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FROM THE SILENCE OF THE SOMA TO THE WORDS OF THE PSYCHE

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Psychosoma and psychoanalytic process

I hope in this paper to conceptualise the means through which the body-mind matrix (from which all psychic structure originates) may, in the early transactions between mother and infant, be a determining factor in the tendency to somatic rather than psychological reactions to internal or external stress, and the articulation of psychosomatic phenomena with language.

The risk of somatisation is greater for everybody in circumstances in which there is an unusual increase in internal conflict or external pressures. There is scarcely any patient in psychoanalytic treatment (or any analyst either) who does not, at some time or another, display somatic disturbance due to psychic distress. But as analysts we are more concerned with those patients whose psychosomatic manifestations are a prominent part of their overall clinical picture, and with the extent to which these may or may not be helped by psychoanalytic therapy.

We might pause for a moment to ask how we are to define psychosomatic as opposed to organic disease or bodily disfunctioning with no organic basis, such as we find in hysterical phenomena. I am including in the definition of psychosomatic phenomena any organic illness for which there is no biological cause and which would appear instead to be a reaction to psychological distress. This would include not only banal phenomena such as insomnia and other inhibitions of normal bodily functioning for which there is no physical reason, to allergies of all kinds, and of course will include what have come to be known as the celebrated 'Chicago Seven' (because of the early research of Franz Alexander and colleagues in Chicago.) These illnesses, classically considered as psychosomatic are: ulcerative colitis, bronchial asthma, skin allergies, thyroid gland disease, rheumatoid arthritis, gastric ulcer and high blood pressure that has no physical determinant.)

My own theoretical voyage

My interest in observing and trying to understand the unconscious significance of psychosomatic manifestations in the course of psycho-

analytic treatment derived from a larger interest, going back many years, an interest in detecting the factors that tend to escape the analytic situation. That is conflicts, anxiety situations, fantasies and character patterns that are never mentioned in the course of the analysis, but in which unacknowledged mental pain and psychic conflict, whether stemming from inner instinctual pressures, outer environmental stress or even tensions created by the analytic process itself, are being discharged in some form of action outside the analytic situation. The analysand does not question this kind of behaviour, since it is something that is felt to be part of his way of being or an habitual way of coping with stress, and the analyst therefore remains unaware of it. My first inkling of this sort of leakage came about through a countertransference feeling of stalemate in the analytic work. Something was escaping the therapeutic situation and neither I nor my patients seemed to know what it was. (I might add, that these acting out patterns, which I came to call 'action symptoms' may also contribute to an outcome that is feared by all of us: the interminable psychoanalysis).

Action symptoms short circuit the work of psychic elaboration that is required to construct psychological symptoms. Of course I came later to realise that these forms of discharge in action as a way of dispersing emotional tension, are also attempts to find a solution to intolerable conflict, but such solutions follow a more primitive pattern. Briefly, we might say they depend less on language and thus can be thought of as a regression to an earlier phase of mental organisation, the ways of thinking of an infant, ('in-fans' which, etymologically, means 'a being without words'). We all have access, at all times, and throughout our life-span, to this form of mental functioning.

I should like to return for a moment to my definition of symptom: whether these are neurotic, psychotic, or character symptoms, action symptoms (such as addictions) or psychosomatic symptoms, they are all, without exception, the result of infantile efforts to find a solution to mental pain and psychic conflict. I formulate an unending plea for the respect of symptoms, for the need to remind ourselves how difficult it is to be a human being. And of course I am leading up to a plea for the respect and understanding of manifestations of a psychosomatic nature: while they may be life threatening, they are nevertheless an attempt to survive psychically.

We are all obliged to develop psychic organisations and mental structures to deal with the physical and mental pain we are going to

meet from birth onward. If we are able to do it at all, this depends on two major factors. First: *the capacity we all have, as human beings, for the development of symbolic functioning*. Second: *the extent to which our personal history and early environment were able to help rather than hinder the development of this capacity*. What is important is the extent to which the *parents' unconscious problems* may have rendered the task of growing from infancy to adulthood more difficult than it already is.

Most psychic pain arises from two problematical challenges that face every human being: the first of these is the complicated process of acquiring and assuming one's sense of individual identity and the second, that of coming to terms with one's gender identity and assuming one's future sexual role. Freud was the first to emphasize the inherently traumatic nature of human sexuality; Klein and the post Kleinians (in particular Winnicott and Bion) have thrown light on the much earlier traumas that are involved in separating oneself out from the primordial Other, in order to become an in-dividual (someone who belongs to himself, who is an in-divisible unit). Both of these essentially human dramas: the acquisition of subjective identity and the acquisition of sexual identity involve a mourning process; and this naturally requires some reinvestment of what has been given up. The first conflict turns around the desire for fusional oneness versus the desire for separation and individuation, and the second around the equally difficult conflict aroused by the desire to be both sexes: this entails the wish for libidinal possession of both parents as well as possessing their sexual organs and the magical powers that each sex symbolises in the mind of the young child.

Individuality and monosexuality are major narcissistic wounds to the megalomanic child, but they are richly compensated: overcoming the claim of fusional rights includes renouncing the magical fulfilment of wishes (as in babyhood) without having to pass through the code of language. The second great narcissistic blow, the demand to give up bisexual and incestuous wishes involves the renouncement of the impossible demands attached to the oedipal crisis (in both its heterosexual and its homosexual dimensions) is of course compensated by the gift of sexual desire and satisfying love relations.

The answers we find in childhood to these conflictual wishes, and the psychological processes that they initiate, will be maintained throughout our lifetime, using considerable psychic energy. Some of these solutions will make life a creative adventure in spite of the

inevitable frustrations and disappointments that are part of human life, whereas other solutions will be maintained at the expense of psychic and frequently somatic well-being also. The latter, the somatic reactions, invariably involve some breakdown in the capacity for symbolisation and therefore in the capacity for elaborating mentally the impact of stressful experiences. When anxiety, distress, unacknowledged rage or terror, are somatised instead of being recognised and worked over mentally, the subject is using some primitive form of thinking in which the signifiers are of a preverbal nature. In other words we are observing a regression to infantile ways of dealing with stress, for a baby can only react somatically to psychological stress when this is not able to be modified by its mother's handling and care.

Whether this results in an addictive psychic economy or in severe psychosomatic explosion, these so-called solutions originate in the early phases of psychic organization, before the use of symbolic communication (in the form of language). In other words, the individual in question is using earlier forms of symbolic functioning. (We might call it a 'protolanguage.' I shall come back to this idea later.)

As a result of my interest in addictive patterns in which affect was discharged in action rather than being represented mentally and therefore available for thought and verbal expression, I became interested in the problems of affect as such and the different ways in which it became inaccessible to conscious thought. (Two chapters in *Theaters of the Mind* deal with this question and I have extended my reflection on the 'addictive economy' in *Theaters of the Body*.)

It was about this time that I began to follow with interest the research of the psychosomaticists: the Paris School with their concept of 'operatory thinking' (a delibidinised way of relating to the outer world as well as to oneself) and the research of the Boston School which led to the concept of 'alexithymia' (the inability to name and recognise one's emotions, or if experienced, to distinguish one emotion from another).

However as time went on, I discovered that many severely polysomatising patients, my own and those of my students, were neither operatory thinkers nor alexithymic, and this led me to further hypotheses regarding psychosomatic vulnerability.

From there on I became interested not only in the psychic economy that underlies somatisation but also the primitive symbolism and protocommunication that is seeking expression through psychosomatic symptoms.

The body-mind matrix

I should like now to consider the body-mind matrix from its beginnings in the new born infant. At the origins of psychic life, body and mind are not yet experienced as separate, and in addition, there is little clear distinction in the nursling's psychic experience between it's own body and self and that of the mother's body and being. In the beginning mother is not yet another human being but at the same time she is something much greater than this, she is a total environment of which the infant is but a tiny part. Although modern research points in the direction of a 'core self' already existant in the newborn baby (Daniel Stern; Carole Morgan), without too much stretch of the imagination we might posit the existence, in the psychic experience of the infant, of a universal fantasy in which there is only one body and only one mind for two people.

Even in adult life the fantasy of fusion continues to exist in the deeper recesses of the mind. Deep inside all of us there is a longing to return to this undifferentiated universe in which all needs are cared for, in which there are no desires and no responsibilities. At the same time the fulfilment of such a nostalgic longing would mean the loss of personal identity and would therefore be equivalent to a form of psychic death.

What then are the psychological consequences for any individual who has not been helped to compensate adequately for the loss of illusory oneness? This fantasy may, through its unconscious force, become an important contributary factor to (among other pathological outcomes) the outbreak or the perpetuation of psychosomatic illness.

Before coming to the consideration of severe psychosomatic dysfunctioning, and its genesis, I would like to repeat that we are all likely to somatise when internal pressures or external circumstances overwhelm our usual defenses against mental pain, or our habitual ways of discharging, or mentally dealing with, stressful emotional experiences.

To come back then to the beginnings of mental life, and the first traces of psychic structure, the fusion-confusion between one body and another deserves attention because of the role it plays in the psychic economy of any and every individual (being an important element in the capacity to experience orgasm and also to be able to sleep without difficulty) but particularly as a contributing factor to psychosomatic vulnerability.

The fantasy of being merged with the primitive mother-universe has, of course, a biological prototype in interuterine life in which the

mother's body literally serves the vital needs of two beings. After birth the baby seeks to prolong this blissful state, and will cry whenever the illusion is lost. In the same way, most mothers intuitively try to recreate the illusion for their nurslings through the warmth of their bodies and the sound of their voices, holding them, rocking them and singing to them. This enables the introjection of a first memory trace of the maternal environment which helps the infant to overcome physical or psychological distress and also enables it to fall peacefully asleep.

And here we come upon one of the earliest forms of disturbance in the mother-nursing dyad and one that may readily lay the groundwork for future psychosomatic fragility. While it is normal for a mother to share the illusion of merging and oneness with her baby in the first weeks of life, some mothers, for a variety of unconscious reasons, prolong the continuation of this fusional fantasy, and indeed unconsciously experience their children, long past early infancy, as an integral part of themselves. Thus they ignore the baby's signs and signals and impose on their infants their own interpretation of what their baby needs and wants. In other words it is the mother's separation anxiety and not the child's that is the problem. (Infantile sleeping disorders provide us with a clear example of this. See Dilys Daws: 'All Through the Night.')

This then leads to the mother's inhibiting another equally important psychological need in every infant, that is the parallel drive towards separation. A mother who wishes to remain as one with her baby, because of unconscious conflicts and unresolved problems stemming from her own childhood experiences, will tend to remain blind to her baby's need to differentiate itself from her own body and self, and prevent it from taking any spontaneous action that has not been initiated by the mother.

We can observe this phenomenon in two different ways: first through studying psychosomatic illness in babies and second in psychotherapeutic work with adults suffering from psychosomatic disturbances or certain severe narcissistic pathology.

I have referred frequently to all that we are able to learn from psychosomatically ill infants, concerning the mother-baby dyad (which includes in a most important way the father, and the role he occupies – in both real and imaginary ways – in the mother's life). These observations play an important role in confirming theories of early psychic functioning and the transactional world of the infant and its mother, much as the experiments with hypnosis in Freud's time confirmed his theories about the unconscious and its timeless qualities.

Body and language

We come finally to the important theoretical question of the relationship between body and language; that is the verbalisation of body experience and the corporalisation of language.

In fact the dissociation between body and mind is a perfectly arbitrary one-a dictum inherited from Cartesian philosophy-and one that can cloud our thought and even affect our theoretical conceptualisation and our clinical work.

Can we indeed affirm that the body has no 'language'? Perhaps it is the only language that cannot lie! In addition it is evident that the body and its somatic functioning have a remarkable memory.

To return to the infant: the infantile psyche is manifestly organised in a prelinguistic mode, yet we are well aware that the first transactions between mother and baby take place in an atmosphere that is impregnated with language: the 'mother tongue.' From birth onward the tiny infant is surrounded by environmental influences that are organized by a system of verbal signs and meanings. At the same time another language is being transmitted. The infant's small body as well as all its sense perceptions are in constant contact with the mother's body (her voice, her smell, her touch, her warmth) so that the baby's body receives these early language signs almost like bodily inscriptions although accompanied and offered by speaking individuals. This is surely the reason that somatic experiences are always capable of being translated into words that affect everybody – and the same may be said of the words that convey emotion. These too are rooted in bodily metaphors: we 'tremble' with fear, we are 'crushed' with sorrow, 'weighed down' with cares, 'choked' with anger; our hearts 'beat' with pleasure or are 'pierced' with grief. An affect can never be considered as purely a psychic phenomenon, nor as purely a somatic one.

Clearly the body is always, from the beginning, interwoven with the symbolic world. But it is not yet a question of verbal signifiers. The celebrated formula of Lacan 'the unconscious is structured like a language' leaves much to be desired if we are to reflect more closely on the early relation between psyche and soma.

In the same way every analyst has had occasion to witness a severe split in certain patients between psyche and soma, that is, a striking separation of language from body experience. There are individuals who have a brilliant command of language and logical thought but accompanied by total deafness with regard to their somatic language. In some cases the split between soma and psyche, when it applies to

the messages of emotion, may create a psychic economy in which addictive behaviour, character patterns of an acting out variety and somatic explosion may be feared. These different forms of action in a certain sense may be thought to take the place of the missing words and verbal thought, and thus act as a unique kind of communication.

Of course we all, like Freud, are readily fascinated with, and indeed hypnotised, by words. Throughout his life Freud displayed a remarkable confidence in the power of language. For him words were invested with magic; as he put it 'magical in their very origin.' It is noteworthy that Freud never wavered from this position, even after his discovery of 'the demoniacal power (these were his words) of the death instinct.' This all powerful instance itself could not attack the written word. Even when Freud witnessed dislocation, fragmentation and relentless destruction in both the internal psychic world and the world of external events, in the midst of catastrophe, his faith in language held fast.

Thinking in this context of the biblical phrase: 'in the beginning was the word', I began to ask myself if this were not the heritage of a paternalistic religion. In the beginning was the voice, and before that, in the interuterine world, there was already sound, movement and rhythmic beating – the dawn of music. Did not Freud himself admit that he could understand nothing about music, that he was insensitive to its charms? Clearly he did not admit of such a penetration into his heart and soul. Is it not feasible to suggest that Freud may have erected a phallic barrier of words, taking language (as Lacan does) to be representative of the paternal order, in order to protect himself from the voice of the siren, the power of the primitive mother?

Whatever may be the answer with regard to Freud and his mother's voice, everyone knows that a mother gives not only words and phrases to the baby she holds in her arms. The very timbre of her voice is impregnated with her own bodily self and its emotions. Our words are capable of caressing – and just as readily of wounding – another person. The sound of a voice may be warming to the heart, or chilling to the ear; it may have the same effect as a gesture or a way of looking at another person. But here the voice insinuates itself into the bodily self, whereas looking – the visual world – tends rather to create a distance from the other, as do words themselves.

The work of Didier Anzieu in France has given great importance to the early 'skin' self ('le Moi-peau') but I should like to plead also for the concept of an early 'olfactory self' and indeed a 'respiratory' and a 'visceral self', as other equally important sources of preverbal signifiers that contribute to communicative exchange between mother

and nursling and the early structurization of the psyche. In this context it must be emphasized that *it is not the perceptions in themselves that we observe and that interest us, but the way in which they are registered psychically.*

It is clear that these infraverbal signifiers cannot be repressed in the manner in which this concept is classically defined by Freud: that is a psychic mechanism which maintains, in the unconscious, representations that are linked to drives through the medium of verbal thoughts and memories. Since infraverbal memories cannot be dealt with in the same fashion, they run the perpetual risk of giving vent to their dynamic force by sudden eruption either in the form of hallucinatory experiences, or in the form of somatic explosion.

This gives rise to a difficulty in capturing and thus becoming aware of any mental representations (whether from inner or outer sources) that threaten to be highly charged with emotion. Patients in which this type of psychic economy predominates, are handicapped in representing mentally much that occurs in their psychic reality and their emotional lives: an apparent *incapacity to dream*; a *blockage in waking fantasy life*; expression of conflict through *action rather than through mental elaboration*, and so on. My clinical observations over the years have led me to discover that behind a facade of seeming normality lie psychotic anxieties: these come to find verbal and imaginary expression in terms of a terror of nothingness, of chaos, fears of being sucked into a void, of being emptied out, vampirised, or falling apart physically or mentally. There are also many confusions: for example between outer and inner perceptions, between self and other, between the real world and the imaginary.

The protective shield of 'pseudo-normality' often helps these patients go about their daily lives, and in fact frequently permits them to engage in highly intellectual pursuits or run important enterprises with great efficiency. I came to call these analysands 'normopaths' and to consider their pseudo-normality as a sign of deep, unrecognized distress. Years of clinical experience also taught me that the psychosomatic vulnerability of these patients was extremely high and that many of them already suffered from a number of illnesses usually considered as psychosomatic: such as gastric ulcers, high blood pressure, asthma and skin allergies.

The task of analysis is then directed toward hearing the anonymous terrors behind the analytic associations (what Bion called 'nameless dread'). Our task then becomes that of helping our analysands first of all to find the courage to listen to their feelings, to support the over-

whelming anxiety that slowly becomes perceptible, to imagine what fantasies might accompany such emotion, finally to name the formerly nameless dread and thus to be able to think about it perhaps for the first time in his memory. This nameless dread, against which such patients have defended themselves all their lives, may then acquire psychic representation at the level of verbal thought. These representations therefore become capable of being explored in fantasy and, eventually, of being linked to present day conflicts and analyzed with regard to their unconscious meaning.

Everything tends to confirm that these overwhelming anxieties result from traumatic events that have occurred in earliest childhood before the acquisition of language. (However this nameless dread may also arise in patients who have experienced unassuaged terror at a time when they were totally verbal, if the events are such that their capacity to use verbal thought is put out of action. The work of Henry Krystal dealing with concentration camp survivors is illustrative in this respect.)

Of course what interests us is the way in which, during our analytic work, we capture such communications, and are able to follow the gradual coming to consciousness of the infraverbal experiences that are struggling for expression. This struggle to find words to contain and communicate these early events is often an inaugural experience in the patient's life.

To illustrate these hypotheses I am going to take a few short vignettes drawn from the analysis of a patient whom I have called Paul Z. [(I first quoted a brief extract from this analysand's analysis in an article written some twenty years ago and published in French in 1974 under the title 'Corps et Discours' (Body image and Language). This eventually became a chapter in the book titled: *Plaidoyer pour une Certain Anormalité* (1978), English version (updated): *Plea for a Measure of Abnormality*, (1989).]

The fragment of analysis quoted here was noted from work with the same patient some years later, published in 1979 under the title 'Corps et métaphore' ('Body and metaphor') and was also eventually included in a book titled in its English version: *Theaters of the Mind: illusion and truth on the analytic stage.*

I took many notes on this analysand because to begin with I didn't understand his mental functioning. Also I was fascinated with the way he used language – poetically, but without ever being able to express clearly what his feelings were. In fact he was terrified of his feelings

and was afraid that to let his thoughts and emotions run freely would make him go crazy, as we shall see.

Paul was 39 years of age when he first came to see me. I had told him on the telephone that a consultation was possible but that I had no place for an analysand for another year. A good looking man, director of a small enterprise, he surprised me by not once looking into my eyes while he talked. He seemed to have difficulty in finding his words, but other than that appeared composed and spoke in a measured voice with little trace of emotion.

PZ: 'I've come to see you because there's something wrong with the way I live.' I invited him to tell more about his way of living and he went on to talk about his work where he felt he was well regarded but he added: 'as long as there's no hostility in the air. When that happens I am seized by a strange feeling. My arms shake. I suppose it's panic. Anyway when it happens I can no longer think, or even utter a word.'

As though this experience that he found difficult to describe were linked to his bodily health, he went on to say:

PZ: 'I have a long history of gastric ulcers. I was in my early twenties in the middle of my university courses. My life was a desert. I lived in absolute solitude which for some reason I associate with the ulcers. I spent two years trying to find a position that was comfortable for walking, studying or eating. Although I was in constant pain, I didn't give it much thought ... used to tell myself that if you're alive you have to expect misery.'

Still not looking at me, Paul continued as though this misery were a punishment for his sexuality.

PZ: 'My sexual life was a desolation. Masturbation filled me with a sense of horror because of all my father's dire warnings about it. So I would feel dirty, degraded, valueless. I also had rapid relations with girls but they never led to any continued friendship. I was too tied-up to have a normal woman.'

After a long pause he went on.

PZ: 'And then the ulcer perforated when I was nearly thirty.'

He goes on to discuss his difficult relationship with his wife, Nadine.

PZ: 'We met at the university where we were both studying Political Science. We've been married twelve years. ... She criticizes me all the time, but the worst is that she rejects me sexually. However, I'm not that easy to live with either.'

I then asked Paul what he hoped for from his analysis.

PZ: 'Nothing is as it should be in my life. Everything soft, colourful

and musical escapes me. It's all blocked – here.' (Paul laid his hand on his heart.)
JM: (imitating his gesture) 'Here?'
PZ: 'Yes, it's uh ... well, how would you say it ... (he seemed to struggle to find the words) ... it's like sobbing in my heart.' ('Sanglots dans mon coeur').

After a short silence, during which he continued to stare at my walls but still carefully avoiding any eye contact, he went on in the same rather emotionless voice.
PZ: 'The gastric ulcers keep recurring but there's nothing to be done about it. It's been going on for eighteen years. Like all my skin allergies. Something I just have to put up with.'

In saying this Paul scratched the back of his hand then made a movement as though to touch his sex. He looked at me briefly and said, 'Well when can we begin?' I repeated what I had said on the telephone, that I would have no place for another year yet.
PZ: 'And how much will it cost me?'

I told him my fees. Again he threw me a rapid glance and said, 'I have a friend who pays less than that for his analysis.' I offered to give him names of analysts whose fees were lower than mine. He replied in an offended voice.
PZ: 'No thank you! So we see each other in a year's time?'

I suggested he call me some time in the following year if he was still sure he wanted to begin analysis with me.

My first impression after the interview was that Paul was suffering from depression, but on reading my notes some months later I realised that he had been truly unable to express his feelings of depression. Instead he had struggled to communicate them in a concrete way, laying his hand on his chest and saying: 'It's stuck here' and also a metaphoric translation: 'like sobbing in my heart,' in the way that children – and poets – communicate.

In exactly one year to the day, Paul telephoned asking when we were going to start! I understood later that this was part of his way of functioning, as though he enjoyed a magical belief that everything he wanted would automatically occur. I learned also that I was experienced as a part of Paul himself and there was therefore no need to inform me of his decision to keep to the tentative project made one year ago. Coupled with this was his conviction 'that one shouldn't reflect too long over anything important,' but 'harden one's body against troubling thoughts' and 'just plunge right in.'

In the years to come I was to learn that Paul experienced his mother

as someone who had total rights over his body, and that she had breast-fed him until the age of four.

During the first years of our work together, Paul was frequently silent, or else would vituperate against his wife and her lack of enthusiasm for their sexual relationship. He dreamed very rarely and produced no fantasies. However he frequently mentioned the return of his ulcer and his various dermatological problems and I began to wonder whether these took the place of dreams and fantasies.

I was a relatively young analyst at this time and understood little about the underlying significance of the somatic complaints of my different patients, but I frequently had the feeling that something was escaping me. I began to take more extensive notes and I encouraged Paul to try to capture his feelings and fantasies and search for any links between these and his somatic outbreaks. I had pointed out to him on numerous occasions that he frequently had eczema and a return of the ulcer just before a vacation break. Little by little we found traces of long forgotten childhood and adolescent attempts to deal with his overwhelming anxiety not only about his sex and his body, but about his whole feeling of identity. He would allow himself now to be invaded by sudden eruption of ideas and grasp hold of strange perceptions and sensations which before had apparently been forcefully ejected from consciousness. He thus taught me a great deal about the psychic economy that underlies psychosomatic phenomena. (See McDougall, J: *Em defensa de una certa anormalidade*, *Chapter 9* 'Corpo e discurso,' concerning the first part of this analysis.)

The session I now wish to quote was taken some three years later than the analytic work referred to above, at a time when Paul was visibly much more relaxed than he used to be. Now he looks at me, and although he still rushes precipitately onto the couch, his whole attitude is distinctly less tense and bizarre that it used to be.

During last week's sessions Paul had developed a series of daydreams in which he imagined himself hollowing out 'large black craters' in women's breasts, a theme inspired by a poster he saw daily, of a woman with naked breasts. This theme has been accompanied by another preoccupation, in which Paul, in his quick glance at me before flinging himself on the couch, would perceive me as 'smashed up' or 'physically ill.'

PZ: 'Are you tired? If you only knew how anxious that makes me! I'm always terribly afraid of finding you looking worn out. Don't know why.' (Long pause).

