENNY JAQUES

Publications Received

Anthony, Maggy
The Valkyries: The Women around Jung
Element Books

Anzieu, Didier. (ed.)
Psychic Envelopes
Karnac Books

Baumgart, Hildegard (trans. by Manfred & Evelyn Jacobson)
Jealousy. Experiences and Solutions
University of Chicago Press

Bellack, Alan S. & Hersen, Michel, (eds.)
Handbook of Comparative Treatments for Adult Disorders
John Wylie & Sons

Bion, W. R.
Brazilian Lectures
Karnac Books

Blume, E. Sue
Secret Survivors. Uncovering Incest and Its After-effects in Women
John Wylie & Sons

Boston, Mary & Szur, Rolene
Psychotherapy with severely deprived children
Karnac Books

Boyd, Robert D.
Personal transformations in small groups – a Jungian perspective
Tavistock-Routledge

Casement, Patrick
Further Learning from the patient – the analytic space and process
Routledge

Chodorow, Joan
Dance Therapy and depth psychology. The moving imagination
Routledge

Crooke, John & Fontana, David, (eds.)
Space in Mind. East–West Psychology and Contemporary Buddhism
Element Books

Dethlefsen, Thorwald & Dahlke, Rüdiger
The Healing Power of Illness. The meaning of symptoms and how to interpret them
Element Books

Docker-Drysdale, Barbara
The Provision of Primary Experience. Winnicottian work with children and adolescents
Free Association Books

Federn, Ernst
Witnessing Psycho-Analysis
Karnac Books

Grinberg, Leon
The Goals of Psychoanalysis. Identification, Identity, and Supervision
Karnac Books

Havens, Leston
A Safe Place. Laying the Groundwork of Psychotherapy
Harvard University Press

Heimann, Paula
About Children and Children-No-Longer
Routledge

Hellman, Ilse
From War Babies to Grandmothers. Forty-eight Years in Psychoanalysis
Institute of Psychoanalysis – Karnac Books

Hobson, J. Allan
The Dreaming Brain
Penguin

Holmes, Paul & Karp, Marcia (eds.)
Psychodrama: inspiration and technique
Tavistock-Routledge

Kaplan-Williams, Strephon
Transforming Childhood. A Handbook for Personal Growth
Element Books

Kapstein, A. A., Van der Ploeg, H. M., Garssen, B., Schreurs, P. J. G., Beunderman, R., (eds.)
Behavioural Medicine. Psychological Treatment of Somatic Disorders
John Wylie & Sons

King, Pearl & Steiner, Riccardo (eds.)
The Freud–Klein Controversies 1941–1945
Tavistock-Routledge and the Institute of Psycho-Analysis

McGuire, William (ed.)
The Freud-Jung Letters
Penguin

Molnos, Angela
Our responses to a deadly virus – The Group Analytic Approach
Karnac Books

Morea, Peter
Personality – An Introduction to the Theory of Psychology
Penguin

Parfitt, Will
Walking through Walls. Practical Esoteric Psychology
Element Books

Perelberg, Rosine Jozef & Miller, Ann C. (eds.)
Gender and Power in Families
Routledge

Perry, Christopher
Listen to the Voice within. A Jungian Approach to Pastoral Care
S.P.C.K.

Rakos, Richard F.
Assertive Behaviour. Theory, Research, and Training
Routledge

Rutter, Peter M. D.
Sex in the Forbidden Zone – when men in power – Therapists, Doctors, Clergy, Teachers and others – betray women's trust
Mandala

Ryle, Anthony
Cognitive-Analytic therapy: Active Participation in Change
John Wylie & Sons

Segal, Hanna
Dream, Phantasy and Art
Routledge – New Library of Psycho Analysis

Skynner, Robin
Explorations with Families. Group Analysis and Family Therapy
Routledge

Solms, Mark and Saling, Michael (trans. & ed.)
A Moment of Transition: Two neuro-scientific articles by Sigmund Freud
Institute of Psycho-Analysis – Karnac Books

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John Wylie & Sons

Tustin, Frances
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Vaughan-Lee, Llewellyn
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Tavistock-Routledge

Winnicott, D. W.
Maturational Processes and the Facilitating Environment
Karnac Books

Yalom, Irvin D.
Love's Executioner and Other Tales of Psychotherapy
Penguin

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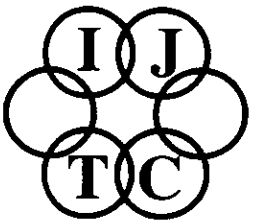

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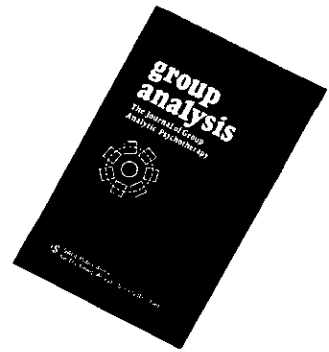

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