JM: 'You may remember that last week you imagined yourself digging

black craters in women's breasts. Might this sort of activity make a woman look tired and worn out?'
PZ: 'Now that irritates me, because it has nothing to do with reality. I'm not at all interested in fantasies!'
JM: 'You see me looking worn out, rather like the other day when you found my face was "dislocated." Would these impressions arise in place of imagining or feeling something concerning me?'
PZ: 'I sometimes "see" strange things just before falling asleep, and it terrifies me.' (Paul rarely has memories of dreaming.)
JM: 'As though there too you might avoid having fantasies, or let yourself imagine just anything, like in a dream? Maybe if you refuse to let such thoughts come up, they appear in front of you like real perceptions?'
PZ: 'But I've every reason to stifle my mad ideas. They cause me much greater panic than the things I "see." My ideas are truly horrible. Something important has changed though. I can now look people in the eyes, and I'm no longer afraid of their looking at me. It still troubles me because I see them all smashed up much of the time, but that doesn't worry me like it used to. So they're like that! (long pause) Or is it *me* who makes them look way?'
JM: 'Like the way you saw me just now?'
PZ: 'Yes, it's exactly the same! *I have a destructive stare.* Mon Dieu, why do I do that? What do I reproach you with? ... I've got it! ... your interpretations. I hate them – especially if I feel they are important and useful to me. ... I can't take it when you think of things first.'
JM: 'As though you were afraid of being dependent on me? That I might possess something you could need?'
PZ: 'Exactly! Especially if it's something I could have thought for myself. At those moments I'd like to tear you to bits.'
JM (remembering the fact that Paul was breast-fed for nearly four years): 'Like a small child who's hungry might feel furious to have to depend on its mother, depend on her breasts, in order to be fed? Would that make him want to "tears them to bits"?'
PZ: 'You know, I think that's very true. And I hate you for that. Merde alors, why should I have to *need* you?'

Paul then began to think of his father (about whom he rarely ever spoke in his eight years of analysis). He remembered how 'strong and calm' he was at home; I believe he needed this image of his father at this time to protect him against the vision of the sadistic attack he might make against his mother's (the analyst's) breast.
PZ: 'My father was so concerned about bodies and dirt that I could

never imagine how my parents ever made love. My dad always issued grave warnings against the dangers of masturbation, and yet curiously enough he pushed me constantly to be "virile." I was never to forget that I was a "man." I had to screw! Like a masculine ideal that was beyond my capacities.'

(This portrait of Paul's father suggests that the father might have wished his son to live out heterosexual wishes in his place so that he might, through identification, participate homosexually. I also recalled that he had often spoken of his mother's outbursts of crying at night. It seemed evident to me that his image of the primal scene, as it applied to his own parents, would include a fantasy of sadistic attack. While pondering this I leaned forward with the intention of asking Paul what he thought about it.)

PZ: 'What's the matter with you? Mon Dieu, what's wrong? You moved suddenly.'

JM: 'What might be wrong?'

PZ: 'My first thought was that you'd had a cerebral hemorrhage! I saw you quite clearly before my eyes, your face out of joint and dislocated. Paralyzed for good. It was really horrible.'

JM: 'If you behave like a virile male, as your father said you should, then I'll have a cerebral hemorrhage?'

PZ: 'Mon Dieu, if you only knew ... the worst is that I truly believe it! I'm really afraid of destroying you and smashing you up. You're fragile and I have to be very careful of my thoughts about you. (Long pause) I wonder if you realize how great my panic is?'

JM: 'What might happen to me?'

PZ: 'I'm scared to tell you ... it's because of that poster – the girl with the beautiful bare breasts, and I was so frightened because I dug those big black craters – you know it's come true! I saw the poster again yesterday and *I saw the craters*. When I got up close I noticed there were huge flies on her breasts, and I swear they made craters just on the nipples. I nearly fell over ... everything spinning. All my old ideas came rushing back. Impossible to stop them.'

Paul tosses his head from side to side as though to shake the images out of his mind. A simple external perception has suddenly come to confirm an inner fantasy and brought him perilously close to a psychotic moment. He mutters, 'I saw them, I saw them!' So I ask him, much as I would have done if it had been a dream scene:

JM: 'And what about the flies?'

PZ: 'They're the kind of flies that sit on shit. Good heavens – the

black craters – would they be craters full of shit? Have I thrown all that shit on them?'
JM: 'Maybe all your shit produced that cerebral hemorrhage in me?'
PZ: 'Yes, you're absolutely right. I know exactly what the cerebral hemorrhage means – it's the orgasm! Women's orgasms fill me with horror ... always the same image of her inside in a state of liquification ... everything black and shapeless and floating about.'

Paul's primitive and condensed Oedipal organization, fraught with sadism and largely built around the presence-and-absence of the breast-mother, has been very little elaborated, and has left him with a persecutory vision of the external world. His capacity to expel troubling perceptions from the psyche, however, has enabled him to keep terrifying ideas at a distance. Grafted onto his archaic sexual fantasy is an adult sexual life of a false-self kind; the father, though lacking in symbolic significance in Paul's inner world, nevertheless incited him son to 'virility' and thus to a certain phallic-genital compliance, giving rise to a form of 'pseudogenitality' and 'pseudonormality.'

Without any representation of his father as playing an important role, whether real or symbolic in his mother's life, and with no belief that his parents' bodies and sex were complementary one to the other, he can only imagine his mother as an unending chasm; thus every sexual act was unconsciously lived as terrifying and dangerous. We might summarize Paul's unconscious dilemma (and that of many others who resemble him) in these terms: It is dangerous or even fatal for me to love a woman and to have sexual relations with her. Not only do I risk destroying her, but I too may be destroyed in return. Yet my father pushes me to be 'a man,' pushes me to smash up my mother and also pushes me to my own death (a death that perhaps he is afraid of and wishes I would undergo in his place).

At the following session Paul again takes up his vision of my face broken up.
PZ: 'Oh, là! Now you're the one who's getting it. But I mustn't even think such things, or you might really fall ill. I'm terribly afraid of such thoughts, you know.'
JM: 'Afraid your fantasies might be magic and fulfill themselves?'
PZ: 'There you go again! OK, let's plunge on. Why is it so terrible to imagine you with black craters in your nipples anyway? (He tosses his head from side to side again.) But I know why! It's because for me the breasts are the most beautiful, most soft, and most sensual part of the woman's body. I just can't bear to see myself attacking them. (His voice trembles and he seems to be on the verge of tears. This

might well be considered as an approach to the depressive position as defined by Melanie Klein.) I feel as though I destroy everyone. Nadine – my mother – I look at them and I see them looking grotesque, deformed, aged. But with you it's worst of all. To you I mete out death. It's truly horrible. (Long pause) I really don't understand anything anymore. Why is everything erotic invariably full of horror for me? I want to make love and I imagine scenes of torture. Ow! I'm beginning to have terrible gastric pains! I harden up my whole body, tighten my inside, to *prevent* such horrible thoughts; if I tense up enough maybe they won't come to mind. But that's a bit crazy. What's wrong with these thoughts, anyway?'

(While he is exploring this idea he suddenly becomes aware that his sharp gastric pain has disappeared. He is astonished by this 'miracle', and he begins to question his way of using his body to prevent himself from thinking.)

PZ: 'But it would mean total confusion to allow just any thoughts to take possession of me. Disorganization – illness! I couldn't stand it. I'd go crazy.'

The eyes attack themselves:

A further fragment from Paul's analysis illustrates the 'neurotization' of his conflicts. He continued to have sudden 'visions' and pseudoperceptions, but in the weeks following the sessions just described he was able to examine them more thoughtfully and with less fear that he was going crazy. During this period he also became aware of 'blind spots' in his field of vision; his preoccupation with this phenomenon, which he referred to as his 'scotoma', reached hypochondriacal proportions. After a visit to the opthalmologist he reported that there was nothing wrong with his eyes: 'I just don't see things the way I should.'

This indicates that Paul now uses his body-images metaphorically. That is, he is beginning to 'de-somatize' his approach to himself. He still has pseudoperceptions, but he now questions them. In this session he speaks of a woman at work who attracts him sexually and whom he refers to as 'the young mother'.

PZ: 'I can't stop thinking of her breasts and her fragility – um – where was I? Funny, I've completely lost the thread of my thought. A void. Just as though I were up against a blank wall. Good God! *There's my scotoma back again*!'

(Sudden repression is followed by the reappearance of the hysterical manifestation.)
JM: 'What were you thinking of just before the scotoma appeared? When you said you felt you were up against a blank wall?'
PZ: 'Haven't the vaguest. Don't even remember what I was talking about.'
JM: 'The young mother who seems so fragile ...'
PZ: 'Oh là là! Do I dare let myself think just *anything* about her? Well, I see myself undressing her, and I'm biting her breasts, and I start to make love furiously to her, like a madman, and I sodomize her, and I eat her feces ... I can't do this! If I follow your system of saying everything that comes into my mind I'll go quite crazy. Heavens – the scotoma has disappeared!'

Archaic hysteria and its transformations

Such symptoms might well be described as a primitive form of hysteria, a defense against pregenital libidinal wishes that have remained blocked and encapsulated rather than elaborated as fantasies to be subsequently repressed. As we can see the 'black craters in the breasts' now seem to have become 'black spots' in Paul's eyes. In the above session however, it may be seen that Paul is no longer faced with anonymous terror. He is now able to attach his painful affective states to mental representations; these begin to reflect common infantile sexual theories and their accompanying pregenital impulses. In the sessions that followed, Paul frequently observed the 'scotoma' whenever he was angry or filled with violent erotic fantasy.
PZ: 'The scotoma makes me anguished, and I'm sure that it's a way of not seeing, that is, not *knowing* something, but the trouble is I don't know what. At such moments I'm filled with a most terrible anguish, like a frenetic primordial dread, especially just after making love – I simply can't look at the woman; *she becomes a vampire.*'
JM: 'Yet you were the one who had daydreams of eating up women who attracted you sexually – like the young mother: you wanted to eat her breasts and her excrements. Do you think that the frightening and destructive side of *your own fantasies* could make you afraid that the woman is going to vampirize *you*?'
PZ: 'Oh, I don't know about that! God, I've got palpitations just thinking about it, exactly the same palpitations that I get now when I make love – or even thinking I'd like to. In that Polanski film about

vampires the man carried off the pretty girl. Tiens! *The vampire was a man*!'

JM: 'Are you the vampire, then?'

PZ: (laughs with astonishment and delight at this discovery) 'Of course, it's me!! How come I never thought of it? I'm sure all this has to do with my sexuality.'

(We see that in Paul's fantasy, making love is equivalent to destroying the partner.)

PZ: 'Why is all erotic pleasure turned into poison for me? I can see those black holes in the breasts again – just like dead holes, as though they'd been stung by hornets. Yes, that's what they are – poisonous bites into the nipples. (Long pause). I believe I've always associated eroticism with death. Sometimes lately I'm afraid to make love to Nadine. I get an image of those hornet holes – and suddenly I lose my erection. Otherwise I'd be making love in that dead hole!'

JM: 'As though you wish to avoid being the hornet who attacks the breasts or who goes into the dead hole?'

PZ: 'Absolutely! I'm the hornet! The one who's dangerous; even my eyes can destroy. The vampire, that's an image of my father and also some part of me.'

Thus we arrive at the beginning of Paul's oedipal analysis. His psychosomatosis, inaccessible to verbal thought is gradually becoming an analyzable psychoneurosis.

The analysis lasted ten years and I have several times had news from Paul in the many years that have elapsed since then, in which he tells me, among other things, that his gastric ulcers and skin allergies have not returned.

I would conclude by saying that *Paul's true illness was not his gastric ulceration and neurodermatitis, but the profound split between psyche and soma, between his verbal everyday self and his emotional self, a split that had been constructed in order to keep deep pain and psychotic terror as well as archaic sexual fantasy from emerging*. His mind sent only primitive messages about these dangers, but as analysis continued his 'delusional' body with its deranged somatic functioning slowly became a symbolic one, a psychosomatic unity, which kept him in touch with his inner life as well as conscious of the impact of the outside world upon him. The incoherent *somatic messages* became *psychic representations* and the life forces in him sought many new avenues of expression. His relation to his children changed radically and his love-life also became richer and more satisfying. Finally Eros triumphed

over the destructive and deathlike factors that, until his analysis, had invaded and threatened to take over his life.

Conclusion

To sum up I would like to come back to the central question: *how does the biological body eventually become a psychological one*, a body image that can be *named*, that is *whole* and *erogenetically invested*?

There are, from the beginning of somatopsychic life, double messages that pass between psyche and soma. The soma, as Freud puts it, 'imposes the need for "work" upon the psyche,' by means of what he called its 'representative'. These messages concern states of need and a demand for satisfaction. The mind in turn sends messages to the body usually originating in the experience of conflict because no solution to the somatic message has yet been found. The soma must then reply to this emotional message. Of course for the tiny infant, physical and mental needs are not yet dissociated. We have seen from the vignettes taken from Paul Z's analysis how, on many occasions he confused somatic and psychic experiences, treating them as one and the same thing. (I think here of patients suffering from chronic pain syndrome who also confuse physical and psychical pain.)

It is clear that our body, the body we live in and of which we are consciously aware, is largely a psychological construct. Those aspects of our body and its functioning that do not achieve psychic representation do not exist for us.

One of the most important links between body and mind upon which I have insisted on many occasions is the role of emotion. *Affects are the most privileged link between soma and psyche, and any radical cutting of these links increases not only the eventuality of psychological symptoms but also of psychosomatic vulnerability.*

Thus we may propose that *psychosomatic symptoms are communicating a form of primitive body language*, and maybe they are signs of *a protolanguage which, early in the history of the individual, was intended to communicate something to the outer world.* To the extent that there is an image of an 'Other' believed to be capable of decoding and responding to this protolanguage we are justified in speaking in terms of *communication.*

It is important for us as psychoanalysts to realise that *this protolanguage frequently comes also to be used as a symbolic language*, as the analysis progresses, so that the distinction between 'purely psychosom-

atic' and 'purely hysterical' eventually becomes less clear. Each psychosomatic sufferer, under the impact of analysis, comes to experience his symptoms also as communications, to listen to them carefully, trying to understand the internal or external pressures that have beset him, and from there to invest the somatic outbreak with metaphor and meaning. Sometimes this has already been accomplished in that many a patient uses his or her somatic symptoms as the embryo around which to build neurotic constructions. In this way the symptom may secondarily acquire symbolic status such as we find in neurotic organisations.

Apart from this neurotic overlay, *the processes at work may be seen in many ways to resemble dream processes as Freud describes them. Freud regarded dreams as employing a regressive mode of expression of an archaic kind.* Might we not envisage many a psychosomatic expression *as a primitive body language for which the nervous system is potentially programmed in everybody*? (In much the way that Chomsky conceptualized the deep structure of language?)

The task of the analyst is of course to translate this *biologic* into '*psycho*-logic' thus enabling an anarchic, psychosomatically expressive body to become, finally, a symbolic one.

GETTING INTO THE BODY

J. W. T. REDFEARN

Getting into the body is one of the biggest growth-industries of the West. This paper is not an exhortation to join the bandwaggon of these cults of the body, nor a bewailing of this mass flight to the body. I shall be pursuing an analytical approach, describing how one's ego, or 'I' as I prefer to term the ego of subjective feeling and experience, can sometimes get into the body image, the body as we subjectively experience it.

To give the reader some idea of how I approach the practical therapeutic issues involved, I shall describe two sessions with an analysand, a married professional woman in her early forties, whom I shall call Mary, after the nursery-rhyme 'Mary, Mary, quite contrary'. I'm sure she won't mind this and I want to say straight away she was by no means a contrary person on the whole. This fragment of analysis is just about a Mary bit of her, a Mary subpersonality as I am accustomed to call it (Redfearn, 1985).

She arrived rather late for a session having dallied at a reception at her place of work. I decided we should look at this lateness. She would not treat her children or her employees in this cavalier fashion. It was in her rôle of 'child' that she behaved like this. She took my love and approval for granted and 'messed me about' to a certain extent. She felt sorry about this when she realized how much she did this.

During the next session she spoke of her rigid pedantic superiors at work, as opposed to myself and one other friendly and admired superior. She said that in the environment of the disliked ones she seems to 'stick out like a sore thumb' (her words). At another time she said she must be a 'thorn in their flesh'. She then recalled that she had felt like that in her own family. She went on to describe how her superiors ought to negotiate with her and be more flexible.

Then she immediately went on to say she was feeling an aching pain at a certain place in her jaw. She wondered whether she had a growth there, a cancer for example. She often had worries that she might have a cancer. When I asked her to say more about this feeling in her jaw she could only say there was this sore place which she imagined was a cancer. I reminded her of what she had said in connection with her superiors and her family in her childhood; she had said that she was

like a sore thumb, a thorn, a sore place in fact, in relation to the parental figures. At one moment she is feeling like a sore place in the body of the family and at the next moment she *has* a sore place in *her own* body. 'I am a sore place' changes immediately to 'I have a sore place inside me'. To cut a longer story short, the sore place or cancer seems to be the subpersonality who is the revengeful shit-victim of anal control (of her anal-controlling subpersonality to be more accurate, of course), the rigid pedantic parental figure she tried so hard to believe I was *not* like.

So from one moment to the next the location of her 'I' in relation to her body-world scheme is reversed, quite unconsciously, and without any awareness of change of location of her 'I' or self, any change in viewpoint, any sense of migration of herself into a different place. The 'I' who was a sore thumb in her family, a thorn in her superiors' flesh, was for her exactly the same 'I' who had a sore place, perhaps a cancer, in her jaw.

In this instance the link between the two 'I's' was provided for me by her use of the word 'sore'. This was striking and hard to miss. You might say it stuck out like a sore thumb! But there were other factors. My hurt-parent feelings alerted me to the rebellious child part of her. The angry child is a pain, perhaps a pain in the neck, to the containing parent. It was no doubt out of my feelings of being hurt by her lateness and the reason for it that I wanted us to pay attention to her rebellious-child subpersonality.

In this instance the link was obvious and I was grateful to her for presenting me with it. But supposing she had not, or supposing I had missed it, could I have helped her attain *insight* into the pain-producing bit of herself? We all know that therapy is not merely a matter of *seeing into* the relevant subpersonality, but of entering into that rôle in a feeling sense, both feeling the rôle and feeling *about* it. So how could we have worked on the pain if she had simply come complaining of a pain in the jaw, which might be 'real' or hypochondriacal in origin. I suppose I could have encouraged her to feel herself into the pain in some way, or to be the pain, or imagine what the pain wanted to say or do to her. How far we would get would depend largely on how ready she herself was to make the link. As the therapist I might easily be fully aware of the subpersonality involved and not feel that it was the right time to interpret it as a 'shadow' part of herself, a part having a very negative and hurtful relationship with her own narcissism in all probability. For me the main way into such a subpersonality is through the dreams, the feelings, fantasies and behaviour in the trans-

ference, the counter-transference feelings, sensations and fantasies, and such non-verbal communications there might be. The therapist cannot possibly get all this together if he is either all body or is a disembodied intellect or spirit.

The disembodied analyst

In supervising trainee analysts I have for many years tried to help them to use themselves and their own feelings and bodily sensations in the detailed, here-and-now understanding of what the patient is unconsciously doing or trying to do. For example a question from a patient can be asked in many different ways. It may be concerned, hungry, needing of support, re-assurance, closeness, companionship, or illicit intimacy. It may be naive in this or other ways, or condescending, cutting, scathing, crushing, or simply information-seeking, or goodness knows what else. My first task as supervisor is to help the trainee with his own anxiety about answering questions and with his consequent temptation to fall back on some set technique or rule of thumb. One way of doing this, and a way I have found helpful, is to discuss with the therapist what the question made him or her feel or feel like inside. An invasive question may invade the therapist in a specific physical way. It is relevant to enquire where in the therapist's body or body-world schema the threatened invasion is experienced. The therapist may not quite remember but will sooner or later learn to use bodily feelings and sensations and emotional awareness generally to understand the underlying fantasies and impulses in the patient. These counter-transference experiences should of course be used along with all the other material we use in order to arrive with the patient at an interpretation. No one sensation or feeling is sufficient as a rule for this, any more than is one dream or piece of behaviour, the context being all-important. To the therapist who is not disembodied, there is no boundary between the concrete and the metaphorical insofar as the so-called metaphorical attack or whatever originates in the patient's body self and acts on the body self of the person attacked, even though there is no physical contact in the everyday sense. But this can only be appreciated by the therapist who is in his or her own body. In this area the supervisor can help to give the trainee sufficient freedom and space to use himself or herself as the most important tool of trade, without falling into the opposite error of ascribing everything to the patient's psychopathology and never one's own. This opposite error

is now becoming more frequent as the use of counter-transference experiences enters more and more into our teaching.

Illness as a way into the body

Jung and his followers have always been very conscious that our neuroses, our psychotic areas, and our bodily illnesses may lead us into neglected areas of ourselves. My next example of migration of the 'I' involves an actual as well as imaginary illness, an illness I myself had recently, which will elucidate at least two important subpersonalities within me. They are extremely infantile in their nature and, I hope, quite a contrast to the caring, teaching old man responsible for writing this paper.

In early June 1991 I was due to begin a holiday which, most years, I manage to spend sailing. This year I decided that I had to spend it writing this paper, otherwise it would not be ready in time. A week before the holiday I dreamt of my wife and myself staying in an hotel. When we were not occupying the bed in our room it was slept in by a shadowy character who was blind, mute, and semi-comatose. One could say that this particular subpersonality took possession of me during my illness a week later.

Two days before my holiday was due to begin I dreamt that I was on a naval working-vessel which was powering upstream and crashing into several pleasure-craft and canoes which were being carried along downstream willy-nilly by the strong current. I feared that some of the people involved in these collisions might actually perish. In the dream I did not see how the collisions could have been avoided, but immediately on waking I realized indignantly that it would have been a simple matter for the naval commander to telephone a warning upstream or use some other way of warning the people ahead in sufficient time.

The first day of my scheduled holiday was my 70th birthday and at the family birthday party I ate too much rich food and undoubtedly drank too much. That night I was taken ill with upper abdominal pain and a temperature. The illness lasted for the whole of my holiday and for a week or two beyond that. Two weeks after it began I was admitted to hospital for investigations to be carried out following indications of intestinal bleeding, but the only abnormality discovered after barium meal, ultrasound scan, CT scan and gastroscopy was gall stones. As the biliary system has given no further trouble it seems

possible that the illness was a violent reaction to my decision to work and not to sail, especially in view of the excessively destructive effects of the working vessel in the prior dream, whose warning I had not treated sufficiently seriously. Incidentally, regarding the semicomatose subpersonality, during the pain and fever I was unable to do any mental work, and indeed a premature attempt to start work on the paper produced a relapse into pain and fever. But later in the illness I dreamt one night I was a moronic individual who could not even use a telephone, and I awoke from that dream with my mental powers paradoxically restored.

An even more interesting subpersonality showed itself about a week after the illness first started. By this time there were signs of involvement of the lung and I began to fear that I might have cancer. The abdominal pain by now was less severe than it had been on the first day, and it had moved from the mid-line to just under the ribs on the right side. I had a dream that I was pregnant with what was called a cancer baby. The site of the pregnancy was where the pain was, just under the ribs. I was determined to hang on to the embryo and not have it taken away. My wife, myself, and another person who was a medical person would have to learn how to cope with this cancer-baby if I was to get well. On waking I 'knew' that I myself was the cancer-baby and that if my omnipotent demands were thwarted I would explode into murder and destruction. I was feverish and thirsty and wanted a cool drink. I was too shivery and in pain to feel I could get one myself and thought I would ask my wife to get it. But still in the rôle of the cancer-baby, I felt that if my wife showed any reluctance to get the drink for me I would murder her and wreck the bedroom. It took me over half an hour to summon up the courage to ask her to get me a drink, and then of course all was well. If she had in fact been reluctant I don't suppose I would have gone berserk but would merely have become quiet and felt angry, and cut off.

In this particular instance, when I crossed over the mother-baby boundary, i.e. when I awoke and shortly afterwards felt like the baby, I had a slight feeling of actually getting into the cancer-baby inside me, and indeed helped rather than resisted the movement from pregnant mother to cancer baby. But once into the baby rôle, the mother I felt I had to control or destroy was represented by my wife and the bedroom and the situation of being an ill person in need of care. I was not at this point conscious of being inside the mother's body.

I am aware that in reporting these phenomena I am exposing the relatively unintegrated condition in which I find myself, but I feel that

it is a necessary part of the work of writing this paper. The integration of the omnipotent, destructive cancer-baby part of myself is obviously, or should be, a high priority in my life. Arnold Mindell (1989), a pioneer in mind-body relationships, goes as far as to say, from his study of comatose patients and patients in extremis, 'pain indicates that we need to integrate the pain-maker. The pain-creator is a part of our psychology we need, and if we do not pick it up consciously it hurts us.' I am painfully aware that I have in no way integrated my pain-producing cancer-baby. I was a much too well-behaved 'Truby-King' type of baby myself, and it is clear that an omnipotent, destructive, narcissistic, cannibalistic subpersonality remains a part of my shadow. In a book I have called 'The Exploding Self', which is to be published this year, I have suggested that I am not alone in having this problem with a split off and projected omnipotent destructive subpersonality. I elaborate the hypothesis that the present apocalyptic acting out in which the human race is indulging itself is the collective manifestation of this dark side of the Self. However I am greatly encouraged that both in my dream and in my waking life I am determined to take care of and be responsible for my cancer-baby, and learn to co-operate in coping with it. Incidentally the pain disappeared after a further week or two and has not returned, though of course we cannot at present be quite sure why this is so.

There were a few days following my admission to the hospital and the equivocal results of the barium meal and ultrasound scan that it was thought that I might well have a carcinoma of the head of the pancreas. During these few days the cancer-baby seemed very far away from my 'I' and my behaviour and I came over as rather strong and supportive to my family (or so I fondly believe), arguably at some cost to myself; it is not easy to judge these matters, and sometimes one just has to accept what happens in these de-integrative movements and vicissitudes of the subpersonalities of the Self, including the major ones.

How an analysand got into his knee

One's feelings towards a symptom-producing subpersonality may be persecuted, rejecting, and alienated, in which case we are dealing with a paranoid hypochondriasis; or they may be over-concerned and worrying, in which case we have a kind of depressed hypochondriasis. It is obvious that the latter situation is much closer to an integration

into the ego of the subpersonality in question than is the split-off situation.

My next example is of a sort of healing process which occurred when the symptom-producing victim subpersonality felt cared for, by the analyst, and when the patient himself was learning to be more caring towards it.

A successful professional man in his middle forties was saying that he was having a tough and stressful time in his work. He found that he could drive himself to cope by living slightly above himself. He could feel fairly comfortable in this state for quite long periods, with his 'I' being located higher than usual in relation to his body. This slightly disembodied situation reminded him of an incident in his teens when he had to pass an examination in physical education which involved performing an exercise over a vaulting horse or else losing marks. He had previously always contrived to get excused from doing this exercise, but on this occasion he felt he just had to do it as he could not afford to lose the examination marks. He steeled himself by getting outside his body and forcing it to perform the jump. He landed on the edge of the mat and heard a loud crack which was his leg breaking. There was no distress, simply a feeling of triumph, of 'That will show them what they have done to me.' The fracture was a serious one which required an operation in which the tibia was pinned together by driving a long metal pin downwards from the knee-joint surface of the tibia. There was much pain after this, and another operation some months later when the pin was removed. When describing these events to me he commented that he had never really lived these experiences and had no emotional memory of them.

After this session, on the same evening, the knee in question swelled up with fluid, and the knee remained swollen and painful all week before he saw me again. At the next session we talked about the part of him that forced himself to do things, and the part of himself that was the knee-child-victim of this forcing parent part. Life had been very tough in his adolescence in his country after the war, when money was short and food hard to come by. After this session the pain and swelling subsided. Two weeks afterwards I was again moved to talk about himself being the victim of this successful, hard-driving part of himself, about his knee as this victim self, and about his having the odd-man-out victim rôle in his hard, Calvinist family. I also talked about his hard, bullying side which he feels he occasionally manifests towards his employees. He remarked that his sister had been surprised at how authoritative and different from the brother she knew he had

seemed to her when she had recently called on him at his place of work. As I again talked about his victim knee and his victim employees and reminded him of his own victimized feelings I must have been talking in rather a warm, sympathetic way. He felt his affected leg lengthening and his knee getting warmer, and he felt that he was being healed. His leg had been thought to have been actually shortened as a result of the fracture and the operation, but when he found it relaxing to its normal length he realized that he had held it contracted in a protective way since the operation, and that this was related to his never having allowed himself to feel any emotions about it. So he was able to get into his knee and identify with the victim; then he was able to project the warm loving mother on to me and give up the victim rôle. The negative or victimized child and the negative parental subpersonalities tend to be replaced by their opposites at times during therapy, before the opposites can be held and integrated by the patient. This kind of de-integration is a kind of benign splitting, and we are all aware of the problems which may occur if splitting becomes a fixture.

Mother = baby = world

Both Freud (1923) and Jung (1951) regarded the ego as a surface phenomenon resting on the remainder of the conscious contents and beyond that on the sum total of unconscious contents. The 'I' therefore stands at the gateway to the 'not-I'. The 'not-I' includes the 'not-I' aspects of the body image, the unconscious, the dream life, the underworld, and the mother in her archaic forms.

At a seminar I was leading, one of the trainee analysts began to tell of a patient's dream, in which he found a hole in the ground. After clearing away the undergrowth around the hole he was able to enter a passage which led into a cave in which he discerned – here I interrupted the therapist's account and asked the other participants how they might understand the meaning of the image of the cave and its entrance. One said it might represent the mother's body or the mother-analyst's body in the transference; another said it might represent the unconscious; another said it might represent the patient's own lower regions or nature, or his inner world. I remarked that between them they had put forward a fairly comprehensive view of the possible ways of understanding the cave and its entrance, and asked the narrator to continue her account of the dream. What did

the patient see in the cave? The answer was a pyramidal heap of hard round objects that looked like cannonballs, but they had been moulded in what looked like an ice-cream scoop. How these cannonballs with the ice-cream associations would be interpreted would obviously depend on which meaning of the cave one chose to emphasize. They could be seen as aspects or contents of the mother, of the analyst-mother, of the 'Thou'. They might be unrealized or unwanted aspects of the patient's self, or aspects of his behaviour of which he was usually unconscious. They could be viewed as bodily parts of the mother or of the lower self, as anatomical entities within the mother, as bodily parts of the father within the mother, and so on. A complete interpretation might have to include many of these overlapping meanings and more besides. As a matter of fact the subsequent discussion with the patient in this instance centred around the patient's own masculine attributes and his felt need to be more aggressive and self-sufficient, in other words, on the phallic aspect of the balls. Other associations and contents determined the selection of this particular meaning or rather this particular emphasis out of the many possible ones.

We do not have a word which includes all the aspects of the 'not-I' which I have listed. There is a clear need for such a term. Mindell (1984) uses the term 'dreambody'. Although primarily defined as the body as subjectively experienced by the 'I', Mindell also includes many of the other aspects of the 'not-I' to which I have referred, and others too. So if the ego controls the approaches to motility, as Freud stressed, it also stands at the doorway to the inner perceptions and at the gateway to the underworld and the unconscious.

Now it is clear that we both apperceive and understand our world, the outside world, by using the sensory body-scheme present in our dreams, extending it, and projecting it on to the outside world. This equation or conflation between the human body image, cosmos, social structure, etc., is present in many past and even present systems of medicine and many cosmologies throughout the world. In his classic book 'The Great Mother', Erich Neumann (1955) devoted a chapter to the central symbolism of the feminine. Combining the 'Body-world equation of early Man' with 'the fundamental symbolic equation of the Feminine, Woman = Body = Vessel' he arrived at 'a universal symbolic formula for the early period of mankind, Woman = Body = Vessel = World.' This basic formula for the matriarchal stage of mankind is, I am sure, a stage which exists powerfully for us all at a deep level of our modern psyche, although I am not competent to judge the formula from an anthropological point of view. The importance of

the formula for psychosomatic medicine, in the form Great Mother = Body, is however obvious (Redfearn 1985). Corresponding with the paranoid-schizoid stage of the ego, this Great Mother tends to be split between the terrible, devouring Great Mother and the holding, comforting, feeding Great Mother, who is the archetype associated most with healing. 'Splitting' would be the correct term if they naturally formed one Great Mother in the first instance, but I don't personally believe they are One originally. It is with the good Great Mother archetype that getting into the body in the positive sense is mainly concerned. If we feel slightly comfortable putting a tick in a box on a form we are filling in, or if we feel better when we enter a church or holy place, we are dealing with our instinct to burrow or snuggle into the containing mother-figure and it is this instinct which is associated with this aspect of the mother archetype.

Analytically oriented work on body awareness

Jaynes (1976) makes the point that many of our most important psychological words were originally concrete descriptions of bodily parts and events. At the time of the Homeric authors of The Iliad, the Greeks, at the beginning of the last millennium B.C.E. until the Mycenaean period, used words such as psyche, soma, thymos, and noos, later nous, in this very concrete way. However, when the Aenaead was written much later in the millennium, and when the conscious ego had evolved, these words were used in much the same psychological sense as they are today. For example, the word 'psyche' in early Homeric times meant life-substances such as blood and breath. Soma in these early writings was always used in the plural and meant the limbs or parts of a corpse. Thymos, nowadays pertaining to mood or spirit, at first meant the actual motion of the limbs. The gods could give strength to the thymos and thus initiate concrete movement, later action, or they could cause one to eat or drink. Phren, later meaning mind or sometimes heart in a figurative sense, was at first used in the plural, and meant sensations coming from the midriff, arising from causes which we would now recognise as emotional. Perhaps even more importantly, noos, later nous, at first meant seeing, and only when the conscious ego was established could it refer to the conscious mind. Having gathered together all these subpersonalities, gods, bodily parts, emotional impulses, and so on, into our modern ego, which can to some extent conceptualize, contain, and resolve conflict instead of

always having to project it or act it out, why should we now sometimes want or need to get into our bodies and our archaic selves or primary processes? Since World War II we have seen the proliferation of therapies based on the work of Wilhelm Reich, whose book 'Character Analysis' was first published in 1933 (Reich, 1933). These post-Reichian therapies have been incorporated successfully into various 'humanistic' approaches in which physical work on the body and its emotional and somatic defensive tensions is combined with psychodynamic psychotherapy, with massage, exercises, and abreactive techniques, especially in groups. Psychosynthesis, Gestalt therapy, Primal Scream therapy, and Rebirthing all use work on the body in conjunction with guided fantasy, abreaction, and psychodrama in varied proportions according to the choice of the client and the available expertise. In addition to the energy engendered by close proximity or actual bodily contact, the group itself acts powerfully both as stimulant and as temporary or ongoing container. The importance of transference may be belittled or ignored, and sometimes psychiatric illnesses have occurred in vulnerable persons. But in the cases which have come to my knowledge these have been due mainly to the lack of experience of the therapist, and they do not occur with skilled and experienced humanistic therapists. We have a similar situation in analysis, where disastrous regression or acting-out may also occur with inexperienced or badly-trained practitioners of our craft.

The charge of engendering splitting defences is another accusation commonly levelled against these therapies by therapists who try to 'gather everything into the transference,' therapists who demand everything while in reality giving nothing. Splitting is often the necessary way of the Self, and it is 'splitting' which rehearses adaptive behaviours and thus makes the world go round. Certainly, I have often found that my patients, when trusted, may use a combination of these humanistic methods and individual work with me to good effect. Movement and learning can take place in both directions. Therapies on the fringe of classical analysis, like those on the fringe of orthodox medicine, have arisen because of the gaps in what is available and when the orthodox mind is closed in relation to these gaps.

Of particular interest to analytically oriented therapists is the extension of analytic methods into the field of the body and of body awareness, targeted at overcoming the alienation of the body which is a characteristic of psychosomatic and some schizoid patients. I will take as examples a technique used by a German psychoanalyst Becker

(1981) called Concentrative Movement Therapy, and one used by an analytical psychologist, Mindell (1984).

In Becker's technique the patient is encouraged to concentrate on and become more aware of his bodily experience, on his experience of an intensified, spatially experienced body image as an 'I' experience rather than as a 'not-I' experience. He may be asked to lie on the floor with his eyes closed and to attend to his body and the space therein. At the same time he is helped to come to grips with his environment using all his senses in a concrete way. Awareness of closeness and intimacy, and of distance, of his own and other's needs, and of supported and supporting feelings, are all learned afresh through actual bodily experience. Becker tries to help create an averbal and pre-verbal space in this way. Abandoning classical psychoanalytic abstinence in the sense of strict mirroring, he tends to be open and frankly protective at first, but hands more and more active experience back to the patient as the patient can make use of it. Free associations occur on the level of bodily expression. Simple eye closure causes the attention to be focussed on unaccustomed internal events. Experience of the body while lying, sitting, walking, and exploring the surrounding space are all part of the therapist's 'offer'. Sometimes, simple objects like ropes, balls, and sticks serve a similar purpose. Group therapy is often combined with individual work.

An interesting example of a therapeutic breakthrough, after 18 months of such therapy, occurred in a man whose main symptom was an intractable ear noise. A fellow group patient urged him to concentrate his mind on the noise for a change, physically feeling his way into it instead of constantly trying to push it away as he had done so far. The patient succeeded in doing this, and this moment of getting into the ear noise is the kind of of getting into to which I am referring in the title of this paper. It was a very significant experience for Becker's patient, and although the foundation for it had obviously been laid by months of analytical work, the timing and the circumstances of the healing breakthrough experience could not have been predicted. No doubt the therapist had said things like the fellow patient said dozens of times, but the sibling figure was needed for it to get through for the first time.

Becker considers that the analyst's basic attitude towards the patient is the all-important therapeutic factor: it involves offering oneself, at least in the early phase, in Balint's words, as a 'primary object'. In Jungian terminology we are dealing with archetypal experiences at the pre-boundary, Great Mother stage. Speaking for myself, I often find

that this 'primary relationship' may have to be learnt gradually, sometimes at a cost, by the therapist, as a result of failures as well as successes as a 'mother'. But my repeated maternal failures, although at first felt as catastrophic by the patient, become both less maladroit and more survivable as therapy proceeds, and produce milder and milder degrees of illness and malfunction.

Becker's methods may possibly seem less alien to Jungian therapists than to Freudians, although eye closure and focussing on bodily experience have not been specifically encouraged by Jungians to my knowledge. Active imagination as used by Jung involves becoming more intensely aware of internal phenomena including impulses and images, and sometimes involves moving around the room, changes of posture, and bodily expression akin to dance. With Arnold Mindell, work on the body may or may not involve body contact. 'Physical contact,' he says (1984) 'is repressed by our culture because we divide the personality into mind and body, good and evil. The body has been made into the devil. Body communication remains undeveloped as a result of cultural repression. Either we illicitly fornicate or weakly communicate through a handshake, a kiss on the cheek, or a final word-sound'. When this semi-forbidden area is entered consciously, immediate relief is experienced by many patients, especially those gifted in bodily communication. The close connection between bodily expression and dreams is the main theme of his book 'Dreambody'. 'The body is dreaming,' he says. 'We discover that body processes mirror dreams when the body is encouraged to amplify and express its involuntary signals such as pressures, pain, cramping, restlessness, excitement, exhaustion, or nervousness.' Mindell's methods of employing body signals, often involving conscious imitation by the therapist, are described in this and subsequent books, such as 'Coma' (Mindell 1989), explaining how even minimal bodily signals, such as those from a comatose patient, can be picked up and reciprocated, eventually providing the seeds of arousal. Perhaps the essence of his method, as with Becker, is the full and generous participation by the therapist, and the focussing of attention and awareness on body signals and body experiences in the verbal and non-verbal interaction between patient and therapist. The bodily event focussed upon becomes less 'not-I' and more of an 'I' experience. The patient to this extent gets into the particular bodily phenomenon or symptom. As Mindell says, this stepping into the body is essentially the same process as stepping into one's dreams, as opposed to merely listening to them. This involvement or stepping-into is an essential characteristic of Jung's 'active

imagination', where the imagined comes alive and becomes a kind of person with whom the 'I' is having a living relationship.

It is important to note that Mindell, like other analysts, sharply distinguishes the analyst from the healer. 'There is something wrong in the uncritical tendency to heal,' he says. 'It neglects the messages of Death. It tries at all costs to dull the intensity of body signals in order to reduce suffering ... it suffocates potential consciousness and development ... Beneath the surface of the earth the spirit of disease appears as the spirit and meaning behind life' (Dreambody). 'Body consciousness most frequently awakens with illness,' he says, (ibid.). Death itself can liberate and teach ... it can liberate the real personality from the material body and from world affairs (ibid.). Addiction to, or at the very least the over-emphasis on, healing and the good Great Mother in our present times may contribute to the disasters of population explosion and the destruction of Mother Earth, but will also further blunt our full consciousness and our ultimate potentialities. But this is mainly to do with getting out of the body rather than getting into it, and that is not my present brief.

Essentially the same warning about the one-sidedness of healing as an aim for itself is voiced by Bernie Siegel (1990), a surgeon who has learned much from the exceptional individuals who have made recoveries from normally lethal diseases. 'Once we learn to take responsibility for our health by listening to our bodies, and talking back to them as well, then we will begin to be able to use our diseases to redirect our lives' he says. 'An illness may be your greatest dream trying to come through'. This is very much Jung's message of course; and 'Words, music, feelings, progressive relaxation, yoga, meditation, hypnotic trance, visualization and prayer can all help you find your way home'.

Keeping the dreambody at bay

Peace, love, and healing all tend to be associated with faith and trust in the positive, containing Great Mother archetype we succeed in 'getting into' when we get 'into' our bodies in a positive sense. These feelings are typically accompanied by sensations of warmth and comfortable well-being, of sinking into the mother and of emerging refreshed and in a sense reborn. This is sufficiently often the experience of the client of the healer, of the successful meditator, of the hypnotic patient, of the patient undergoing Autogenic training or training in progressive relaxation, to account for the continued success of these

well-tried pathways into the good Great Mother. The initiate into the Eleusinian and Orphic mysteries was following the same downward path into the Underworld, to emerge transformed and reborn. Now we can see on television people being healed and changed by all sorts of charismatic and healing groups and we can see how important feeling loved and having trust can be.

But frequently, too, the descent may be a negative or even destructive experience. Primitively the good and the bad Great Mothers are different beings, difference places, and it is only at a higher level that there is one being with dual characteristics. The bad trip, the destructive regression, the malignant psychosis, and the cruel and destructive forces of Nature that we can only survive by flight or by help from even more powerful outside forces, these would be aspects of the bad, devouring mother-subpersonality. Much of one's skill as a therapist consists of an awareness of the balance between the good and the bad forces and of the relationship between the ego and the unconscious in the patient, in oneself, and particularly in the interaction in the analytic sessions and in the time between them. With such an awareness, an analytic attitude can to some extent be maintained by the therapist and will be communicated to the patient mostly through non-verbal communications.

But when danger from the Great Mother threatens, patients can use themselves and their bodies to counter it, and keep themselves out of the abyss. An analysand described to me how, many years before, in his early twenties, he had kept going during a psychosis, when he was alone in a foreign country. During this psychotic period, he sensed that he needed to head towards coldness, darkness, and physical hardship. This would be invigorating and avoid dangerous relaxation. He walked and travelled on buses, always going north, during the day. If he rested, his delusions returned, and he behaved oddly so that people might notice. Not speaking the language helped him to disguise his oddity. At night he had great difficulty in getting to sleep. When he went to bed he had cramps and aches and pains. His only way of getting sleep was to relax and let the delusions have free rein. He felt he was Jesus Christ, also Hitler, and he had many ideas of reference and influence. At these times he often felt he was leaving his body and entering a different world.

On waking, he had to fight to recover bodily and mental control. Muscular activity was necessary to keep the psychosis at bay. Both voluntary muscular activity and involuntary tensions and cramps helped to achieve the necessary arousal, whereas voluntary relaxation

allowed the psychosis to return and engulf him and take him into another place, another state.

But we must remember that *keeping still* may sometimes be the way to avoid engulfment from below, from begin overwhelmed by regression, psychosis, loss of control, or transport to another world. For example, a patient dreamt of being in a group of people walking through a muddy jungle. They came to a clearing in which couples were engaged in horrifying, violent, sadistic sex. It was devilish, and reminded her of the paintings of hell by the Flemish artist Hieronymus Bosch. At one crucial moment it seemed that these creatures would pursue and overwhelm the patient and her friends, but she ordered the latter to be perfectly quiet and still, and to avoid looking at the scene. This keeping still was associated, as we worked on the dream, with her immobility on the couch during sessions, and never looking at me. Being overwhelmed by the violent sado-masochistic primal scene feelings was thereby avoided, and the normal, obviously in a sense too normal, interaction could be maintained. We can all recall examples of methods which our patients have needed to use to keep engulfment at bay. Hand-clapping, hitting oneself, the couch, or the wall, clenching the fists, and hurting oneself are examples of how the real body can be enlisted to master the dreambody. Head-banging, self-mutilation, acting out, abreacting, and emotional behaviour are all common, perhaps not in sessions but outside, at times of stress. Finally, leaving the body, distancing, denial, and depersonalizing defences may be necessary in order to avoid the maternal abyss.

Getting into the Heart-beat

The autogenic training exercises which I learnt at the Centre for Autogenic Training in Harley Street, London, consisted of 7 standard exercises plus some others which need not concern us in this context. In the standard exercises the attention is directed to various parts of the body as if gently talking to them; the aim is to be aware rather than to strive to attain whatever state is referred to in the exercise. The words used by the subject as he goes through the exercises are, with some permissible variations, as follow:

1. My arms and legs are heavy and warm;
2. My heart-beat is calm and regular;
3. It breathes me; (this encourages a passive attitude toward the breathing);

4. My solar plexus is warm;
5. My forehead is cool and clear;
6. My neck and shoulders are heavy; and
7. I am at peace.

The general feeling induced is of warmth, well-being, security and containment by what I am referring to as the good Great Mother archetype. Anxiety, tension, heart rate and blood pressure are reduced, and a state of mind called the autogenic state is often achieved, similar to that produced by self-hypnosis and meditation. We are dealing with suggestive exercises in which a good parent attitude is adopted towards oneself. One says the loved-child words, as it were, and one does not strive to produce the loved-child feeling, yet it comes, sooner or later, without forcing, after the usual assortment of unconscious sabotaging devices and tricks used by one's rebellious child subpersonality have occurred and have been discussed in the training sessions.

The possibility of such experiences giving rise to dependence has been pointed out by Deter and Heinze-Hook (1988).

As an example of the achievement of the contained, even loved, feeling, let me take some of my observations in connection with the heart-beat exercise. When I did this exercise on waking in the morning while lying on my back in bed, I could as a rule feel my pulse beat in my upper neck and hear the slight thump at the same time, and these were the only sensations referable to the heart-beat which I was having. As I repeated the exercise, I found that the thump of the pulse was often replaced by a sensation of being rocked by the pulse instead of being thumped by it. There was no sound and no thumping signals; the perceived signals were now those from other sensory receptors from more deeply inside the body as a whole. In short, attention was switched from one set of receptors to others, contributing to the cradled, loved feeling, and specifically helping me to trust the heart-beat and whatever that meant to me. One must also remember that a direct effect on the strength of the heart-beat and the state of the arteries was at the same time contributing to the overall calming, soothing, healing process.

So the position of the 'I' in relation to the pulse changed from being outside the pulse to being inside the pulse, which is now a good, containing 'person'. This change was imaged in dreams I had on a few occasions just before waking and doing the exercises. For example, I dreamt of a radio-transmitter mast being held up by several cables, each secured at one end to the ground and at the other to the top of the mast. I 'knew' that this image corresponded with the state in which

I am 'outside' the 'thumping' pulse which radiates its signals like the radio transmitter. Immediately following this dream image I dreamt that I was in a train which kept moving into a station, then backing out of it, in regular oscillations. I 'knew' that this dream corresponded with the state in which I am 'inside' the 'rocking' pulse which carries me to and fro like the train. It is of course possible to place our emphasis on the phallic aspects of both these images, or on the fantasy of anal masturbation or coitus clearly present in the second, but both these emphases would be focussing on a developmentally later meaning than the one I myself am dealing with here. Looked at from the point of view of adult male genital sexuality, there is a considerable regression from having the penis and penetrating the mother-station in a loving way to being inside the penis-as-container and being rocked to and fro. Furthermore, we are dealing with a relationship, or in this case two relationships, between container and contained, and furthermore there is no third father-type person involved. Of course, a third person may determine the nature of the infant-mother, or the container-contained relationship, determining even whether the good or the bad mother is projected. But in the matter of getting into the body the relevant level is at the borderline between the one and the two.

Summary

For the dynamic units of the personality I use the term 'subpersonalities'. These are the characters in our dreams. They also determine our feelings and behaviour in personal and impersonal interactions including the transference. They comprise the archetypal and the complex figures of Jungian psychology, and they are analogous to the internal objects and the mental structures of psychoanalysis. Considering the subpersonality as a rôle, the I can either assume or rather be possessed by that rôle, or can assign it or project it on to the other person or persons in a particular situation.

This paper describes how the 'I' can migrate, from being subject to object in relation to the body or bodily part. It can also migrate in relation to the subpersonalities. Such migrations are usually unconscious but awareness is often attainable, and migration can be a learned skill. Many therapies are available which help to enable the 'I' (often in the rôle of loved infant) to feel securely contained inside the body as loving mother-container; often this experience is a profound and healing one, but with important limitations.

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THE PENIS AS BRIDGE

ROSEMARY GORDON

The penis, it seems to me, is an organ quite particularly rich in symbolic meanings and associations. Sexual organs themselves, contrary perhaps to the theories of the earlier psycho-analysts, are not only the objects of the symbolizing process, but are themselves rich in symbolic meaning and significance. This seems to have been an implicit assumption for Jung, who believed that every phenomenon can be a symbol in so far as it entails otherness and something additional which is somehow foreknown or foreshown or of which one has an inkling.

The symbolic meaning of the penis derives naturally from its structure and form, but also, perhaps more importantly, from its functions. Some of these symbolic associations are described and discussed in the literature.

The penis is first and foremost the organ of fertilization, and hence lends itself to be the most powerful symbol of all creative work and of all creative inspiration.

But the penis is also the organ that ruptures, that opens and penetrates, breaks and enters; indeed its fertilization function depends on this. Consequently its association with aggression, with weapons and with cutting instruments is not surprising. Moreover, apart from life-giving semen, the penis also produces urine and as a result of this it may also be experienced as poisonous and soiling.

Again, the penis can be experienced as an organ that feeds, and so it is available to be used – or abused – by the needy or greedy female: the identification of the penis with the milk-giving nipple has been pointed out by Melanie Klein.

Finally – and here I come to the thesis I want to develop – the penis is the organ that relates, in a very physical and basic way, two separate and unlike persons. Because of this function, a symbolic link between the penis and the bridge may strike one as obvious. For, like a bridge that spans the intervening space between two adjacent, yet separate lands, so the penis establishes a meaningful communication between the separate existence of the man and the separate existence of the woman. In intercourse the penis is cast, just like a bridge, into a foreign soil. Or as Hobson's patient has said very clearly, quoted in his paper

on circumcision 'You emerge into another world inside the woman.' (Hobson 1961)

Remaining aware and exploring this symbolic link may help us gain further insight into the meaning of such sexual difficulties as impotence, castration anxiety, venereal disease, phobia, etc. It may also help us understand why such specific sexual difficulties have usually far-reaching effects on social and personal relationships, on work and on intellectual efficiency. If the penis really represents the bridge then it may be experienced as that organ whose possession gives one the courage to venture out of one's essential isolation and move instead towards the making of relationships and more real and trusting intimate contacts.

When people decide to make a bridge, then there must exist a certain configuration of incentives and expectations: the people must *want* to get across to the other side. They must believe that the group on the other side is relatively friendly and will stay friendly; or if the group is thought to be hostile, then it is thought of as too weak to offer any effective resistance to conquest. On the other hand, if a people *fears* invasion, conquest or absorption from the group on the other side, it will oppose all bridge-building projects. After all, it took very many years to build the Channel Tunnel.

In order to experience the penis as a bridge, in order to allow it to function as a bridge, a person must, I suggest, have felt and become aware of the anxiety and the depression of his essential separateness. In other words, in order to think of a bridge one must first of all perceive and experience that which divides and cuts one off.

After an initial acknowledgement of one's separateness, after the achievement of some differentiation and self-identity, one's boundaries may still be experienced as so fragile and so flimsy that the building of a bridge may be felt as a deadly threat. This may be so either because the temptation to regress to an original union is still exceedingly great or else because the regressive needs have been split off and been projected, so that the 'other', the one on the other side, appears excessively dangerous and destructive. If absorption and fusion – that is, individual death – is expected to result from copulation, then there will be impotence and frigidity as protection and defence. Consequently the more vulnerable a person feels himself to be, the less can he risk to *test* his boundaries; for whether experienced as temptation or as threat, the disintegration or collapse of the fragile ego structure is then felt to be an ever-present possibility.

The symbolic link between a bridge and a penis first suggested itself to me when a patient, Mr D., brought me the following short dream:

> 'I am in a Japanese prison camp. A man is to fix an attachment to the struts of a drawbridge; he fails. So he is given the sack. Later he is pursued and beaten up.'

Associating to this dream, Mr D. explained that he does feel as if he is inside a prison camp, but he wants to find a way out. He has at times the fantasy that only the 'good woman' can release him from his unhappiness and his imprisonment. He must get out, he insists, he must get to the other side; after all, he cannot live like a monk all his life.

The patient had this dream while on a walking holiday. He had met there a woman to whom he felt vaguely attracted. The woman had then suggested that they might go together on another holiday. This suggestion had made Mr D. extremely anxious, for, as he explained, if there should be flirtation between them without actual sexual intercourse, then the veins in his leg would 'blow up', then he would not be able to walk; he would injure himself and do himself permanent damage. And while talking about the dream and associating to it, he asked me angrily what I was doing about the veins in his legs, all the while kicking the couch violently with his legs.

Looking at the transference feelings at the time, it is clear to me that Mr D. found it impossible to keep a bridge anchored on its two sides. He experienced me both as a possessive mother, who would not let him go off and make love to a girl, and also as the rejecting mother who wanted to *push* him off on to some girl and so be rid of him. The possibility of having analysis *and* an affair with some girl was inconceivable to him. No wonder therefore that the struts of his bridge needed mending.

Mr D. was a severely schizoid man of 40, who worked as an acupuncturist. His predominant psychic technique was splitting. His body was split and everything above the solar plexus was felt as relatively good; everything below the solar plexus as decidedly bad. Masturbation, sexual excitement and fantasies as well as actual sexual intercourse produced a swelling of the veins in his legs, varicosed them and so interfered with his great passion – walking and mountaineering. Sexual activity could also lead to what he described as urethritis, to excema on the penis, or, if anal masturbation had been practised, to haemorrhoids. Hence walking and sexuality were experienced as opposed and inimical to each other. So were introspection and the sensuous experience of objects; so was mind and body. For instance,

talking about having been obsessed by the fantasy of a penis penetrating him, he remarked:

> 'Anuses were not made for penises. It is only happening in the stupid monkey fashion of one's psyche. It is a stupid part of my psyche which juggles with those ideas; but it is wrong to think that my anus wants a penis. The psyche is amoral, it is a polymorphous pervert. It is just like a monkey in a cage. It puts a bit of the banana into its mouth and another bit up its arse. It *is* an ape-man, that is what it is.'

And a few weeks later ...

> 'The whole unconscious is sordid as far as it affects me. Masturbation is inconvenient and messy ... I resent the fact that one's mind mucks about with the basic physical facts and that the body becomes the victim of the mental confusion. The body is a good thing; leave it alone, it is only that ridiculous, confused junk acting on it that makes it go wrong. It is dreary, sordid, sad and confused, this damned vagina/anus identification.'

Though he daydreamed of travel and adventure, the patient still lived at home with his parents. He was the eldest of three boys. His next brother had suffered from rickets as a child and so got special attention from the mother. This brother seemed to have developed into a tough working-class man. The third son, though married, occasionally indulged in transvestite practices. When this was discovered he and his wife moved away from the parents' home.

The parents appeared to be dull and withdrawn, social isolates, who had made no contact with their neighbours or with any other social group around them. The patient described his father at various times as:

> 'weedy, taciturn, negative, inert, colourless, someone who gives nothing of himself, is not interested in anything and who lives in suspended animation.'

He described his mother as more cheerful than father, but also very passive, submitting silently and without revolt to her fate, always afraid of the consequences of taking a risk. She had suffered from varicose veins while pregnant with his next brother.

The patient felt that he had inside him a grinning devil, who blocked every step forward that he, the patient, might try to take. This devil, he thought, probably represented the father's unconscious sadistic side.

Early in the analysis he had brought along a key fantasy: father is raping mother while she is pregnant with him. Thus he actually participated in the parental intercourse. It is probably a development of this fantasy which led him to tell me a few months later that he had had the following 'insight':

> I was wondering why my father takes on that negative form for me; and I thought maybe I wanted mother. I wanted to possess mother – probably at the time when I came back home and found a new baby in the place – but you cannot possess mother or anybody; so the next best thing is to become mother, but the main obstacle to mother is father. Therefore one becomes mother but one also becomes father, because all mothers have fathers. Perhaps this is why I cannot make contact with women; mother gets in the way.

It was after telling me about this 'insight' that he discussed the 'good' body that gets damaged by the 'bad' psyche.

In fact he tended to feel as if 'assaulted' and raped by his own sexual wishes and fantasies. On the other hand, at times he experienced his whole body as if it were a penis in erection; he had in fact a very stiff and unbending posture.

He felt considerable envy of the woman's sexual experiences, and could get very excited when he tried to imagine the sensation of a penis going into the vagina. He thought that this sensation must give the woman a sense of completion which is denied to the man. The woman's experience is 'more intense and it lasts longer; a man just loses something and that exhausts him.' This made me remember Tyresius, who was blinded by Hera for expressing this same view.

About a year earlier, for a period of a few months, the patient began to complain that I was too passive; that I was merely receptive; that analysis was impotent. He had all along complained that he hated being analysed by a woman, though in actual life he seemed to make no real social contact with men at all. I began to share his experience of me as very impotent and felt that he demanded to be penetrated by a powerful penis. Only looking back over my notes did I discover that at that time I began to smoke in this patient's sessions; it may have been my cigarette and holder which provoked another period of overwhelming anal fantasies, which he then had to act out in private in masturbation.

After a session in which we had both been very active, he produced a homosexual dream. In this dream he is anally penetrated. But he then claimed, with some bitterness, that he had never had homosexual fantasies before coming into analysis. When I suggested that my interpretations seemed to be experienced by him as a penetration by my penis, he remarked:

> 'If you think that I associate you with my father, you are wrong: you are the very antithesis. He has no insights, he cannot penetrate anything' ... But then he added: 'but your type of penetration is essentially feminine because you are a woman ... there really is no wise old man.

The old wise man is really a woman. It is nothing to do with a man, it is the sphinx if you like or the cat. This sphinx is the keeper of riddles, she never gives the answers, therefore she is annoying to most men.'

Perhaps the clearest statement of why Mr D. felt too vulnerable to contemplate the building of a bridge came three months later, when he seemed to put into words my vague reflections about the symbolism of the penis and the bridge.

'I don't trust women. As far as men are concerned, they are dangerous. Women don't do men any good. Women like to look after men and make them conform to their ideal. A woman's interest in a man is dangerous to a man being a man. A woman emasculates a man ... A woman stands still. In a sense she does not move out from herself. But the man moves out from himself. This makes him vulnerable. He must almost become a woman in order to go to a woman. That is something that is unfortunate. Women do it i.e. have intercourse, when their foundations are firm. So you, the man, must move out into her sphere to meet a woman. Take work; you leave home, you go to work and you go back home to the woman, to be taken care of. It is man's fault anyway. Men start by exploiting women, women end by exploiting men ... So you leave your own masculine world and get trapped in her feminine world, and before you know where you are you feel like a woman and you react like a woman ... This idea of sharing – it is just a myth ... there is always competitiveness ... why do you have to open your gate to the enemy ... If you have a raiding party and move from a safe position into the enemy's country, the enemy is much safer ... he is in his own country. Men take risks ... women do less so ... women know they are safe ... why should one stick one's neck out? ... all women are mothers ... if you raid them you have no chance to get away whole ... we all have had mothers ... that can't be eliminated, but it is unfortunate. Women are indestructable, men are expendable ... that is the tragi-comedy of sex: it's on her terms, in her time, on her conditions and in her territory ... Some people just don't like being made a fool of.'

Obviously he was very suspicious about the things that I may put into him. During the same night in which he had dreamed the bridge dream, Mr D. had another dream which showed this well.

'A doctor wants to give me a blue pill, as an anti-polio treatment. But I refuse this, because I know that it will not do me any good. Then he offers to give me an injection into my bottom from a long needle. Although I know that this will be painful, I accept to have it.'

This dream and his other homosexual fantasies seemed to express this patient's great need to receive the good penis; for with it he might then be able to relate actively to others and to bring together inside himself the many split-off fragments. In other words, the penis would act as the bridge which would help him to bring into contact the bits and pieces inside him and to communicate with the people around

him. But instead of a bridging penis, the patient seemed to feel that there was available to him only either the father's impotent penis, or his sadistic, raping and poisonous penis. In his sexual adventures, Mr D. lived out in his body the fantasized sadistic intercourse of the parents, from which all emerged injured.

I have tried to find some references to the penis-bridge association in the psycho-analytical literature. To my surprise I have found very little indeed. There is, however, a passage in Melanie Klein's paper Infant Analysis. I quote:

> 'I have repeatedly in analysis discovered birth anxiety to be castration anxiety reviving earlier material and have found that resolving the castration anxiety dissipated the birth anxiety. For instance, I came across the fear in a child that when he was on the ice it would give way beneath him or that he would fall through a hole in a bridge – both obviously birth anxiety. Repeatedly I found that these fears were actuated by the far less obvious wishes – brought into play as a result of the sexual-symbolic meaning of skating and bridges, etc. – to force his way back into the mother by means of coitus, and these wishes gave rise to the dread of castration' (Klein 1948).

But apart from this passage I have not been able to find anything else. Is this association so obvious that nobody has bothered to write about it? Is my thesis false? Or is twentieth-century urban man so alienated from the natural world that this particular association has become lost to him? By contrast, the Yoruba of Nigeria seem quite familiar with the association of penis and bridge, as shown in the song that they sing about Elegeba or Esu, their Trickster god,

> We are singing for the sake of Esu
> He used his penis to make a footbridge
> Penis broke in two
> The travellers fell into the river.

Of course, there is also the Winnebago trickster described by Paul Radin, who has a very long penis which he carries over his shoulder in a box. One day he comes to a lake, sees the chief's daughter bathing on the opposite side, takes his penis out of the box and sends it across the water to have intercourse with her. Actually he does not really make a bridge of his penis, for his penis slithers through the water like a snake to reach the chief's daughter on the other side; but, though not a bridge, the penis does here connect the two and opposing sides of, in this case, a lake. I shall return later to the possible meaning of crossing above the water or through it (Radin 1956).

In both these trickster figures, therefore, we find the theme of crossing the water with the help of the penis; but both, as might be

expected, trick. Esu's bridge-penis breaks; Winnebago trickster's penis passes underneath the water and has intercourse with the woman in the water. A closer study of Esu which I owe to personal communications from Morton-Williams and Joan Wescott may throw some light on these tricksterish bridges and also on the general meaning of the penis as a bridge. There appears to be a taboo on all sensuous relationships between Esu and the world of the women. For instance, according to most myths, Esu is the only unmarried god in the Yoruba pantheon. He is, like Hermes, without family, a homeless wanderer. In all the market places there are shrines to Esu, containing a phallic representative of him. But the following substances may not, under any circumstances, come into contact with this phallic representation.

Blood. In primitive societies this is usually associated with women's procreative functions.

Indigo. This is a colour that amongst the Yoruba is handled by women only.

Kernel oil. This substance is always rubbed into newborn babies. It is thus likely to represent, to the mind of the Yoruba, the neonate's dependence on and need for the mother.

The taboo of all contact between these particular substances and Esu signifies, I think, the general segregation between Esu and the women. And this segregation seems to me to parallel the segregation from the women's world of adolescent initiates, who are being prepared for the *rites of passage* which will transform them from boys into men. Such complete severance of all ties and contact with the world of the mother is necessary and essential at a time when a boy's independence and masculinity are still frail and insecure, and when he is still liable to succumb to the temptation of a return to the comfort and containedness of the world of the mother. Such segregation can therefore be understood as a means of reinforcing the incest taboo, and so it further inhibits 'the fulfilment within the psyche of that which the taboo forbids in the flesh – the union with the uncontaminated mother principle, represented by the spiritual return to the womb' (John Layard: personal communication).

That the penis *must* have symbolic meanings other than that of procreation is clearly suggested by the figures of Hermes and Esu. Rudolph Otto has emphasized that Hermes is 'no god of generation and fertility' (Otto 1959). In fact, Esu's sensuous contact with the woman's world is tabooed. Instead, the phallic quality of these two tricksters is deployed as a force that breaks up existing structures, that surprises people, fools people and shakes them out of their com-

placency and stagnation, as so amusingly narrated by the Yoruba of Nigeria, when they tell that Esu one day 'walks down the boundary of the farms of two friends; he is wearing a cap that is black on one side and white on the other; and he causes the friends to become enemies because they argue over the colour of his cap'. Wescott firmly asserts that:

> 'It is not in its procreative aspect that the phallus is a symbol; but it is rather by virtue of its autonomous nature that it appropriately symbolizes the wilfulness and free-floating energy of the trickster.'

Esu's penis functions as a catabolic force, the force that leads to deintegration. This is well symbolized by the broken calabash which Esu carries around his neck and which reminds me of the story of the birth of Eros, as described by Kerényi:

> 'After Eros had sprung out of the cosmic egg, he revealed and brought to light everything that had previously lain hidden in the silver egg' (Kerényi 1951, page 17).

But Esu and Hermes do not only trick and fool and confuse; they are also present at the crossroads and in the market square, that is, where people are most likely to come together, to meet and to communicate. Hermes is also the guide and the lord of the roads. Esu is the mediator between men and the gods, for without Esu, so the Yoruba say, the gods would starve, since it is Esu who carries to the gods the sacrifices men have made to them. Disruptions on the one hand, and the crossing of gulfs on the other: such are the primary functions of the tricksters, Esu and Hermes, whose symbol is the phallus.

The trickster personality seems to stand at that delicate point when some separateness has been achieved; but this separateness is still so frail and so insecure that it can only be defended by tricks or by the erection of formidable fences and barriers. Emergence from behind these fences is likely to take the form of 'tip and run raids'. The tricksterish individual may do this by fantasizing that his penis is a detachable structure – preferably of infinitely great length, so that the 'other' can be kept at a safe distance, at more than arm's length; and if it is a detachable structure, then the penis can be readily abandoned without the risk of total destruction. Such seemed to be the meaning of the homosexual relationship of another patient of mine, Mr V., a man of 25. When he first came into analysis he was living with another young man, Mr B., who thought of himself as heterosexual and had relationships with women. My patient was very dependent on his friend. But particularly remarkable was his tendency to fantasize poss-

ible sexual relationships with his friend's girlfriends. His friend would in fact describe to him in great detail his heterosexual adventures and experiences, and this would excite V. greatly. B., we came to understand, was really used by V. as a penis which he sent out into the world and into that dangerous and yet sacred territory that to him was woman, while he, Mr V., stayed at a safe distance, though participating in the pleasure and excitement. Mr V. produced two major dreams which both suggest that for him also bridge and penis were associated; at least the bridge he dreamed of led in each case to a meeting with a woman.

This is his first dream:

> 'I am the father of a family and experience a great suffering because I have lost my children who are young. But while I am thus suffering and expressing my pain my oldest son, who is about twenty, and who shares my pain, dies also. I am on a *bridge* that passes over a flowing river. A woman is behind me, probably veiled; I cry and say: "I suffered greatly, but now I suffer even more for my last son has died. He was with me on this bridge, sharing my pain. Now I am alone." The woman behind me starts to console me, though she does not move and does not come nearer to me. She consoles me by saying: "Yes, there is terrible suffering in life, such is life. But if one renounces life, if one renounces the fight, one loses also the human condition, which may be little in terms of the universe, but which is all that man has." '

Two months later he had another dream:

> 'I am with several people on a tower. Underneath the tower appears my sister who wants to take photographs. But she takes an awful long time over it. Then the scene changes to a stream which flows at the bottom of that tower and there is a bridge. My sister has fallen or jumped into the river. Although I am very frightened, I jump in from the bridge in order to save her. At first I dare not dive down, but then I learn to do this and find my sister; I drag her to land and give her artificial respiration. She is naked and very cold, as if dead. When I almost despair of reviving her, she begins to stir. I manage then to carry her to the house of an elderly, intelligent-looking woman'.

Mr V. feels very close to his actual sister, who, like himself, fights to emancipate herself from the parents, and who like himself had an early sexual experience and so 'there is something broken in her too'. This patient, by the way, fits remarkably well Metman's description of the trickster figure in schizophrenia who is at the mercy of the tug-o'-war between the autonomous complexes and an incipient ego (Metman 1957).

Turning to the general literature I have come across two dreams that seem to me to be relevant to my theme. One of these is recounted

by *Jung*: 'A woman patient', he writes, dreams that 'she is about to cross a wide river. There is no bridge, but she finds a ford where she can cross. She is on the point of doing so when a large crab, that lay hidden in the water, seizes her by the foot and will not let her go.' This patient had had an exaggerated relation to her mother which she seemed to have displaced at her death, when she formed a sentimental attachment to another woman; their relationship was close and so intimate that '... it excluded many of the other possibilities of life'. Jung interpreted, on the basis of that dream, that she was unconsciously trying to put a distance between herself and her friend (Jung 1917, para. 123).

Another bridge dream is described by Stekel. It was produced by a man, a patient, who had come for treatment because of his experience of such intense anxiety during intercourse that he usually had to withdraw his penis before reaching orgasm. He was married to a woman whose choice had been encouraged by his mother. His mother was jealous and possessive; she had favoured this marriage because she knew that her son felt no great love for this particular woman, but that she had a good job and would thus make an important financial contribution. The patient's symptoms appeared when his wife lost her job. This is the dream:

> 'I want to cross the bridge that leads into the town. Then I notice that the bridge has broken down, but that there is an underground passage beneath the river, a sort of tunnel, leading to the opposite bank. Through the dark tunnel I make my way to this bank, and I find to my astonishment that there is here a big brass monument, which from the other side was scarcely visible in the mist. Why on earth, I wonder, did I never see that monument before. Then I wake up with a sense of anxiety much like those that come on during sexual intercourse' (Steckel 1943, pages 354–5).

This dream returns me to the question of the possible difference in meaning between passing *above* the water, as one does if there is a bridge, and passing *through* the water. I believe that to pass through the water involves very much less differentiation than does real bridging. It is more natural, it involves much less foresight, planning and skill than does the construction of a bridge. And the water, after all, is the element of the mother.

John Layard gave an example in his study of Malekulan society which also supports the penis-bridge hypothesis. At the time of their initiation, the young boys are placed in rows inside the initiation lodge adjoining an open space. On the other side of that open space there are drums, representing the ancestral spirits. One of these, the biggest

drum, is the mother drum. At a certain point in the ritual, a group of young men, who have already been initiated, lie down head to foot in a line that runs from the mother drum to the novices; a rolled-up banana leaf connects the penis of one man to the penis of the next young man and so all along the line. This then, one might say, forms a penis-bridge from the mother drum to the novices. Perhaps it is to suggest that the umbilical cord that links the child to the mother must now be transformed into the penis which relates the man to the woman.

Nor is the image of the penis as a bridge altogether unfamiliar to modern man. In Lawrence's *Lady Chatterley's Lover* Duke exclaims:

> 'Our old show will come flop; our civilization is going to fall. It's going down the bottomless pit, down the chasm. And believe me, the only bridge across the chasm will be the phallus ... the phallus is the bridge to what comes next' (Lawrence 1960).

Simon Stein, in a personal communication, told of a patient who was in treatment with him but not for any sexual problem, who when in bed playing with his girlfriend, said spontaneously just before he actually entered into her:

> You see, the penis is really a bridge between the two of us.

Stein has also been kind enough to search for any possible etymological support for my thesis. It seems that the word *BRIDGE* is derived from the root *BHRU'*. From this same root come terms like 'cudgel', 'stick', 'club', 'beam', 'plank', etc., that is words referring to that from which a bridge is built. But from this same root are also derived words meaning 'to break' or 'to smash'. The terms '*CLUB*' and '*STICK*' are, of course, much-used slang terms for the penis.

Nor is the situation very different if one examines the origin of the Latin word '*PONS*'. This comes from the root '*PENT*', a root that gives rise to words meaning again 'cudgel', 'stick', 'struts', 'planks', etc., as well as two verbs suggesting such action as walking, discovering, inventing, experiencing.

Thus from both roots – '*BHRU*' and '*PONS*' – are derived words which denote linking as well as breaking, bridging as well as smashing.

Man's attitude to the bridge contain a sense of danger because bridging is felt as a venturing out of that which is known and familiar into that which is strange, which is the 'other'. This sense of risk when one challenges the boundary, parallels the feelings which Mr D. expressed when he described his fears and fantasies when in contact with the woman.

If it is true that there is an unconscious symbolic link between the

penis and the bridge might there be wider theoretical and clinical implications?

What first comes to mind is that just as the penis acts as a bridge between the body of the man and the body of the woman, thus forming a link between their separate existences, so is the ego a link between the processes within the psyche and the external world. It is in Melanie Klein that I have found a recognition of the association of ego and penis. In the *Theory of intellectual inhibition* she suggests that there is a common basis between sexual potency and what she calls the epistemophilic instincts since, in the unconscious, 'to discover and to penetrate into things are activities which are equated'. And she argues further that potency is the basis for the development of a large number of activities and creative interests and capacities because:

> 'the penis has become the representative of the person's ego. In the earliest stages of his life the male child looks upon his penis as the executive organ of his sadism, and consequently it becomes the vehicle of his primary feelings of omnipotence. For this reason, and because, being an external organ, it can be examined and put to the proof, in various ways, it takes on the significance of his ego, his ego functions and his consciousness' (Klein 1931).

The essential function of the ego is, of course, that of discrimination and differentiation, which involves first of all the separation of what is inside from what is outside and thence the separation – and probably splitting – of good from bad, of known and familiar from unknown and unfamiliar, of safe from dangerous and above all of reality from fantasy. The prime function of the ego is therefore the making and the recognition of boundaries and the mediation of the experience of boundaries. Once boundaries have been established, once the 'I' has been differentiated from the 'all', then can develop the awareness of a 'Thou', then relationships can be made. Until a viable ego structure with viable ego boundaries exists, there can only be the experience of fusion or of complete isolation. Relationship and communication presupposes separateness.

Summary

The penis, I have suggested, is rich in symbolic meanings. But the link between the penis and the bridge has not, up to now, been much explored. The concept of the bridge involves both awareness of separateness and the possibility of communication across the boundaries of

separateness. The fact that the bridge-penis association appears so often in schizoid individuals and in trickster figures is probably due to the fact that for them, the making and remaking of boundaries or the feelings of either fusion and ego-loss, or else of complete isolation, are basic concerns and predominant psychic experiences.

If the penis is indeed unconsciously experienced as a bridge, this may help us understand some of the wider implications of castration anxiety, impotence, penis-envy and the various sexual perversions. For they all represent different techniques of dealing with the basic problem of separation and communication. They are all attempts to handle the dilemma of risking death through an adventurous emergence from the safety of that which is known and familiar into that which is unknown, unfamiliar and mysterious. At a certain stage the choice seems to lie between being suffocated or being assassinated. Only when the bridge has been safely secured can it be enjoyed and experienced as a highway, bearing a two-way traffic.

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THE STATE OF PARANOIA: A SEARCH FOR NEGATIVE SIGNIFICANCE?

JEREMY HAZELL

For the purpose of this discussion I am regarding the distinction between psychotic and non-psychotic paranoia as one of degree rather than one of kind. I am therefore considering paranoia as a psychogenic state, which can range from a fully justified feeling of threat from an identifiable external source (healthy paranoia) through states in which a sense of *internal* threat can be so overwhelming as to colour perception of the external world (projection) to more or less permanent internal states of delusion in which the individual functions within logically reinforced delusional systems which for him form the only reality. This last state, commonly termed a 'functional psychosis' is characterised by delusions both of persecution and of grandeur, and it is from these characteristics, which I believe to be present over the whole range of paranoid states, that I draw my title. For while persecution is undoubtedly 'negative', 'grandeur' is suggestive of spurious significance. My suggestion that the paranoid state itself constitutes a *search* for negative significance arises from my belief that the experiencing subject, at the centre of the paranoid state, has an innate need to experience himself and his life as significant. I also wish to suggest that in seeking this significance in negative terms not only is he seeking it in the only terms that were available to him at the time his paranoid state originated, but also that he is doing so to avoid falling into a state that is even worse: the state of *profound personal insignificance* which, at its worst, carries the threat of psychic death. I am suggesting, therefore, that an experience of profound insignificance, with its attendant threat of personal extinction, underlies the paranoid states, and accounts for their relative intractability. They, like other neurotic states, are often intractable because they are *attempted solutions* (cf. Guntrip 1968) to an ultimately worse problem and through them the individual is struggling to deny feelings of varying degrees of personal insignificance and weakness. Thus insofar as it is possible to persuade an individual to see the fallacy in his paranoia and to abandon it, he is confronted with the state which it arose to conceal. A male patient in his early 30's believed that he was always under surveillance,

both from people and from vehicle headlamps, so that walking up the street was made possible only by means of obsessional rituals, which gave him a spurious sense of control. He was also subject to bursts of destructive aggression, especially against women whom he experienced as tantalising. From such a dangerous and threatening world he longed to get away somewhere safe, and as the therapy proceeded he produced phantasies of 'safe places': for example, the back seat of a car with the windows blacked out. As the possibility of feeling safe with me grew stronger he became 'less paranoid', only to be troubled by feelings of 'invisibility'. When, for example, he entered a telephone booth he suddenly felt that he was fading away, and felt a compulsion to beat on the walls, shouting, '*Look* at me. Look what I'm doing'. He seemed to me to have come up against the deeper problem: the fading out of his sense of personal reality. The loss of 'negative significance' threatened him with the loss of all significance. The same problem was repeated in sessions when he would place his hand between us so I could not see his face, saying it was 'for protection'. And yet, my continued interest felt vital to him. He needed to know he could be 'safe inside' without losing me as he oscillated between the paranoid state in which he felt the object of hostile, menacing stares and the deeper schizoid state in which he felt the terror of isolation and the threat of personal extinction. In the light of these considerations it is not surprising that the only way forward for this young man was 'back'. Concentration solely upon his paranoid state only intensified it, for either I was fitted into his delusional system as persecuting him with interpretations or I was experienced as threatening to expose the underlying schizoid state by failing to collude with his defence. To have said as one might to someone in a mildly paranoid state, 'Do you really feel so important as to be the object of round the clock surveillance?', would to this person have felt like an all-out assault on his defences, and a threatened exposure of how profoundly 'unimportant' he felt. It need come as no surprise that, faced with such a dilemma, a person may be driven to try to eliminate all need for relationships and to experience suicidal impulses. However, the deeper need so often seems to be for a quality of understanding, in the therapeutic relationship, which allows the individual to remain emotionally absent while the therapist bears in mind his potential presence. So it proved in the case of my patient: in the accompanied privacy of the therapeutic relationship he could allow himself to 'fall back' from the sense of negative significance he derived from the paranoid state into a state of resting in which he could, through many

vicissitudes, begin to take his significance for granted. Harry Guntrip (1968) points out that 'although regression is a search for safety it is only really safe when there is someone to regress with and to'. In that context my patient could at last *afford* to share with me how insecure and frightened he felt in his inner world, with its bad objects, which in turn were representations of his actual experience with a psychotic mother, against whom he mobilised his energies in a desperately destructive way. Now these same energies could gradually be reinvested in personal development.

Experience of this kind suggests to me that the person who seeks 'negative significance' only does so out of a relative lack of a sense of 'positive significance'. His primary quest is for a personal relation of a quality which would enable him to experience himself as inherently significant. To the extent that this fails to happen his developing sense of self starts to fade. He 'falls back', and as he does so he is impelled to try to prevent himself 'falling' by mentally 'hanging on' to whatever environmental quality prevails at the time. Clearly, this quality is a 'negative one', since it is the one responsible for the 'fall'. But, faced with imminent personal extinction the subject grasps at whatever is there. 'Fear of loss of contact with the external world constantly motivates efforts to regain contact with it, but this cannot be done by loving relationships, and can only be done in terms of the other two basic emotional reactions, fear and aggression. To relate simply in terms of fear sets up the paranoid state, which can pass over into ... mere destructive aggression.' (Guntrip 1968) According to Bowlby (1961), there are broadly three observable stages which children under pressure of *separation* pass through: protest, despair, and detachment. It has also been suggested (Gough 1962 and Winnicott 1965) that *impingement* forms a threat as great as separation and that, for example, a baby whose breast-feeding mother stares *at him* is inhibited from feeding, a suggestion borne out by the young man mentioned above, who came to relive the menacing experience of his mother's 'scaring, staring eyes' (the vehicle headlights) at a time before his hand (note the transference on to me) could protect him. The point is that the impinging parent is *also failing to relate personally to the child*: the bad relationship conceals a non-relationship. In Bowlby's three stages, the child's sense of relationship gradually weakens as he passes into 'detachment'. But before he reaches this stage he does all that he can to retain the relationship in negative terms through despairing protest. A female patient was surprised to find herself feeling 'volcanic rage' with a shop assistant who served another customer out of turn before

her in a queue. The protest appeared to be quite out of proportion to the incident and it came as no surprise to learn that she suffered severely in childhood with a very schizoid mother whose cut-off state aroused in my patient such intense rage, that she cried in one session 'I'd like to tie up and gag my mother so that she would just *listen* to me!' However all that emerged to express the volcanic rage in the shop was the statement to the shop assistant, 'I feel I've become invisible', since this contemporary 'deprivation' bore painfully upon earlier experience in which her rage was impotent to 'bring her mother (and her sense of herself) back'. In fact her dreams were of symbols of starvation and personal extinction: in one she was sealed up in a mausoleum 'in a wall between two rooms' in one of her childhood homes; whilst in another dream she went down to the basement and opened a door to reveal a cellar full of starving dogs with lolling tongues, upon whom she shut the door in horror, and hastily returned to the ground floor. We can see clearly how she 'fell' back through the three stages as her 'grasp of reality' faded through paucity of genuine relatedness, until at the weakest, she could only feel invisible, weak, and insignificant in a remote and overwhelming world. In fact, when she entered therapy, this person could only suffer in silence, and her capacity to protest only began to develop as trust in the therapeutic relationship started to grow. In one dream, for example, she was surprised to find herself demanding to be 'let in' to a family circle who had begun a meal without her, and later still, the 'dog' in her became much more lively, so that she was able to recall her progress, back to the surface of life in a world that seemed less hostile. Neither her mother nor the shop girl *deliberately* ignored her; they simply failed to notice her. By contrast a sense of persecution creates the feeling of a relationship and thus her chosen, instant defence was paranoid: the shop girl was *deliberately* ignoring her. Better to be visible and deliberately ignored than merely invisible and not seen at all.

A person who has lost heart through poor relations – especially early in life when all is new – can only feel he has a bad world to keep in touch with. In his initial weakness and need he can only retreat – fall back – from such a world since it gives his social nature nothing by which it can live. And yet, he feels compelled to fight and thereby to retain some sense of attachment and thus of his value as a person. He cannot feel good in a world that feels bad, except at the expense of his reality sense. He therefore projects his bad feeling on to the external world and clutches to himself the remnants of his good experience – a 'siege mentality': all the good inside and all the bad

outside with the ever present threat of starvation. Such an impasse is often reproduced in dream symbolism, as for example, when a patient who was abandoned shortly after birth and then institutionalised had frequent dreams either of being besieged, or of attacking a fortress (siding with his aggressors against himself). In one such dream, after a monstrous, military attack the fortress was stormed to reveal a naked and traumatised child.

With such patients, psychotherapeutic relations, not surprisingly, are hard to establish. In severe states of paranoia the appeal to a 'neutral' figure for aid, is made only under severe pressure of imminent 'starvation'. Negotiations are therefore made with *deep suspicion*, whatever socially-contrived mask the person may wear, for to the besieged every and any approach is potentially hostile. Thus the female patient, mentioned above, described her visits to me as 'a willing suspension of disbelief'. In fact, her experience had given her little reason to feel anything else, and as therapist I was regarded with extreme cynicism, as she negotiated from her embattled fortress. Hatred and fearful suspicion of a world with which one is obliged to negotiate are specific paranoid states. How the 'world' responds is crucial.

In practice all experience is a mixture of good, satisfying experience which promotes ego-growth, and bad, unsatisfying experience which inhibits ego-growth. Bion (1962) and Guntrip (1968) have suggested that whereas good experience can be 'mentally digested' and used in ego-development, bad experience remains 'undigested' and forms an inner world of unsatisfying relations between ego-fragments and part-objects, which excite and frustrate them. I believe that this inner world is a repressed product of the individual's angry and despairing attempt to retain a sense of relation with his receding world as he begins to fall into a state of detachment. This 'world' occupies a middle region, half-way between outer reality and a psychotic state – a schizoid compromise (Guntrip op.cit.), in which the self takes refuge from full commitment to personal relations in the outer world, on the one hand, and yet avoids abandoning these altogether and living completely in an inner world (psychosis). The purpose of the therapeutic relationship is to assist the person out of his compromise and in the direction of good relationships in external reality, by facilitating a state of safe relatedness which supplants, by its reliable quality, the need for retreat into psychosis.

This difficult task is saved from total impossibility by the *remnant of good experience* by which alone an individual is able to experience himself as 'in being' at all: an original 'unitary psyche' (Guntrip 1968)

with a deposit of originally good formative experience, hidden in the depths of the unconscious. According to Guntrip (ibid) the badly threatened individual goes in search of this lost good experience when he enters the stage of detachment. One female patient had had a brief period of good experience with her mother before an overwhelming explosion of bad relations with both parents when father returned from the war. For a long time in the therapy it seemed as though her paranoid state was unshiftable. Father had been unremittingly hostile to her real nature and Mother, herself too weak and afraid to stand up to him, capitulated to his oppressive value system, imposing on my patient a repressive and punitive regime. My patient had suspended her deepest feelings and was entrenched in an embattled, paranoid defence. It was a long time before I was able to sense in her that vestigial 'self' of the early months with an unafraid mother capable of enjoying maternal loving. And yet it had been implied in her survival: something had given her the power to reject inwardly (though at great cost) the values of Father, and also of the Mother in her later childhood, and to know that they were false. Whereas she was able to manufacture a spurious sense of satisfaction in negative terms from her stubborn defiance of her father, and later, of men in general, this reactive state failed to represent her real nature which lay buried in deepest unconscious, inert and waiting, *yet retaining the capacity to respond to a psychotherapeutic equivalence of that deposit of early good experience*. Beneath the paranoid defence lay the schizoid core needing an experience of unity with the therapist, as a result of his awareness of this hidden capacity in the patient. Spontaneous response could gradually replace manipulated reaction, enabling her to know that she was beginning to live from the personal centre and no longer from the periphery. Thus, sessions became characterised at this stage by the patient's long silences and sleeps, by which she indicated to me her need for a protected rest and consequent awakenings with a feeling of completeness. Seen from this point of view Melanie Klein's (1946) paranoid/schizoid state appears to be two states, one underlying the other – for as Guntrip (op. cit.) puts it, the schizoid has given up whereas the paranoid hangs on to negative relations.

I am suggesting that in seeking 'negative significance' paranoid sufferers, whilst avoiding a truly committed relationship with the outside world, with which they have become disillusioned, are also concealing a state of weakness at the core which, unbeknown to them, carries the potential for true growth and life. The implication of this is that the core of the self, which we find most clearly expressed in

infant life, is basically social and not basically antisocial. Our regressed patients – in the face of all their feelings (and sometimes their conviction) that growth is impossible – do in the end respond, if the quality of our understanding and our capacity to survive their attacks and dismissals, is adequate. Clearly they can only reach this point if we consistently relate to them as basically social and not anti-social beings. What, then can be said about aggression? I believe that aggression, pure and simple, is part of the baby's social outreach, expressed in a vigorous and energetically enthusiastic way in gripping, sucking and generally reaching out to the world. It may seem ruthless, but that is a product of immaturity and not a fixed anti-social instinct. Nor is a 'capacity for concern' (Winnicott 1965) necessarily the product of fear of the destructive force of the outreach damaging the so-needed breast/parent. All depends on the relative states of parent and child which make up the overall atmosphere of their relationship. If the child/patient's social outreach meets frustration, impingement or separation, the aggression becomes destructive in an angry attempt to force the environment to respond, and as such it qualifies as 'protest' in Bowlby's (op.cit.) sense, or as the frantic grasp of the potentially paranoid person as he 'falls out of relation'.

A further look at Bowlby's three stages may elucidate further. Hate, expressed as protest is the first reaction to be observed in the deprived child. His residual trust and sense of himself are starting to give way to doubt. He is afraid, and his frightened need is expressed as hate. One grossly neglected person leaped up out of her chair and reared up over me as I sat in mine. She was screaming and weeping and about to attack. I simply said, 'You must be feeling that I am not listening to you'. Whereupon she subsided to the floor, weeping with relief. That is, I believe, the kind of inner situation which underlies angry, destructive aggression.

In the second phase, when the hope implied in protest gives way, an angry sense of need becomes a despairing sense of need: quieter but with a poignant sense of yearning for a lost person. The battle is going on within; the individual feels weaker – less powerful to influence the situation – even more dependent on the 'significant other' to notice and respond. In these two phases which intermingle in practice, the therapist may sense how the patient is feeling and respond: there is still enough of a sense of relation for interpretation to be helpful and enough of a sense of self to respond. Still later, however, the child has lost all faith in personal relations. He is quieter and people think he has recovered. In fact he is traumatised and whereas in the first two

stages the mother's return can restore connection, in the final stage of detachment the child seems not to recognise the returning parent. Here active intervention (including interpretations) is unavailing, and only a steady, understanding accompaniment can restore the relationship. Meanwhile the child feels progressively detached, unreal, strange, cut-off and remote. He has 'retreated inside himself'.

Paranoid feelings can arise at any of these stages, increasing in severity towards the third stage. In the first stage the anger which arises to compel the environment to react and to master the individual's fear that he is losing himself, may well beget a *fear of reprisal* and *actual reprisal* from the environment he is raging against. He feels his own anger, plus anger coming back at him, seemingly from the missing parent. In a strange way this may comfort him for it produces a spurious sense of significance: better a bad relationship than none and better a negative sense of significance than none. In the second phase, that of despairing longing, the tendency to experience the environment as hostile is even greater, since the sense of true significance is fading fast. The child may be more than ever convinced that he is responsible for his situation – a conviction that adults so often help to reinforce by blaming the child for being so clinging and disconsolate. When the stage of detachment is reached a state of inertia eventuates in resistance to any approach. The child's basic nature is under siege, and capacities and talents which might in better circumstances have been organs of confident self-expression become exploited to ward off a bad world. As previously mentioned, impingement occasions the same withdrawal as separation, because impingement always involves to some measure, an incapacity to relate to the child's true nature. It is, however, more productive of 'healthy paranoia' than separation is, since it provides an externally real threat to focus on. But eventually the inevitable component of 'non relationship within the bad relationship' has to be faced.

Paranoid states, since they are, in my view, always underlaid by the schizoid state to some extent, must always be approached with the schizoid core in mind. The patient needs the therapist to locate this hidden self with its deposit of good experience and potential for growth, its need to be loved, and its capacity to respond in kind.

Guntrip, (1968) Balint, (1968) and Winnicott (1965) have all in their respective ways described the 'fall' into detachment as a *search* for sanctuary, so that what is seen from the conscious point of view as a fall, a loss, can also be seen as a determined unconscious search for a psychic equivalent of the womb state. All the patients mentioned earlier

needed me to be attendant upon this regression – neither intruding upon nor deserting them. For them it was this experience of 'patient abiding', underlying any interpretive work, which enabled them to realise that the state they consciously experienced as deadness, feared as passivity, and fought against, was the potential matrix for the evolution of their true nature. As the patient begins to grow from this deep level, patient and therapist together partake of a mutually enriching dynamic which both attest to. The way in which the therapist accompanies his patient at this level may best serve to illuminate the kind of approach needed by those in paranoid states: a person who feels he/she is besieged needs a respectful distance to be maintained by a potential rescuer. He needs to be able to re-experience his inner hollowness and poverty as a sanctuary to which the heart of his nature has been driven, and in which he may remain until/unless he feels a genuine desire to emerge. He needs the therapist to respect his need to harbour and to hoard his meagre resources whilst continuing to shut his would-be rescuer out. He needs the therapist to understand, through the transference, the kind of circumstances which obliged him to accept responsibility for his own survival. The paranoid sufferer is not going to be convinced by any proselytising mission to persuade him of the goodness of his world when he has from early on worked out his whole strategy of survival in terms of negative values and significance. He doesn't know what a good relationship might be or what his genuine nature might be, let alone how it could evolve.

It is thus at the stage of detachment that the problem is most severe for the therapist as well as for the patient for there is nothing coming back from the patient which could confirm the value of the therapist. One patient made her position explicit at the outset: 'I don't want to know anything about you', she said. She had had an overwhelming experience since very early life of being impinged upon by her mother's needs, forcing her into a detached retreat from which she viewed the world with extreme cynicism and suspicion. Not surprisingly, she was drawn to the very type of personalities which confirmed her negative feeling about the world and about herself. It was a very long time before she could accept that perhaps the one thing she did need 'to know about me' was my preparedness to wait whilst she came to experience and enjoy unthreatened privacy. What sustains the therapist – aside from his/her own supports? It can only be a steady analytic perception of the conditions which enforced such a withdrawal in a human child, and, now of the 'child' in the patient who has been so

deprived of genuine love, as to be compelled to remain locked up within.

Since the other two levels – protest and despair – represent an attempt to retain or salvage some experience of relation, in the outer and inner world respectively, and therefore of personal significance, albeit in negative terms, their presence implies a sinking or falling of the heart of the self on account of which they are mobilised. Thus to reach and restore a person in either of these phases – we may still expect to have to wait. Angry protesting and despairing states can become as fixed as the more detached states they deny and imply, and they will remain fixed unless we can detect and relate to the detached element within them. They always represent an attempt to compel a deserting or impinging needed-person to relate in beneficent terms; and an attempt to avoid the drastic loss of heart and spirit represented by detachment.

Accordingly, paranoia can be the result of an *active* angry state, or a despairingly manipulating state, or a *passive* detached state from which the subject looks out at a hostile or remote world. In practice, all three states intermingle, and in attempting to negotiate with someone in any of these states, the 'loss of heart' involved calls for some degree of 'patient abiding'. Just as with a child one would outlast his tantrum by being interested in what might lie behind it, so with a withdrawn, silent child one waits, though for far longer, for him to notice that, after all, he is not alone, in order that he may experience the gradual evolution of his true nature in a satisfying relationship.

Seen from this point of view paranoia is thus the result of an anxiety driven attempt to retain contact with a world in which faith has severely diminished or been lost. The anxiety is over dying for lack of relationship – and the struggle is therefore for survival in a deficient world – whilst the core of the self 'waits', in the isolated insulation of the unconscious, retaining the potential for growth in better circumstances. The potentially therapeutic relationship includes as a chief ingredient a recognition of the weakness and fear of the isolated core, but must also include a good, consistent example or model with whom a good identification and then differentiation may be achieved. According to the view expressed here the specifically paranoid 'flavour' is constituted by the actual quality of the 'world' which causes the problem, and is often reinforced by punitive attitudes towards the inertia (often seen as 'laziness' or deliberate inattention) which accompanies detachment and withdrawal, and also towards the fear and suspicion which characterise attempts to retain or regain contact

with a harsh world. In time – and usually by the time the patient arrives in treatment – the persecution is carried out by part of the sufferer against his own inner self. This arises in the first instance because, in his weakness and dependency, the child has no means of differentiating and so must remain, at a deep level, identified with his rejecting parents – a problem which must affect all his relationships in the everyday world, on to which he projects bad parental qualities. This is also the way he sees the therapist in the transference – as yet another representative of an uncaring world – and it is largely upon the ability of the latter to survive these projections by maintaining his own identity and capacity to understand the origins of his patient's experience that therapeutic effectiveness depends. It is important, however, to note that this cannot be done by transference interpretations alone. The understandable consequence of working through a projection of negative significance in transference is a clearer need and readiness on the part of the patient to experience and use a relationship in which he really feels a sense of positive significance which he can use for growth. Dependence is likely to be considerable, and in his relatively weakened state he will be unlikely for some time to find such a relationship in the outer world. It is therefore *required* by the patient that the *therapist himself* use his understanding and support to encourage the gradual natural evolution of his proper self, undistorted by paranoid fears except where these are observable and justified by outer circumstances. This mature, parental, affectionate support for a new life is what the patient needed and lacked in his childhood. Thus the female patient whose 'willing suspension of disbelief' represented her efforts to overcome her fear of her barren world and her own weakness and starvation came eventually to experience her sessions as a 'good feed' and to use the therapeutic relationship as the mainstay and background for her personal development. It may take a long time for the confidence developed within the therapeutic relationship to pervade the patient's experience of the outer world and many references from one to the other may have to be made. It is also often the case that something unpleasantly like the original state may return if outer reality isolates or impinges upon the patient unduly – but with this vital difference: somewhere at quite a deep level in the patient's experience there has now formed a conviction, based on sufficiently therapeutic experience that he/she is of positive significance to someone who is of equally positive significance to him/her. This was expressed quite simply by the above patient who said in a plain statement of fact: 'You saved my life.'

In objective terms, perhaps we are privileged to watch a gradual reduction of an arrogant denial of natural needs, expressive of the patient's method of self-cure, down to a capacity for interdependence. The world is accepted as a mixture of good and bad, helpful and frustrating personalities: a testing experience, but not now an ultimately defeating one.

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LOYALTY OF THE ABUSED CHILD

VICTORIA ELLIOTT

Introduction

This paper is an account of two and a half years of intensive (3 × weekly) psychotherapy with a young boy whose external world was of an unpredictable and sometimes terrifying nature. There will also be a brief reference to the subsequent two years of once weekly psychotherapy which still continues.

Paul showed remarkably little awareness throughout therapy of his mother's extremely ambivalent feelings towards him. He actually blocked from consciousness his fear of his mother and his experiences of abuse and rejection. This enabled him to preserve the image of a good mother and to deny his powerlessness. His view of himself and his objects became quite distorted. Paul identified with his mother's aggression and reenacted abusive experiences in therapy, often with himself in the powerful role. In addition, Paul's very negative picture of his father and his fury and intolerance of him helped him to direct his anger and murderous impulses away from the mother who was failing him, thus making life with her more tolerable.

The external traumas in Paul's life have impinged on Paul throughout therapy, hindering his development. Consequently they impinged on the therapeutic work making our task more arduous. In addition to talking with Paul about his internal world it has felt to be essential to acknowledge the painful reality of his external world.

The referral

Paul's mother, Ms H, requested a referral to Child Guidance through her social worker. Ms H expressed considerable concern about Paul's disobedience and her difficulty in managing him. She described him as extremely possessive of and aggressive towards her if he had to share her attention. Often he laughed if punished.

Qualifying paper for Associate Membership of the British Association of Psychotherapists, awarded Lady Balogh Prize 1991.

In a report from his day nursery Paul was described as very demanding, attention seeking, and showing no remorse when punished. He was seen as a leader amongst his peers, impressing them with his assertiveness and his clowning behaviour. The nursery workers wrote about him with affection despite the difficulties and pointed out how caring he could be towards younger children. Developmentally, Paul was seen as achieving fairly well, having particularly good language skills.

History

Ms H described her own unhappy childhood which included long periods in local authority care. Whilst living with her parents she was physically and sexually abused. As a young adult she spent over a year in a psychiatric hospital where she was diagnosed as suffering from a manic depressive illness.

Ms H became pregnant with Paul in her late twenties after having known his father for several years. They lived together only briefly. Following Paul's birth Ms H suffered from postnatal depression.

Paul's early years

Ms H could not recall much about Paul's infancy. He was a full term baby who was bottle fed. He was walking by ten months and using several words by one year. In therapy it became clear that there was a strong drive in Paul to acquire new skills that would help him master his environment. His early walking and advanced use of language are examples of such.

Paul's father was involved in his care for the first few months. Subsequently his contact was very sporadic due to the acrimonious relationship between the parents. Paul's father developed a chronic illness which was quite disabling. At the start of therapy Paul had been told by his mother that father no longer wished to see him as he found Paul's behaviour too much to cope with due to his disability.

When he was 2 years old Paul started to attend day nursery full time, presumably because Ms H was having difficulties in coping with him. Over the next two years she seems to have continued to find it hard to manage and she frequently requested Paul's reception into

care. In fact he was received into care on two occasions. Mother maintained regular contact each time.

A couple of months after therapy commenced I learnt that Ms H had told her social worker that on several occasions she had hurt or threatened Paul. Sometimes she hit him very hard, she had attempted to strangle him, and on one occasion threw a knife at him. As a result of this a Child Protection Conference was called. Paul's name had not been registered due to Ms H's co-operation and apparent willingness to work on her difficulties.

Therapy

Throughout the first two and a half years of Paul's therapy Ms H was seen weekly by a social worker. Partly as a result of this support Ms H was able to bring Paul regularly to his sessions, a few exceptions being when she was very depressed. I met with Ms H and her social worker on a termly basis.

The first session

At the start of therapy Paul was a sturdy 4-year-old with a round chubby face and light brown hair. He showed brief anxiety about leaving his mum for our first session by this was quickly covered up with an air of bravado and his attempts to keep one step ahead of me. I was soon to learn that this, for Paul, was a characteristic way of dealing with his anxiety. He led the way down the corridor and deliberately went the wrong way, then with a smile sharply turned and went the right way. He seemed to need to turn his uncertainty into a game in which I was made to feel the puzzled one, not him.

Once in the room Paul launched into fantasy play with animals and dolls, the themes of which were to remain relatively unchanged over the next year. I was made to represent the little dolls or animals whilst he played numerous roles of aggressor or rescuer. Letting me get a taste of how it felt to be little and at the mercy of unpredictable adults became a characteristic way of Paul passing onto me his experiences. In this session it was striking how full was Paul's fantasy play of terrible dangers and disasters, of people dying, leaving or disappearing. A daddy who was a rescuer one moment, then deserted his little boy. Paul instructed me to cry as the boy, and then to laugh. This reversal

of affect demonstrated the degree of his ambivalence about his objects that emerged over time, and was also a common defence mechanism that Paul used to deny his anxiety and pain. Selma Fraiberg (1982) in writing about the development of pathological defences in infancy highlights the early evidence of a transformation of affect on children, a parallel to 'reaction formation'. From her observations of deprived and abused children she attributes the laughter of such children in an apparently painful situation to a defence against intolerable anxiety.

I felt quite bombarded by the material of this first session, and confused by the unpredictability of the figures Paul portrayed as well as by his behaviour towards me. I had a glimpse of how controlling he could be and of his frequent teasing, tricking and clowning behaviour. He tended to evoke responses rather than allow things to unfold between us, so I felt I was constantly reacting to him. However, there was an engaging quality about Paul and I found myself warming to him in our first contact.

The first few weeks

Paul's ambivalence

Over the next few sessions Paul continued to demonstrate his relatively unconscious anxieties about relationships both through his fantasy play and his developing relationship with me. There was a recurring theme of danger and rescue in a never-ending cycle. The early dangers portrayed were of falls from great heights, fights and suffocation. Good turned to bad quite unpredictably and little ones became big by magic in order to escape the danger.

In the third week Paul introduced material of an oedipal nature. Male and female dolls were banged together excitably and the mother, father and boy doll were piled on top of one another in different ways. He said they were crushing the one underneath who was gasping for breath. In this and later material Paul seemed to be demonstrating his wish to break into the parental intercourse but also his fascination and horror about it. At the same time he enacted fantasies involving terrible attacks on the father doll. Children tricked adults, particularly males who then came back to take revenge. I began to get a picture of how this little boy had internalised his recent experiences. In line with his omnipotent view of the world, reinforced by his mother's explanations, Paul seemed to believe that he had broken up his parents'

relationship and had won his mother from his father. He subsequently lived in fear of his father returning to take his revenge. The only safe father would be a dead father in his mind. At the same time however, the mother he had conquered was often frightening or rejecting and he needed the father he had killed off in fantasy to come to his rescue. His intensely ambivalent feelings about both his parents had contributed to the changeable and unpredictable images of his mother and father in his internal world. Any attempts on my part to reflect on what was happening led to an immediate increase in Paul's manic behaviour. He would talk over me and become noisy and messy. He strutted around the tops of cabinets showing off his muscles, and trying to demonstrate how tough and agile he was. The pace at which Paul moved from one fantasy to the next made it quite hard to find thinking space and to formulate what I might say to him.

In the toilet Paul would sometimes let me know more directly how important our relationship was becoming to him, such as by calling out from the cubicle that he liked me. It seemed safer to let me know when there was a barrier between us.

After our first few weeks of therapy I took a short break for Easter, which meant we missed four sessions. Paul reacted quite strongly to the forthcoming break. At the start of sessions he began throwing most of the toys from his box recklessly over his shoulder. Sometimes he called them 'naughty' or 'poo' and kissed them before discarding them. Paul seemed to be demonstrating the mixed treatment he felt that he was receiving from me.

In the week before the break Paul enacted a fantasy which seemed to demonstrate his ambivalence about his objects and his perception of the mixed care he received. There were two little cheetahs; one nice, one bad, who were going to fight one another. However, whilst the nice one hid, the bad one attacked mummy. Both the cheetahs became nice but greedy. They asked mummy for milk but all she gave them was horrible milk from the pond, so they left her. She was crying but the lion offered to carry milk to the cheetahs in his mouth, which he did. I suggested that Paul might think that I was like the cheetah mummy who should be giving him something nice but instead was treating him badly by going on holiday. Paul asked if I would cry when I did not see him. I said he was hoping we did have the kind of friendship that would make me miss him when we were not together. I had learnt early on to frame my comments positively rather than neutrally to make them more bearable for Paul. As usual it was not

possible to talk any further with Paul as he had already buried himself in another fantasy. These moments of linking up were like little oases.

During the penultimate session before the break Paul's messy attacks and challenging of boundaries reached a peak. He messed me about continuously in the session throwing toys or water, peeing on the floor and running out of the room. However, he came to the final session proudly holding the story of the Ugly Duckling. With great delight he told me the story of how the ugly duckling that no one wanted to know turned into a beautiful white swan. In this very moving way Paul seemed to be expressing his hopes that I would be able to see beyond his messy exterior and help him find the loving and lovable little boy underneath.

After Easter: second to fifth month of therapy

The need for super heroes

As our relationship developed and intensified Paul's excitement in sessions increased, as did his accompanying anxiety, which seemed to take the form of fear of prohibition, attack and rejection. He would come to sessions kicking doors and walls in the corridor, throwing toys and repeating words like 'rubbish' and 'poo'. Increasingly he rubbished me, calling me names and in fantasy throwing me in the wastepaper bin. In addition he made several complaints about his mother, about her prohibitions, her tendency to call him names and to smack him. In this way Paul seemed to be giving me a picture of how he perceived his mother's view of him.

In addition to his fear of rejection Paul demonstrated his fear of physical attack and danger. His fantasy characters became super men and women as if he believed that he and his objects needed super powers to survive what we might do to each other. His responses to ends of sessions intensified. In one session Paul held up the scissors to his own throat and told me I had better watch out or he would cut my throat. He appeared to be demonstrating an attack that he feared from me, based on the real life threats from his mother.

From early on my countertransference feelings were quite intense. Specifically the experience of bearing witness to Paul's appalling enactments through his fantasy play, yet feeling silenced and often powerless, was extremely painful. He could sometimes tolerate me putting this into words through the little dolls or animals but of course it was

impossible for him to hear my links with his own experiences. It seemed intolerable for Paul to acknowledge my independent functioning as if this could only mean danger and pain for him. I tried to develop ways of talking to Paul that he found more tolerable. I began to give him warning that I wished to talk to him about what was happening, to prepare him and hopefully gain his cooperation. This had limited success. I often talked about him in the third person by talking to animals or dolls, or to myself. He showed some tolerance of this technique. I began to believe that my most useful function was to show that I could bear to know about the horrors of his internal and external world and could survive his attacks and mess, without giving up or retaliating. It seemed that Paul needed an experience of containment over time as a counter experience to his view of the unpredictability, dangerousness and inadequacy of his objects. Frequently the containment was of a physical nature. Early on I learnt the necessity of drawing up fairly firm boundaries for Paul, in order to make it possible for therapy to continue. I often spoke to him about his need to make me into a 'No therapist'. By frequently provoking me to set limits it was as if he could believe it was under his control and that the no or the rejection would not come unexpectedly.

During this period Paul was very conscious of children he could see and hear in the nursery downstairs and of signs that others used the room. When I fetched him for one particular session he introduced me to a boy he had befriended in the waiting room. He was curious about why the boy came to the clinic. Paul's subsequent behaviour in this session was particularly manic and macho. Also, in this session he threw a father doll away with a terrible shriek. The thought that I might see someone else seemed intolerable to Paul as if he had no concept of it being possible for interests and affection to be shared. He also did not seem to clearly differentiate between relationships I might have with boys and with grown men. When I spoke to him of how much he wanted to feel special here he told me he could not be as his mum would not allow it. Again he seemed to be conveying the belief that sharing affection or caring about more than one person was impossible, perhaps without someone getting angry or hurt.

In addition to his preoccupation with the dangers of triangular relationships Paul brought more material about two person relationships. This was mostly focussed on people hurting each other through rejection or murderous attacks. In one example a little boy kangaroo had been playing around and teasing his mother. Mother shouted, 'I'm going up to get that cunt, and then I'll kill him'. Paul shrieked

and in a panic made the little one kill the mother and all the other animals. In another session Paul laid contentedly on the bed but suddenly grasped his throat in a stranglehold, and told me he had no air and was dying. From his history it was clear that Paul was enacting not only his fears of what might happen in a close relationship, but his memories of actual life threatening situations. However, after these dramatic incidents he would suddenly jump up grinning and cocky, saying 'only joking'.

The strong denial and frequent reversal of affect following the presentation of his deep anxieties left me feeling shocked, tricked and muddled. Paul felt slippery and hard to pin down. I often was left carrying the feelings of horror whilst he was off onto numerous other fantasies. If I tried to talk about it such as by saying I could not forget what had just happened it was so shocking and must have been so frightening Paul would become furious and battles to stop me talking and thinking would ensue. Paul's subsequent aggression, messiness and risk taking behaviour demonstrated his terror at being overwhelmed by the reality he was trying so hard to deny. In one sense Paul's defences were quite effective in that they helped him keep up the illusion that he was powerful and not a little boy. I found it hard to get a feeling of his vulnerability and anxieties, and could understand the descriptions of him from his teachers and mother as 'a powerful child'. No doubt some of my feelings of uselessness were a counter-transference response to Paul's poor self esteem which he desperately tried to cover up. Also Paul was bringing into the transference his expectations that his carers would be useless and fail him in significant ways.

In the fifth month Paul began to express some concern for the attacked mother figure and in reality about the real damage to the dolls. All the dolls were falling apart due to being wet so often. Paul was quite distressed by this and sometimes threw them out of sight. He asked me to fix them, and was quite relieved when I tried to sew them together. In contrast to his concerns about the mother figures Paul showed little remorse following the attacks on the father dolls. He made it clear to me that he did not wish to be like his father but like 'He man.' As well as father being portrayed as a potent, revenging and sometimes rescuing figure he would often end up in physical danger, collapsing, gasping for breath and dying. Paul seemed to find it intolerable to contemplate that his father was a sickly man. His guilt at being told his behaviour was too much for father to manage and his apparent rejection of Paul were unbearable. Instead he strongly

denied his wish for a father and he became represented as a bad, useless object in his internal world. As mentioned previously Paul's projection of much of his bad feelings into father helped him to preserve his image of a good mother because although he occasionally allowed hostile thoughts about mother to become conscious, he fairly quickly repressed them again. This splitting helped him survive living with his mother.

Sixth to twelfth month

Impingements on the 'lovely little puppy'

The autumn term, around Paul's fifth birthday was a relatively uneventful period in terms of external impingements. Paul was more relaxed in sessions and there were moments when we were really able to link up. His play became more of a communication than a means of discharging intolerable feelings and the fantasies involved us relating more directly to one another, as if he were bringing his conflicts, wishes and anxieties more into our relationship. As he became more in touch with his loving feelings he also allowed himself to experiences his wish to be loved and well cared for. However, putting this into words remained intolerable. Paul developed numerous fantasies about being a little animal, born to me. He seemed to be considering how it would feel to be really wanted. In one fantasy that developed over several sessions I had to choose him from all the other puppies in the pet show, saying I wanted 'that lovely little King Charles puppy'. I was to fall in love with him as I watched him sweetly sleeping. He built a kennel for us where we were to live together. Sadly, I always rejected him for being naughty, such as for pulling on his lead, or for being too playful, and he was then sent back to the shop. I was sometimes allotted the role of father, and it was during these rare fantasies that Paul enacted pleasurable encounters between father and son, and directly told me that he missed his father. However, on one occasion when I suggested he might wish his dad would come back to help him when he was feeling sad or lonely, Paul replied scornfully, 'my dad wouldn't help me'.

As well as acknowledging his disappointment in his dad he also acknowledged that his mother seemed like a big bad wolf sometimes, was mean to him and hurt him. There were occasions when he seemed

able to differentiate between mother and myself rather than being constantly caught up in non-discriminatory responses.

In my termly meetings with Paul's mother and social worker, Ms H tended to be fairly negative about Paul and therapy initially. As the meeting progressed she always became more positive and I was often surprised by her insights. She described Paul as becoming less aggressive and destructive over the first year of therapy and of being more affectionate. However, I learnt from the social worker that during Ms H's depressive phases she was always very negative about Paul and rejecting of him.

During a more tranquil phase up till the Christmas when Paul was nearly 5 years old I began to believe that Paul was relinquishing his defences a little, as a first step to becoming more in touch with reality. However in the following January I learnt from the social worker that after a disappointing Christmas with her family Ms H had become very depressed. Initially she failed to return Paul to therapy or school after the break. The social worker was so concerned by Ms H's negative attitude to Paul that she contacted Social Services and a Child Protection Conference was considered. The threat of this seemed to help Ms H return Paul to school and therapy, although she remained very depressed for many weeks. In sessions Paul's rescuing fantasies increased, including ideas that father would rescue him and that I would kidnap him whilst he was sleeping. He acknowledged his disappointment that I did not come to see him when he missed sessions. His fantasy play indicated how alarmed and desperate he had felt at times, being shut up in a flat with a mother who was very depressed and angry.

In February Ms H renewed contact with father who was hospitalised following a deterioration in his illness. He was partially paralysed, incontinent and had very slurred speech. Father's illness seemed to pull Ms H out of her depression as she saw a role for herself in caring for him. Paul was taken regularly to visit his father. From this point onwards Paul's defences took on renewed intensity. Seeing his father so powerless and ill seemed to fill him alternately with feelings of power and triumph, but also despair through the confirmation of his father's uselessness. In sessions Paul role-played a macho man drinking at a bar who suddenly began dribbling his beer and talking with slurred speech. At home and in therapy on a couple of occasions Paul soiled himself. He seemed to be trying to make sense of his father's illness by identification.

Over the next few months the idea of rivals became stronger in

sessions. Paul enacted numerous boxing and football competitions in which he beat his imaginary opponents and swaggered before me as the champ. He expressed his loving feelings to me quite openly, talked of his wish to marry me and for us to live together. Subsequently he became enraged at the limitations of our relationship, such as ends of sessions and holiday breaks. His anger, as well as his love, took on a new intensity. In his wish to deny reality Paul became more and more frantic. There was little space for thinking as he moved from one omnipotent fantasy to another. When I made reference to the wishes contained in his fantasies he responded with comments like, 'I *am* the daddy. I *am* a big man. I *am* married.'

Over the summer term when Paul was about five and a half years old his hostile feelings for both his parents appeared to break through to consciousness, although only fleetingly. In one session he told me that his dad did not want to see him, and that no dads were any good. Sadly, he did not seem able to consider that his dad did not want to be a bad father to him and may not be useless on purpose. It was safer to write his father off completely than to acknowledge his own ambivalence, as that would have meant becoming aware of his enormous feelings of longing, need and disappointment. Paul's anger with his mother became very intense as did his anxiety about his murderous wishes. Paul told me that his mother, 'bloody well smacked' him, that she sometimes did not love him, that she was a witch, called him names and kicked him. One day he told me his mother would not stop pestering him and asked me to kill her. On another day he said he did not have a mummy so was going to get a new one. After one of these sessions in which he had been particularly hostile about mother he was reluctant to leave her to come to the next session. Over this period he made a great fuss of mother through the glass doors that we passed on the way to sessions, and seemed to need his mother's approval more than usual.

Near the end of the summer term Ms H withdrew Paul from his school and enrolled him at another school for the autumn term. The teachers had been finding Paul hard to manage and I had attended a couple of meetings to discuss the problems at school. Paul was seen as needing constant individual attention which he responded to well. In a class situation he was attention seeking and disruptive. Interestingly Ms H usually stuck up for Paul when he was criticised by outsiders, such as the school, and would also often defend his outrageous behaviour. Thus Paul and mother showed great loyalty to each other when anyone else was perceived as being critical. In addition,

when Ms H was not depressed her periods of intense anger and rejection of Paul seemed to be forgotten.

Therapy 18–21 months

Contempt for the 'Poorly little Lamb'

When Paul was almost six years old Ms H agreed that his invalid father should come to live with her and Paul in their small flat. When I met with her for our termly meeting she said she was doing it for Paul's benefit, so he could have contact with his dad. Paul's treatment had always felt like hard work but the following few months became an even greater struggle. This was related to Paul's continuing manic defence, his apparent inability to use me and a very negative counter-transference response on my part.

As usual when Paul was anxious his worries and conflicts became displaced into fantasy play with animals and dolls. The old themes of danger and rescue, good becoming bad, laughing instead of crying, tricking and teasing recurred in a relentless cycle. Paul's response to me making sense of what was happening became even more extreme. He blocked me out, became even bossier and noisier, made dreadful messes with water and toys and was rarely interested in helping to clear up. In many ways Paul was quite out of touch with reality and clearly 'knowing' felt far too dangerous. It was much too frightening to know he was only a six year old boy who was dependent on a mother who both loved and hated him and who could switch from one state of mind to another quite unpredictably. He could not bear to recognise his longing for a father, and how little his father seemed to care for him in that he had deserted him and made no contact and now reappeared as a sick and disabled man. His father's presence in the home was like a constant reminder of his own badness, and of his unconscious belief that he had damaged father by his aggressive fantasies. Additionally, amidst his clowning behaviour, Paul sometimes acted out collapsing and dying. Through identification, his father's disability was experienced as a serious threat to his omnipotent defences and also to his hopes for the future.

Paul continued to demonstrate his mostly unconscious sense of vulnerability and neediness in a displaced way. In a session near the Christmas break Paul, 'cried like a baby' on behalf of a 'poorly little lamb' who was sad that he had to go home after having a lovely time.

He went on to say that the little lamb lived in an empty house, had no friends, no toys, no food and no mum and dad. Through his fantasy he expressed his scorn for the little lamb and was cruel to it. In this way Paul was bringing his unconscious feelings about his sense of deprivation and neediness, but also his intolerance of it. Much of his aggression and activity seemed to be a desperate attempt to ward off feeling overwhelmed by his deprivation. The limitations of the therapeutic relationship were particularly hard for Paul to cope with, so much seemed to be possible yet these made it seem like a tease or torture. In another fantasy at this time I had to throw him in a dust-cart where he was taken away and crushed, clearly demonstrating how crushing an experience the limitations were.

My countertransference over this time was painful and hard to deal with. There seemed to be such a gap between the horrors, sadness and deprivation of Paul's internal world and his behaviour and more conscious attitudes. His continued denigration of me and blocking of my independent functioning felt extremely frustrating, infuriating and hopeless. I was struck more and more by the repetitions of these appalling disasters in his fantasy play and by his inability to link them with his own experiences. At times I felt dulled by the never-ending and hopeless quality of these re-enactments.

I found Paul's behaviour quite unbearable at times and on a couple of occasions when he was most provocative I really felt like holding him and shaking him. I felt I understood in a more real way how it is that abused children get re-abused when placed in fostering and adoptive homes. With Paul closeness seemed linked with being hurt, and it was this familiar way of relating that he seemed to want to evoke. Shirley Hoxter (1983) in writing about work with deprived children says, 'The child seems determined to destroy the very capacity for caring attention and receptive understanding and to succeed either in making a fool of the therapist or in forcing him to become, like the child has become, an unthinking instrument of retaliation'. During this phase it was also brought home to me how terribly difficult it can be to influence a child's internal world. It became clear that the experience of being treated differently did not change Paul's expectation of close relationships. It was as if he continued to expect me to behave as dangerously and unpredictably as his mother, and his need to control and defend himself with me was as great as with his mother. Talking, listening, sharing and understanding were not activities that Paul was able to use and value, but were viewed more as attacks or as criticisms. When I spoke about Paul's wish for me to adopt him,

like the poorly little lamb, this was experienced as intolerable, like rubbing his nose in the mud and gloating over his deprivation. Additionally it was what Paul did not get rather than what he did get, that made its deepest impression on him. Hoxter writes 'Painfully we learn that "being in touch" is a torture for some children; what is intended to be a gentle approach to contact may be experienced by the child almost literally as a cruel stab at an open wound'.

From this point on I decided to focus more on the here and now of the transference and on his resistances and why he would not listen to me. I made attempts to reframe his responses by using his values, for example I wondered when he would ever feel brave enough to let himself feel sad with me. When he resorted to denigration, I would say semi-playfully, 'Oh no – not that old stuff again!'. These different responses caught his attention and seemed to make some impact. He began pre-empting me. At times, for example, after shutting me up by swearing loudly, he suddenly stopped and said, 'Oh not that old swearing again'. For the first time he had begun to draw pictures which required some concentration. His first picture was of the world, with people, houses and trees. He told me that God had made the world. It was as if he was becoming conscious of something bigger than himself that was in control. In therapy he may have begun to feel that I could contain him. Additionally this seemed to be the start of a move towards latency.

Therapy January–July. The last six months

The frozen penguins first friends

Remarkably, over this phase Paul had settled well into his new school and mother no longer had serious complaints about him. Father remained in the family home until March. I heard from mother and Paul that father and Paul clashed severely. Father was intolerant of Paul's needs and Paul was scornful of his father's uselessness. Father remained severely disabled and Ms H admitted she had no love for him.

Paul began to talk more directly about his life and about his feelings and seemed less overwhelmed by knowledge of reality. Sessions were no longer dominated by the messes and battles although manic activity continued to be the way in which he dealt with anxiety.

Father's presence and the conflict this created impinged considerably

on the work. On a few occasions he was able to acknowledge his rage with his father and also his sadness and disappointment at having such a 'useless' father who did not like him. However his feelings of having triumphed over father and his fear of punishment were still apparent through his fantasy play.

Paul developed a new capacity to remember past sessions and to hear my links with past material. He would often start sessions saying, 'Remember what we were doing last time?'. Sharing a past together, and making connections added more of a sense of dimension to our relationship and Paul seemed more engaged in the therapeutic process.

However, by March Ms H had become very depressed due to a relationship breaking down. Father returned to hospital and Ms H once again vented her anger on Paul. The social worker was shocked by the intensity of her anger and rejection of Paul, although he was trying very hard to please his mother. Ms H reported to her social worker that in her anger she had kicked and hit Paul wildly until father had intervened from his wheelchair. On another occasion she had tried to strangle Paul and now wanted him to be received into care.

Sadly, the impact of mother's rejection of him from March onwards, when he was now 6 years and 4 months heightened Paul's anxiety and reinforced once again his desperate need to defend himself. Surprisingly however signs of progress were not lost. I continued to feel more in touch with Paul and he appeared more able to experience his sadness, despair and terror. In one April session he had introduced the concept of a little penguin who was frozen by a crocodile's breath. He was able to listen to my links with his frozen feelings and when I wondered what would happen if the penguin was no longer frozen, he told me that his tears would cause a flood adding that the penguin liked ice and not hot water. This partly illustrated why he defended himself so strongly in my presence as he saw my different treatment of him as liable to open him up to the pain he feared would overwhelm him.

Paul made increasing references to external reality; for example incidents in which his mum had hurt him, although he could not tolerate me talking about it. He was particularly protective of his mother when her rejection of him was most extreme. He tended to blame himself for her unhappiness. In one session he told me that his mum was lovely and was not cruel to him. He also said he hated his dad and that I must not remind him of how horrible his dad was. In one fantasy in May Paul surrounded a little pig with all the other animals. He told me they were ganging up on him and would kill him

because he had hurt his parents by accident. Clearly he was demonstrating how he felt to blame for the breakdown of his family. It is likely that when depressed his mother had experienced Paul's very existence as a demand, and his ordinary needs as greedy. In his choice of the little pig Paul had adopted his mother's view of himself, and seemed to be saying that his greed or badness which was unintentional on his part, had harmed his parents.

Ms H had been threatening to withdraw Paul from therapy and had been pressing for some time to know when therapy would end. When she was feeling good she could acknowledge the changes in Paul but when depressed felt nothing had changed. As therapy felt precarious I decided to continue seeing Paul three times weekly until August and then reduce to once weekly. This seemed likely to be more manageable for his mother and so less likely to be under threat of a sudden termination. There was also to be a change of venue from August.

In May Social Services received Paul into voluntary care for six weeks. His foster mother brought him to therapy. Just prior to his reception into care Paul enacted a fantasy with the lonely little penguin who had no friends to fight the big baddies. When I made a link with his feelings of helplessness about going into care he was able to tell me that he thought there would be prison bars and no drinks. He said it was his fault because he had made his mum unhappy and she needed a rest from him. I suggested that maybe he needed a rest from mummy too, because it must be hard living with a mummy who was very unhappy and angry at the moment. I also mentioned that I would be involved in a meeting with his mum and social workers to discuss his going into care. After this Paul gave the penguin some friends and he was no longer in such danger. At times it has felt important to talk to Paul about external reality and to represent him when important decisions are being made.

Paul's behaviour remained quite frantic throughout his time in care. In his fantasies animals and dolls were crushed, drowned and would fall from great heights. They were torn apart and cut up tortuously. He was demonstrating how crushing and cutting an experience his mother's rejection of him was. At times Paul earnestly begged me to help save the children but never allowed me to. I was very aware of my own sense of helplessness in relation to external events. In one terrible sequence a boy doll was going to kill himself because he was so badly hurt by the big dolls. The mother doll was also in terrible danger of slipping over a cliff and the boy tried to save her but could not do so. I learnt from the social worker that Ms H had threatened

to kill herself and Paul. Paul was clearly aware of his mother's suicidal and murderous thoughts. Additionally the boy killing himself seemed to be both an expression of his own wretchedness, and the rage he felt towards his mother and myself turned inwards against himself. The mother slipping over the cliff also seemed to represent Paul's difficulty in holding onto a picture of a good mother.

Paul's manic behaviour continued after he returned home but for the first time he began to show direct evidence of fearfulness in sessions. He was fearful of the water flooding, of the toilet flushing or being blocked, and I became more conscious of his fear of me talking. He seemed terrified of his intense feelings and seemed to feel that he and his objects were in a life threatening situation. He got into big rages with me particularly over limits I set, for example over how much water he should have in the sink, but there was more evidence of internal control. Sometimes in these rages he would throw himself against me and remain leaning on me. He seemed to need physical contact and more concrete signs of caring and containing. I often reflected on why it was so difficult for Paul to cry out of sadness in sessions. It seemed that he had no belief of there being a shoulder there for him to cry on, or that crying could be beneficial. Sadness seemed to represent being overwhelmed with feelings of powerlessness, grief and loneliness, whereas battles brought more of a sense of togetherness.

The response to care became mixed up with his responses to changes in therapy. Many of his rages were related to him wanting more of things and to my limit setting. This seemed to be a response to the knowledge of reduction in sessions and the awareness of the limitations of our relationship. As we counted down to the summer break and the changes Paul was busy counting upwards. He introduced ball games in which he had to beat his own records. In addition there seemed to be an increased motivation to acquire new skills such as catching a ball with one hand, having seen me do it. The changes and subsequent lack of power over them led to an increase in Paul's desire to succeed in other ways.

It was positive that over this very stressful period Paul could go on learning and acquiring new skills. At school there were no problems and he formed a close relationship with his class teacher. Academically he was achieving quite well, and was seen as very bright. He seemed to take pleasure in his school work, often bringing reading and maths books to show me.

As the summer break approached Paul came prepared for change each session. On the way to the therapy room he would run off into

other rooms and would often leave our room during a session. He spent many sessions moving furniture around. Paul needed to feel one step ahead. He expressed directly some sadness about the changes, saying he liked coming here, that he loved me and did not want to leave the old clinic, or come less often, because 'we are happy here'. In the last weeks he played out a little puppy fantasy in which as a little puppy he was chucked out of home by his mum and came to live with me for ever, in a prison. There was a policeman on the outside who would give us everything that we wanted. This adoption fantasy seemed to depict his longing to be loved and really wanted and to have his needs met without seeming greedy. His deep disappointment that I did not adopt him but instead reduced my time with him led to his big rages.

Once weekly therapy

Paul has continued in once weekly therapy for over two years now. He spent fifteen months of this time in a foster home when his mother had once again rejected him. Considerable work was done with Ms H and Paul during this period to ascertain whether Ms H was able or willing to provide a permanent home for Paul. He subsequently returned to his mother with the proviso that should he be placed in care again through Ms H's rejection of him, the Local Authority would institute legal proceedings with a view to placing Paul in an alternative home.

Throughout his time in care Paul continued to do well at school and maintained a good relationship with the same teacher for two years. He settled well in his foster family who viewed him as a very loveable child. In therapy it was possible to talk with Paul more directly about his communications, although he still needed to preserve an idealised picture of his mother. Father remained a taboo topic.

Since he returned home Paul and mother have remained locked in their ambivalent way of relating to one another. Paul's external reality remains precarious and at times he seems determined to provoke his mother's rejection by his challenging and aggressive behaviour at home. Paul's intense anger with his mother for her bad treatment of him appears to have intensified since his last reception into care. In once weekly therapy it has been difficult to draw this into the transference but on occasions he has become enraged with me and has threatened not to return. Since his return to his mother's care these battles with mother have been displaced, unfortunately, into the school situ-

ation at times. Paul still needs help to internalise the battles between his loving and aggressive impulses and thus to acknowledge his ambivalent feelings about his parents and their treatment of him.

In therapy Paul does seem more in touch with his feelings and to have a less distorted view of external reality. We have been able to discuss his disappointment with his dad and recently he has shown signs of recognising that his father may not have been deliberately inadequate as a father. Paul has also allowed us to discuss incidents at home when his mother has lost control and treated him badly. Although he remains protective of his mother it has become clearer that he wishes to hide information from others which might lead to his reception into care, rather than it being a total denial of reality.

Paul seems to discriminate between our relationship and that with his mother. By his capacity to make a good relationship with his class teacher and his foster parents it is clear that he is no longer responding to all relationships as if they were potentially dangerous. Paul has become less reactive and more discriminating. His relationships with other children in the foster home were described as very good. However, since returning home his teachers have described his difficulty in relating to his peers on equal terms; he always has to be the leader.

In sessions Paul communicates to me both directly and through fantasy play. We are able to recap on past material and reflect on the changes that have taken place in Paul's ways of coping and in his view of me. Much of this is done with warmth and humour. It is significant over the last year that I have had thoughts of wishing I could adopt Paul. I believe this has arisen as a response to his wishes but also as a result of how much more open and loveable he has become.

Summary and discussion

Paul was a youngster who had developed an extreme use of defences in order to cope with an intolerable home environment. Although the relationship with his mother could be loving at times he never knew when she might become frightening and rejecting. His fantasy play made it clear that there were times when he had feared for his life. His inability to acknowledge the prime source of his anxiety, his mother, led to him responding to all situations as if they might pose a serious threat.

In addition to helping Paul become more aware of his internal world and how his feelings, expectations and wishes influenced his behaviour

a central part of the therapeutic work has been to help Paul recognise the external sources of his anxiety.

Hurry and Sandler (1971) comment on the importance of the young child's immediate interaction with the external world, and the need for the child to defend itself not only against anxiety from within but also from anxiety-provoking situations arising in the external world. In describing a child's response to an intolerable environmental situation they comment: 'It is characteristic of the defences adopted in such circumstances that they tend to hinder the way to further personality development rather than to foster it ... Thus there is less hope for future autonomy in relation either to the environment or to the drives'.

In hindsight it is possible to see how difficult it must have been for Paul to come into being in his own right. Ms H had so many unresolved conflicts herself related to her own childhood experiences that Paul became a recipient of her projections. Ms H tried to deal with her internal pain by externalising it. When she was depressed Paul and the outside world became a bad place and her battles were fought with the external world. Boszomenyi-Nagy (1982) comments: 'The child is so tuned in to parental conflict that in an unconscious loyal way he permits himself to be used as a target of his parents' rage'. Ms H's need to project her bad feelings onto Paul, and Paul's need to deny the negative aspects of his mother seriously restricted his capacity to develop.

Bowlby (1988) describes the extreme pretences and denials that abused young children often have to keep up, in order to cope with 'knowing what you are not supposed to know, and feeling what you are not supposed to feel'. Whilst Paul remains a child, dependant on a mother whose ambivalent feelings for him remain quite strong, I believe the moves towards knowing and feeling will remain a very slow process.

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ON PSYCHIC BANKRUPTCY: DEPRESSION AND THE MANIC DEFENCE

EVELYN KATZ

Introduction

This paper is the account of two and a half years of therapy with a forty three year old woman patient Mrs I. I hope to convey something of her continuing struggle to overcome pervasive feelings of despair and worthlessness, to break free from an impoverished inner world governed by a relentless superego. This state of psychic bankruptcy has been expressed through a lifetime of repeated failures – a failed school career, two disastrous marriages, two abortions, and a negative, hostile relationship with both parents. It was Mrs I's growing awareness of this unconscious tendency, and her decision to end an eight year marriage to her second husband, which finally pushed her to seek psychotherapy.

In her assessment interview and her letter of introduction, a picture of an angry, deprived woman who felt she had not had parents who loved her or who had taken an active or positive interest in her, emerged. She spoke of prolonged periods of depression accompanied by feelings of anxiety and fear, in which she felt she was dying inside. She expressed a sense of never having really grown up, and added that she felt she lacked confidence and repeatedly undermined herself. She described her life as 'a struggle that I am unable to break free of, continually failing at most things.'

Mrs I's personal statement aroused strong maternal feelings in me. Her clumsy use of language, together with the many spelling mistakes, written within the format of a formal business letter, seemed to confirm the impression of a child trying to be grown-up. I was anxious about the use of the phrase 'bottomless pit' which had been used to describe her, and worried about her capacity to let anything survive internally. These feelings were balanced by my sense of her determination to change the course of her life, and I felt moved by the plea, contained

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in her concluding sentence, to find 'direction, purpose, and joy' in the years ahead.

Personal and family history

Mrs I was 43 years old when she first came for therapy. She comes from a middle-class Italian background and is the younger of two daughters by 4 years. She had a troubled relationship with both parents from a very early age. Her father had become totally deaf as a child from recurrent ear infections which had not been treated adequately. She feels that he has been a disparaging and competitive father, derogatory and unapproachable and thus symbolically 'deaf' to her needs. She has always felt that he would have preferred her to have been a boy. She portrays her mother as selfish and uncaring. Her mother was one of four children, but lost her parents and two siblings during the war when she was eighteen years old. After the tragedy her mother went to live with her father's family and was employed by them in the family business. Although she was not particularly well treated she married her husband some time later when she was pregnant with their first daughter.

As we were to realise, Mrs I felt herself to be born to a mother who was flooded with guilt, depressed and unavailable to her emotionally; a mother struggling to deal with her own damaged internal objects, but experienced by my patient as selfish and narcissistic. This was compounded by her mother's physical unavailability, since she went back to work for long hours in the family fast food shop when Mrs I was a few months old. She and her sister were left in the hands of a changing variety of nannies and childminders. Mrs I appears to have introjected and identified with such a mother, and this has been borne out in the therapy, in which her sense of there not being a good enough mother internally has been repeatedly reenacted in the transference.

By the time she was born, Mrs I's father had demonstrated his entrepreneurial skills, and had turned the family business into a thriving concern. Although she was breast-fed, Mrs I was told by her mother that her milk had 'dried up' when she was a few weeks old. During her childhood the family wealth enabled her parents to live lavishly and they often travelled abroad, leaving the children in the care of nannies and grandparents. They would return looking suntanned and glamorous. They indulged in the latest furnishings and

installed central heating in the house, everywhere except in the bedroom shared with her sister. Mrs I was consciously aware of feelings of admiration and idealization for her glamorous, filmstar parents and also of her hatred and envy of a parental couple wrapped up in each other, who treated themselves as the favourite children, while she felt worthless and excluded.

Mrs I has always been in a close, dependent, but rivalrous relationship with her sister. She is very envious of her sister's achievements. Her own school life was disastrous; noteworthy only for her total lack of achievement in contrast to her sister who was academically bright and who has been successful in her chosen career. At the private school she attended, she was a dreamer. She needed a tutor because she could not cope with the work, and was sent down in the maths class. She surprised no one when she failed her 11+ examination and was subsequently sent to a comprehensive school. She frequently truanted at secondary school and remembers the truant officer visiting her house and her mother denying knowledge of her whereabouts while she lay in bed upstairs. At fifteen she left school, and for some time she flitted from job to job, and tried her hand first as a hairdresser's apprentice and later as a sales assistant.

There were two periods, aged sixteen and fourteen, when Mrs I was taken from one doctor to another because of her 'nerves'. Her symptoms included head shaking, repetitive blinking and panic attacks accompanied by palpitations. She remembers her uncle imitating these mannerisms in a cruel, humiliating way. The symptoms subsided spontaneously.

During her adolescence much of her pathology was expressed through her sexual functioning. She was very promiscuous until the age of nineteen when she met her first husband. She admired him for his swarthy good looks and his money. She became pregnant but did not want to marry him or to keep the baby. His mother arranged an illegal and unsuccessful abortion, which was performed without anaesthetic and was accompanied by unbearable pain. She haemorrhaged and several days later developed a fever. She was hospitalized and continued to deny both the pregnancy and the abortion to the medical authorities and to her parents. She remained in hospital for a further two weeks and when the pregnancy reached eighteen weeks it was terminated. She was told that the baby was a boy and was made to look at the foetus, which exacerbated her guilt. She was also told that she might never be able to have other children.

Mrs I's pregnancy at nineteen may have had some connection to her sister's marriage which had taken place some months before. Her sister's departure from the family home filled her with despair. Her mother told her that it was time she married because she and her father wanted to be on their own and needed space in the flat. She married the father of her aborted baby some months later. The marriage was characterized by physical violence and verbal abuse, as though the neglected abused child in her sought out an abusing figure to be her partner. He was wealthy and they lived in a large, expensively furnished house. She was given a small daily allowance for her personal needs. This made her feel like a helpless child, who was expected to perform the duties of wife and adult woman, but internally felt the opposite. This seemed to be a repetition of aspects of her relationship to her parents, who, she felt, expected her to be grown-up and responsible and yet treated her like an irresponsible child. After six years she left the marriage quite suddenly. There were no children and she was given a four thousand pound divorce settlement.

She lived unhappily with her parents for nine months and then rented a room and worked in menial jobs for several years until she met and married her second husband in 1979. Significantly, this marriage too was preceded by an early abortion. When she married her second husband she, like her mother, was pregnant with her first child. There are two children of this marriage, daughters aged thirteen and eleven. The younger is described as being a difficult, troublesome child with whom Mrs I feels strongly identified, while the older child is clingy and struggles with her schoolwork in much the same way as her mother did.

Mrs I separated from her second husband in December 1987 and now lives with her two daughters in a flat purchased with her share of the money from the sale of the joint home. In retrospect, one could see that Mrs I reenacted her experience of a relationship with a rivalrous, contemptuous father with the men she chose to marry. Through the repetition compulsion she expressed the longing for this to be put right, but was doomed to disappointment. Her husband has access to the children one and a half days a week. Mrs I lives off the money she receives monthly from her husband, together with her earnings as a counsellor, having completed a counselling course a number of years ago. She does not drive although she has had repeated attempts at passing her driving test. She spends large amounts of time commuting between her home in East London, her place of work in West London, and her therapy.

The therapy

Mrs I arrived on time for her first interview with me. I was surprised at how small, frail and vulnerable she appeared. She was fashionably dressed, had medium length blonde hair and sharp, not unattractive features. She appeared pale-faced and rather stern-looking, and I wondered whether this reflected her anxiety, or whether it showed an underlying coldness and hostility – a portent of battles to come.

She expressed doubts about wanting to begin therapy at this time of turmoil in her life, but reassured me that she had felt stronger of late and that she would be able to cope without help over the next few months. She was also concerned about the difficulty of the journey and cited examples of friends who had been in therapy for lengthy periods of time and remained unhelped. When I interpreted her fear of becoming stressed and broken down as a consequence of coming for therapy, so that she feared she might then be unable to deal with the responsibilities and realities of her adult life, she seemed able to acknowledge this and her anxiety lessened. We had difficulty in negotiating suitable times for her sessions, which I later came to understand was an indication of her suspicion, almost amounting to a conviction, that I would be like a mother arranging things to suit me and therefore unable to address her needs. She ended the preliminary interview by asking whether she could stay longer than the two years if she needed to. This was spoken in a child's voice and seemed to me to indicate some awareness of her own neediness, and a fear of becoming dependent on me and then being told to go away and manage on her own before she was ready. We agreed to begin therapy two days later.

Mrs I's enormous investment in her therapy was immediately apparent. Once she had agreed, she began in earnest and left me in no doubt that she regarded this as a life-saving venture to which she was totally committed. She arrived punctually and seldom missed a session. She produced dreams prolifically and worked hard at trying to understand her own material and to take in my interpretations. In the early months she rarely smiled, never laughed, and her facial expression and demeanour was almost always serious. Because of the repeated failures in her life, her therapy was one area in which she was determined to succeed. She tried to live up to a fantasy of the perfect patient, not only for herself, but in order to provide a perfect training patient for me. For my own part, I found it difficult to separate my anxieties about providing the perfect setting for my first training patient, from her own anxieties which she projected into me.

At a deeper level, one could see Mrs I's efforts in this direction, as an attempt to join with me as a perfect, idealised mother/baby couple, a perfect mother with a favourite baby – something she longed for and felt so cruelly cheated of in her actual life. This is illustrated by a dream she brought shortly after the first Christmas break. In the dream, which she described with great poignancy, she had a baby elephant for a pet. They were inseparable and played together all day with the elephant's trunk curled around her neck. I think this dream represents a desire to be in a close, idealised relationship with a mother/me, wrapped around one another in perpetual embrace, joined together by a trunk/umbilical cord in a mutually dependent, exclusive relationship.

Early in the therapy, I was made aware of Mrs I's anxieties about becoming needy of and dependent on me as therapist/mother. She dealt with these anxieties by turning me into the older sister in the transference. She was aided in this by her knowledge of my trainee therapist status, which made it easier for her to see me as a slightly older sister in relation to the counsellor/her. Despite the attendant rivalries in such a relationship, it was obviously easier, at one level, to be relating to a peer or an equal than to risk exposing her needy, dependent self to a mother who would be bound to fail her. Linked to this was her continual use of counselling language in her way of talking to me. Over a period of time there were several ways of understanding this style of communicating. In the first place, she kept me as a junior whom she could talk down to and provide me with explanatory packages about her state of mind. This way of talking also served as a way of joining us together as a couple, both therapists/counsellors-in-training, on the same wavelength. At another level, however, I came to understand the more insidious nature of this way of talking. It seemed she had projectively identified with an internal mother who was not sensitive to her needs and did not understand her pain, but instead provided her with attention, like fast food meals; trite, perfunctory interpretations. I came to realise in this way how her state of internal impoverishment was linked to nourishment from such a narcissistic internal object.

Initially Mrs I found weekend breaks extremely difficult. She would return on Mondays feeling full of despair, empty and impoverished internally. She described feelings of being cut-off and withdrawn on the weekends, as though she had been unable to sustain any contact with me in her inner world. Typically, in sessions she would 'beat herself up', creating a hopeless atmosphere. She described her envy of

other people's favourable financial situations and academic achievements and castigated herself repeatedly for her own deficiencies. While she insisted that she would never be able to find sufficient funds to repair the rising damp in her home, I experienced quite concretely a rising despair in myself about ever being able to help her. I came to recognise that when in this state of mind, she was caught up in a 'circular type of mental activity consisting of going over and over again about happenings and anticipations of an accusatory or self-accusatory type' (Betty Joseph, 1981).

In reflecting further on my countertransference, I was able to discern conflicting impulses in myself – a wish to reassure her, which if yielded to led to further self-villification, and a strong impulse to retaliate for her destructive attacks on herself and the work of the therapy. Betty Joseph talks about a 'powerful masochism' which is at work in these patients who 'will try to create despair in the analyst and then get him to collude with the despair or become actively involved by being harsh, critical or in some way or another verbally sadistic to the patient'.

Such sessions highlighted my patient's fear of poverty which Freud (1915) emphasized as playing an important part in the clinical picture of depression. Mrs I often felt unable to sort out her confusion about the realities of her financial situation, and came to recognise that her perception of whether she was financially solvent was linked to her state of mind. Most often she expressed overwhelming anxieties about her financial situation after a weekend or holiday break. I tried to show her that she used issues of money to express a fear of internal bankruptcy, which surfaced when she felt shut out and excluded.

Fenichel (1946) stated that 'behind this anal orientation' (fear of poverty) 'definite trends of an oral fixation always are present. The refusal to eat is not only the most widespread clinical symptom of melancholia; it is a concomitant of every depression.' After the first weekend breaks I became aware of the way in which my patient's conflicts and difficulties became somatized. Her complaints relate primarily to her digestive tract. She has been diagnosed as having a duodenal ulcer and also Irritable Bowel Syndrome. She informed me one Monday session that she had suffered with a sore stomach all weekend. On other occasions she has told me of her difficulty in feeding herself, but of wanting to eat food cooked for her by someone else. Sometimes she has felt hungry but unable to know what food would satisfy her. She was able to understand something about these symptoms when I interpreted her difficulty in mothering herself over the breaks. I spoke of her wish to be taken care of by a mother who would

know what to feed her starving child, and her anger at being left with the responsibility of doing it for herself.

Continuing work on these issues gave her some insight into her recurring states of emptiness and impoverishment. I tried to show her that the 'fast' food with which she filled herself, like the instant counselling cliches, was unable to sustain her through weekends or breaks. As a recurring dream from this time illustrated, her inability to hold on to the nourishing food I offered, made her feel that she was stuck in an internal world like a bashed, broken down maisonette with 'rubble and debris and dust everywhere.'

Later, another aspect of her weekend feelings emerged; painful feelings of being excluded and unwanted. She told me how she had crept around the house hoping her husband would not notice her and added that she had been the same with her parents. She felt that they did not want her and had made her feel that she was a nuisance and an intrusion. I said that she seemed to feel that I couldn't wait to get rid of her over the weekend, and that she felt superfluous and unwanted on her return. She agreed, and added that sometimes she felt guilty because she was making a dent on my couch.

In the build-up to the Christmas break rivalrous feelings for my other 'children', together with indications of early oedipal issues, began to emerge. She remembered how her parents had gone on one of their exciting holidays abroad and had left her and her sister behind. They returned with presents, a necklace of rubies for her sister but less valuable pearls for her. It seemed as though the impending Christmas break had brought to the fore an image of an insensitive, unhelpful mother who preferred other children to her and left her feeling that if anyone received anything valuable, it was never her. These feelings of being the abandoned, less favoured child, were exacerbated by the separation from her husband, which took place in the week preceding the Christmas break. The prospect of her first long separation from me aroused intense anxieties about managing financially, and fears of depression and disintegration. She described a time four years previously when she had experienced prolonged and severe depression, a 'mini-breakdown'. She had been unable to get out of bed, or to ask anyone for help. During this time I became aware that I had been running several minutes over time in some sessions. In retrospect, I understood that my attempts to give her more than her allocated time must have reflected my own fears about her capacity to 'survive' over the coming break, as well as being a response to her own anxieties about not getting enough.

On her return she was preoccupied with difficulties of being left out. Her exclusion from a parental relationship had stirred up feelings to do with myself as the parental couple. This was evident in her angry description of a visit by her parents in which they spoke only to each other and ignored her completely as though she did not exist. The holiday seemed to have stirred up her rivalry with me as the sexual mother, and she flooded me with memories of her promiscuous adolescence. She began to talk about her relationship with a male friend with whom she spent time over the weekend, each acting as counsellor for the other. This friendship caused her anguish because of her intense desire for a sexual relationship, which was not reciprocated. This relationship seemed to represent an attempt to ensure that she was not left out when I was unavailable and involved with my own life away from her. At such times I was felt by her to be like the parental sexual couple, caring only for each other and not for the children, provoking intense envy as well as jealousy, like that of a deprived child. The notion of the cruel combined parental couple, (a mother containing a father) as described by Edna O'Shaughnessy (1989) is applicable here. She talks of such a fantasy being evident in patients 'struggling to obliterate an early oedipal situation, which feels continually to be threatening.' She continues: 'feelings of exclusion, problems of separateness and of being single in the presence of an oedipal pair ...' are foremost in these patients. Mrs I's attempts to avoid being the excluded child at any cost, were well illustrated by the sleeping arrangements in her new home. She and her older daughter shared one bedroom, while the younger daughter slept alone. Thus, her feelings of being left-out were projected into the younger, troublesome daughter, who was isolated and kept out of the room.

Eight months into the therapy I changed my place of work to a consulting room in my own home. I felt very anxious about the effect this might have on her. In reality, I was aware that this would entail a more difficult journey for her, and knew of my patient's resistance to change, even in issues of far less importance. The turmoil which resulted, made me feel that my fears were well founded. For the first time I felt anxious about her ability to stay the course of the therapy. The move brought to the fore, prematurely, fantasies of being weaned and being aborted by me. As her anger about the change surfaced, she began to talk in some detail about her two abortions and her fantasy that the move was occasioned by my pregnancy and need to utilise the room I was currently using, for the new baby. I interpreted this as her fear of being aborted by me in favour of a new baby/

patient. I spoke as well of her wish to abort the therapy because of her anger at what she felt to be my cruelty in forcing her to make this change, and at the realisation of her dependence on me.

During this period, the complaining, attacking side of her emerged more forcefully. It was noticeable that the change of room had forced Mrs I to reassess her perception of me and of our relationship. Confronted with the reality of my home and the new room, she was initially silent and withdrawn. Later she became angry and complained bitterly about my unwelcoming couch. She was critical of other aspects of the room and the journey. Her envious attacks on my material situation were highlighted in a dream, the setting of which was the Dallas of the American television soap opera. In her associations she referred to my Dallas lifestyle, which she described as plastic, meaningless, flashy and unreal. She thought that I might have a swimming pool in my back garden. I was very aware of the need to interpret this material sensitively in view of her struggle to provide an adequate home for herself and her children.

I came to understand that her fantasy, previously expressed, of being my only special patient, together with a conviction that I had been unable to have children of my own, had been sorely tested at this time. Her belief in our perfect, intimate partnership had been shattered, as though she was suddenly confronted with ideas of my relationship with my partner, standing for parents who could have each other as well as other children. I interpreted her anger at her sense of exclusion from my life and how painful it was for her to feel that I preferred my husband and my family life to my relationship to her. She responded by saying that she felt like 'nothing' when she came for her sessions, and was furious at having to use the side entrance, as though she was inferior to me and 'just like a tradesman'.

At this time Mrs I's material provided clear evidence of an internalised narcissistic mother with whom she had come to identify. I became aware that her envy of a mother who had everything and gave her nothing had been stirred up by the move of consulting room. She felt that I was an unsupportive mother, interested only in the comfort and well-being of myself and my partner. This was expressed through childhood memories of a mother feeding herself and father steak, while giving her mince, or buying new furniture which she refused to share with the children. She went on to talk, quite callously, about the death of her parents some time in the future and her refusal to take care of the one left behind. She reassured herself with the thought that they might well outlive her, and was then preoccupied

with the ulcer which had been troubling her of late. I interpreted the murderous feelings for such a mother which had turned loving feelings sour, like an ulcer festering inside her. I spoke of her identification with a callous, uncaring mother expressed in her conviction that she would not look after the elderly, widowed parent of her actual life.

Her attacks on me were followed by periods of depression and despair. Around this time, Mrs I expressed, yet again, anxieties about finding sufficient funds to repair the rising damp in her home. Her feelings of despair, emptiness, and worthlessness had become concretized in her home, when she felt she had lost me as a good internal object and was afraid she would be unable to repair the damage she had caused. Through my countertransference I became aware of the pressure on me to be the ideal figure of her fantasy world; a totally available mother who would never make demands on her. At times it seemed that either I would conform to her picture of such an idealised object or that she would be unable to continue her therapy.

At the same time, I began to realise my patient's deep anxieties about a fragile, internal object whom, she felt, would be unable to tolerate her complaining, attacking self. Such an object would reject her, either by aborting her therapy or by preferring other patients to her. On one occasion she felt sure that she had caused my illness, which had necessitated the cancellation of her previous session, and admitted grave fears that I would terminate her therapy. These thoughts surfaced at the end of a particularly difficult session in which she complained about an inexperienced solicitor/me to whom she felt indebted, who was completely unable to sort out her rising damp/depression.

Melanie Klein emphasized the relationship between the infantile depressive state and adult depression (Rosenfeld 1959). She stressed that the early loss of the love object during weaning will only give rise to depression in later life, if the infant has failed to establish its loved object securely within the ego at this early period of development. J. Henry Rey (1979) believes, 'that in all depressive states the object with which the subject has a relationship is, contains, or symbolically represents the maternal breast which as a partial object represents the mother who is destroyed, emptied, poisoned and thus in a depressed state: the subject feels this is his fault and becomes identified with this depressed object and, consequently, depressed himself.' The depressed and fragile mother of Mrs I's infancy, as she perceived her to be, could have provided her with the real experience which made for a failure to internalise a loved object before her early weaning from a breast

that 'dried up'. This was re-enacted in the transference in the early months of the therapy particularly, in her inability to keep me alive as a good object inside her.

The second anniversary of her therapy was an important time for my patient. She expressed fears about the end of her therapy. In one session she told me that her daughter wanted to cling to her like a leech, and wanted to be right inside her, but that she tried to push her away. I said that I thought she felt that I was preoccupied with my other, younger children, now that she was a slightly older child in the therapy. I added that this made her want to cling to me, a mother whom she felt would not be tolerant of such clinginess, such infantile needs; a mother who would be unaccepting of her jealousy and intolerance of others. It seemed that she was in projective identification with a rejecting unavailable mother, as a defence against her own experience of being a child who could be pushed out; either aborted or weaned too early.

Her fears that I would abandon the complaining, attacking child/her in favour of less troublesome, more interesting and exciting patients, brought to the fore manic defensive manoeuvres. During her second year, Mrs I began to talk in earnest about her wish to do a psychotherapy training, and her intention to apply to a recognized training organization. I felt it was important to acknowledge my patient's conscious attempts to progress in her life by doing a recognized training, as well as her feeling of being less fragile internally. Nevertheless I was very aware that in my countertransference I felt disturbed and provoked by her decision, which I felt was premature. Although it seemed unlikely that she would succeed, I was concerned that if she was to be accepted it would almost certainly mean the end of her therapy with me. I saw the fact that she made no mention of this, as an indication of her indifference to losing me.

Some weeks before the second Christmas break, Mrs I brought a lengthy dream which seemed to clarify the whole work of the time. At the end of her session the door opened and a group of my 'work' people entered, carrying trays of sandwiches on silver plates, as though they had come for tea. One small, elegant, elderly lady seemed very knowledgeable, and she thought she might be a senior therapist. I ended her session immediately and ignored her, preferring to be the good hostess. Someone offered her a sandwich, and another told her they were meat sandwiches, and that the meat was not ham. This was obvious, she thought, since ham is not kosher. In her associations she spoke of these sandwiches as 'snack food'.

Through the work on this dream, I was able to show my patient how she wished to join my work group by becoming a therapist, in order to defend herself out of a fear of abandonment and rejection by me. She seemed to feel that as a trainee I was not a grown-up enough therapist, able to help her work out both her adult aspirations as well as their infantile aspects. I added that this had been symbolised in the dream by both the snack food on offer at my tea, as well as her dilemma about whether I was a 'kosher', proper therapist. The elegant woman therapist, a recurrent image from her dreams of this time, seemed to represent an idealised, senior therapist who would be able to offer her the substantial, nourishing food she felt I was unable to provide at that time.

The theme contained in the above dream was further reflected in the material she brought about a male client who had dropped one of his sessions in favour of his karate lessons. This image of a karate-chop figure became a significant one through the following weeks of therapy, and was interpreted in several ways. I spoke of how she could be seen to be chopping me dead when she went off to her interviews for the psychotherapy training by chopping off both her anxieties about a potential loss of me should she be accepted, as well as in the way she had been seeing me as not good enough or worthwhile enough as a therapist. On the other hand, I was able to show her that she experienced me as a parent who both chopped her down to size and out of my life, not only at the holiday breaks, but at the moment she brought her ambitions and needs to be the older, growing child and not only a compliant baby. This was exacerbated by my recently having given her the dates of my holiday.

Mrs I's efforts to grow up and move on in her life suffered a humiliating blow when she was not accepted for her chosen training. At first she tried to avoid discussing this immensely important issue and was full of denials and defences in relation to her failure. When she did talk of it, it was apparent that this event had unleashed intense feelings of envy for me, who seemed to have my working and personal life sorted out. More specifically, she felt that I was progressing in my training and she was getting nowhere. She talked angrily about her sister and friends and their many work opportunities as well as their blossoming love lives. When I voiced my contention that she felt bitter and enraged because she perceived me to be in a smug, superior position, she agreed and was then full of despair and masochistic self-denigration.

These attacks against me and against herself continued for some

time. I began to realise that her angry, attacking self gave rise to feelings of guilt which forced her into masochistic identification with her victim. She spoke of how little she paid me, and said that she felt she was not entitled to receive Family Allowance, despite her struggles to make ends meet. She had a dream in which someone spilt ink on my beautiful white carpet and she rushed to soak it all up. I said that she seemed to feel that there was a blot on our relationship because of her attacks on me, which she had to wipe away quickly. Retrospectively we were to see how she felt that by failing to get accepted she had blotted my reputation and felt that I would prefer to keep myself as a whiter-than-white therapist; a mother who could not bear any failures in her own or her children's lives.

I tried to show Mrs I that she experienced her rejection by the training organization to which she had applied as a rejection of all of her and not of a particular capacity to work in a particular way, or her readiness at this moment in time. I was careful to help her to distinguish between realistic, adult strivings towards making progress in her life and her attempts to displace a recognition of herself as patient into her own patients, as a way of filling up her own inner emptiness and of avoiding her own pain. I was very aware of my own countertransference as a trainee therapist in my attempts to address these issues.

On her return after the second summer break, Mrs I was in a manic and grandiose frame of mind. She spoke of applying to five different psychotherapy training organizations. At the same time she was secretive about her intention to rent a room 'at the top of a house in Islington', where she could take on additional patients. She felt unable to tell me that she had been offered the opportunity of doing extra supervision of students at the centre where she had trained. Eventually she told me of her plans, and was perplexed and angry at having witheld this information from me and carrying out these plans secretly.

She brought a dream which reflected this recurrent state of mind. *She dreamt about a chariot in which Queen Bodicea rode. On either side of the carriage there were 'shiny metal things which were round on the outside with another round part inside'. These reminded her of a breast with a nipple in the middle. While looking at them they appeared to lose shape, to become flat and brown and eventually disappear.* Bodicea, she said, was a fighter and a conqueror who carried a lance. The 'round things' reminded her of breast plates, shiny and sparkling. I said I thought she felt as though she was a conqueror, triumphing over me with her ambitions to have her own consulting room at the top of the

house and to be doing supervision of other trainees. In this state of mind she felt as if she demolished my shiny breasts, which disappeared even as she was looking at them. She agreed and said that she felt that I would disapprove of her plans. I suggested that it might be because she felt so rivalrous and competitive with me that she saw me as a retaliatory, disapproving figure and felt unable to discuss her intentions with me. Through this, I was able to show her how she believed that I would not support her through thinking about all these issues in her life, and that instead she felt she had to adopt a defensive, metallic and superior constellation – the chariot. It is clear that she had no conception of a helping hand enabling her to move on in her life!

Melanie Klein saw the need to resort to manic defences as a protection of the ego from depressive pain and utter despair in the face of continuing attacks on the mother and her breast. When such unbearable depression can be resolved by reparation, this leads to further growth of the ego. In the absence of a capacity for reparation the manic defence, characterized by feelings of control, triumph and contempt, is mobilised. (Hanna Segal 1986) Mrs I's manic behaviour manifested itself more clearly in response to her ongoing complaints against me and her inability to contain the guilt she felt as a consequence. She was terrified that I would end her therapy and was anxious about her dependence on me. As Hanna Segal (1986) says, the defence is directed 'against any aspect of the relation between the self and the object which threatens to contain dependence, ambivalence and guilt.'

Melanie Klein (1935) explained the vicious cycles which are set in motion when the wish to control the object, to triumph over it and humiliate it are strong, so that the 'benign circle' initiated by the act of reparation is broken. As a consequence, paranoid anxieties are revived as the objects, which were to have been restored, revert once more into persecutors. Thus triumph is followed by depression and the cycle repeats itself. Mrs I's capacity for reparation is limited. Perhaps, as Hanna Segal says, it is because her ego has not yet acquired sufficient strength to feel confident in its capacity for reparation. This is a lengthy process and Mrs I's struggle to break free from the cycles of depression and mania continues. During the final period covered by this report, Mrs I seemed to be hovering at the threshold of the depressive position. In the weeks before the last Christmas break she was struggling with the conflict of whether she should apply, yet again, to do a psychotherapy training. She found it difficult to sort out priorities in her life. The work of the therapy entailed helping her to differentiate between the demands of her actual life as a single mother

and bread-winner, realistic needs for professional and other growth and development, and a wish to fulfil an omnipotent fantasy in which she was a trained, consultant psychotherapist with a superior status.

The weeks preceding the Christmas break included the second anniversary of her therapy. Mrs I was convinced that I had completed my psychotherapy training, which made her struggles to sort herself out all the more painful. Her envy of a newly-qualified me was made worse by the impending break and my having given her the dates for the Christmas holiday uncharacteristically early in the term. She expressed such envy in relation to her friend Anne, whom she thought had her life sorted out, with a new partner and unlimited career prospects. At the same time her bitter disappointment with me as therapist was apparent in a series of complaints; against her solicitor, who failed to ensure that she would be adequately reimbursed by the surveyors against whom she had a claim; against her Polish dentist who kept her waiting while attending to other preferred, Polish patients; and against a taxi driver who enfuriated her because he called her his 'little darling' and then tried to soft-soap her because she had been so angry.

I interpreted her disappointment that after two years of therapy she felt that I had not provided her with the resources to sort out all that was wrong in her mind and life, as well as her belief that other patients received better treatment than she did. I tried to show her that I had given her my Christmas dates prematurely, provoked by her anticipation of the coming holiday, and that she had capitalised on my 'mistake', and had then turned me into a placating taxi driver. I added that what was hidden in this, and more important than the holiday dates, was the fact that after two years of therapy she saw me as having it all, in contrast to her struggles to have anything at all.

This work centred around many weeks of examining her alternating view of herself as either totally hopeless and worthless or totally wonderful; a perfect product of two years of therapy. After some time she informed me that she had decided to shelve her ideas of doing a training until after Christmas. Her priority, she said, was to get her house in order, which she could begin to recognise was standing for getting her mind in order – repairing the damaged relationship to her internal objects, as well as coming to terms with what she could and couldn't do and seeing herself as neither worthless nor marvelous.

Over the last few months Mrs I began to show an awareness of me as a separate, differentiated individual. This was expressed in her curiosity about me and my life outside the consulting room. She speculated about my educational achievements and why I had become

interested in becoming a psychotherapist. She expressed her belief that I was the mother of at least one adolescent son, and began to question the extent to which her perception of me was coloured by her projections, in contrast to some influence from my life. Linked to this was evidence of some gratitude for the help I had given her, even though she found it difficult to express this directly. She talked about an improved relationship with her parents, which she would never have believed possible. She described how they had been both emotionally and financially supportive of her in her attempts to get her house sorted out. She also expressed resentment at the responsibility she now felt towards me and her therapy, and her fear of being unable to live up to my expectation of her. This was followed, in a subsequent session, by a description of her manic denigration of her father's sound advice not to lay the carpets in her home before the decorating had been done. She refused to consider this, becoming angry and attacking. He threatened to withdraw an offer of financial assistance. This signalled a return to paranoid schizoid functioning because of her inability to tolerate depressive pain; an awareness of and concern for a mother/me who cared about her and helped her in the same way as her actual parents did. I showed her that she wished to jump ahead to things being done before the basic work was carried out, just as she had done with her application for Psychotherapy training. This was further evidence that Mrs I felt she could only move on in her life in a triumphant, defiant way.

Mrs I's struggles to negotiate the depressive position were accompanied by an upsurgence of oedipal conflicts. Melanie Klein repeatedly stressed the link between the developing oedipus complex and the working through of the depressive position (Britton 1987). Her attempts to triumph over me as sexual mother continued. I was often felt to be like a betrayed lover while she became embroiled in complicated triangular intrigues which endangered her relationships with colleagues. On one occasion she saw my husband's car parked outside the house, and spoke about how big and masculine it looked, 'like a penis', next to my dainty, feminine, white car. In the next session she brought a dream in which she was trying to decide whether to buy a black and white, forties-style evening dress which was strapless, tight-waisted and sexy. She said that this was the sort of dress her mother might have worn. This dream showed how she attempted to cope with feelings of being little and left out in relation to the parental sexual couple, me and my partner, by stepping into mother's clothes and becoming the sexual mother herself. During the same session she

informed me that she had decided to alter the existing sleeping arrangements in her family, so that she would have a room of her own, while her daughters shared the second bedroom. The work of the therapy, in dealing with such oedipal conflicts, seemed to have enabled Mrs I to be a more grown-up mother, rather than a mother enacting unfair exclusions with her children.

Mrs I continues in her struggle to work through these depressive conflicts. At times she has made meaningful progress. This has been followed by a return to the use of manic defences and splitting mechanisms. The ongoing work of the therapy is concerned with the analysis of my patient's omnipotent take-over bid to be the consultant psychotherapist/supervisor, and her capacity for cruelty and betrayal.

Mrs I had finally negotiated the rental of a consulting room at a rate of fifty pounds a week. She had also bought herself an expensive typewriter on which to prepare her lectures. At the same time she asked whether she might delay paying me as she did not have sufficient funds to settle her bill. In addition, her bank manager refused to honour her cheques because she was overdrawn on her overdraft. She was full of guilt because she felt that she had seduced the bank manager into allowing her a generous overdraft by playing the helpless little girl, and had then betrayed him.

In this context, Mrs I related two important dreams about rats. *In the first she took her daughter to the school nurse for treatment of nits which had been caused by rats. She was to look for the rats in a deep, dark cupboard in her home. In the second dream a rat was perched on her shoulder, its tail 'swishing against her face.'* Mrs I expressed her loathing of rats and added that she was thinking of Freud's case study of the 'Rat Man'. She said that rats spread disease and are dirty and messy, so that the dream must concern her 'anality'; a beautiful example of the way she packages her understanding of herself.

Work on these dreams continued over several sessions. Mrs I became increasingly distressed as she was faced with the rat within: the betraying part of herself, which both seduced and disgusted her. We could see that through her ratty, competitive behaviour she abandoned herself and me, becoming therapist/consultant to all and sundry in an envious take-over bid. I agreed with her feeling that the dreams had exposed the core of her difficulties – her deserting, ratting self which infested her inner world and contributed to a lifetime of keeping herself in the position of 'stupid nit'. I was able to help her with her feelings of depression and worthlessness associated with this material, by showing her that she resorted to such defences when she saw me as a

separate object who could be admired and envied and had a life outside her own, even a life with difficulties as well as success. (A recent bereavement had been preoccupying me for some time and had necessitated an unscheduled interruption in the therapy some weeks before.)

Mrs I's struggle to come to terms with me as a separate, human, non-ideal therapist/mother, with strengths and weaknesses of my own, is the current work of the therapy. Eric Brenman (1985) says that this involves being confronted with 'inferiority and envy of the mother,' as well as the 'frustration, guilt and anxiety of losing her.' As he sees it, it is the wish to deny this which leads to an attack on any awareness of separateness as well as on the internal mother, leaving the patient in a cruel, loveless world at the mercy of a harsh superego. Such attacks may obliterate separateness and reassert a narcissistic relationship in which whole objects are experienced as 'a nipple the patient owns', but the price paid is a heavy one; a narrowing of perception leading to a narrow mind, restricting the awareness of conscious love and conscious guilt. The cruel attacks on the real mother for failing to live up to the infant's demands to be the 'ideal breast', lead to the incorporation of a cruel superego, demanding satisfaction from the infant for the rest of its life. As Brenman puts it: 'Added to this the infant casts out and abandons the real human mother to cruel exile, and introjects a mother that does the same to him, and therefore gives him no home. In addition, the narcissistic part of the personality exiles the needy real baby part of himself. A home is therefore only given to gods and the godlike narcissistic part of the self, leading to a "false self" and living a lie.' This is illustrated by my patient's attempts to maintain the fantasy of the ideal mother/baby couple in the transference. Her way of packaging her understanding of herself, and her use of counselling cliches earlier in the therapy is further evidence of such a 'false self'.

Brenman (1985) emphasized the further complications which may arise when the infant may have been, in reality, deprived of a 'home' early in its life, by a mother who found it difficult to contain her infant's anxieties. This is particularly pertinent for my patient, where all the evidence suggests that Mrs I was born to such a mother, without the mitigating support of a loving father. Such a child 'lusts for vengeance and the re-creation of the ideal world.'

Mrs I has been able to work vigorously and intensely with all these issues and to struggle with these conflicts. At the end of three years of therapy I am aware of her increased strength and solidity and feel her to be less vulnerable internally. This is reflected in improved

relationships and work opportunities and a growing belief in her ability to succeed in life. I am cautiously optimistic that she will come to find a good home in her therapy and in her internal world. A home with secure, containing walls, plumbing intact and an absence of rising damp, both concretely and metaphorically.

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STRANDED STARFISH

MARILYN MATHEW

Looking for a view

In the quest for an understanding of my experience as observer of a baby girl and her mother from a short time before her birth until she was 2 years old, I have browsed through various fascinating writings: Donald Winnicott, Michael Fordham, Melanie Klein, Donald Meltzer, Wilfred Bion, Esther Bick, Mara Sidoli, Martha Harris. Their enlightening contributions have offered many ways in which I could begin to wrestle with what I saw: their ideas and languages peppering my thoughts.

Why then, pulling the strands together, am I left unsatisfied? Could it be that my adult intellectual strivings for structure and sense are obscuring an inner vision where the archetypal qualities of experiencing and encountering a crystallising personality can perhaps be better hinted at in the language of poetry, music or art?

I began by using fantasy in thinking about the baby and it has been fleshed out by theories of development, but rational thinking perhaps misses something crucial and leads me to return again to the world of imagination. There has been a value to my mind in attempting to imagine into: to see/feel/taste/smell/breathe/hear the world through this child's eye. In attempting the near impossible task of trying to feel her world from the inside, glimpses of past/present/future parts of the baby, her mother and myself all became tangled.

In this realm of confusion it seems to me to be the mind, body and soul together that attempt to organise chaos, using imagination emerging from the spectrum of senses to unfold a personality. Working inner with outer, gradually patterning an ego from and with the self as an evolving image. That seems to demand an imaginative and imagistic approach of the observer.

Somewhere searching for light in this I recalled the archetype of the Child. What place does this Child have in my observations? James Hillman writes in Loose Ends:

This Infant Observation Paper was awarded a Commendation by the Jungian Training Committee

> What accuracy can our studies of the human child have so long as we have not recognised enough the archetypal child in our subjectivity affecting our vision? (Loose Ends, p. 10)

I observed a very real individual flesh and blood baby girl, but the observations and imaginings were recorded through my vision. Would another observer have seen a different baby? Perhaps what I have encountered along with Victoria were the archetypal aspects of the Child.

Child as god: divine. Awesome & innocent, blind & all-seeing, bursting from the inner underworld.

Child as God: Word made flesh. Christian symbol of hope, salvation and rebirth.

Child as hero: human and divine. Seeking, finding, fighting and rescuing.

Child as outcast: utterly human. Simple, naive, abandoned orphan.

More recently, James Hillman describes Freud's contribution to our view of the Child:

> Freud gave the child primacy: nothing was more important in our lives than those early years and that style of thought and emotion of imaginal existence called childhood. Second, Freud gave the child body: it had passions, sexual desires, lusts to kill; it feared, sacrificed, rejected; it hated and longed and was composed of erogenous zones, preoccupied with faeces, genitals and deserved the name polymorphous perverse. Third, Freud gave the child pathology: it lived in our repressions and fixations; it was at the bottom of our psychic disorders; it was our suffering ... (A Blue Fire, p. 235)

All the other thinkers, perhaps especially Donald Winnicott and Melanie Klein, have likewise contributed to an expectation of what a baby and indeed Baby or Child as an archetypal image might be.

Continuing in my search for expression and meaning I find myself finally returning to Jung:

> The 'child' is all that is abandoned and exposed and at the same time divinely powerful; the insignificant, dubious beginning and triumphal end. The 'eternal' child in man is an indescribable experience, an incongruity, a handicap, and a divine prerogative; an imponderable that determines the ultimate worth or worthlessness of a personality. (Jung, 1940)

With all these thoughts in mind I attempt to give something of the flavour of my encounter with Victoria.

Victoria

Born on November 1st, a few days before Guy Fawkes night, Victoria brought sparks into the world with her that seemed to ignite a series

of massive explosions in her family. Fireworks between herself and her mother.

Victoria arrived to join a 9 year old football-crazy brother, Tom, who feared his mother would die in childbirth; a home full of his toys and drawings by an artistically gifted autistic boy; a warm bear-like daddy, Robert, who was regularly hospitalised with asthma/pneumonia; and a mother, Sylvia, who taught disturbed schoolchildren and told me she didn't like babies.

The furious battling between mother and daughter, and Victoria's aggressive urge to change Sylvia, witnessed as observer, was frequently a disturbing experience. Often, taking notes, I would confuse the initials for mother and daughter. Whose baby was being observed: Victoria or the baby part of her mother? How much was she expressing her mother's unconscious processes?

And at the same time, all of this was triggering the various baby aspects of myself.

DIY baby

When she was newborn, Victoria used to fall asleep with her right hand up behind her right ear. Maybe this was the way she had come to hold herself in utero?

Perhaps it was the long silky hair by her ear that contributed to her interest in touch and textures; the regular sounds of heartbeat and later sucking that led to repetitive rhythmic movement and play; and the round walls of the womb that linked with the circular movement which she would repeat, looping from her head to the breast with closed eyes. From 2 days old Victoria's right hand would stretch out and around, the index finger of that hand finding her mouth. Apart from the looping action, she very often held her own hands while feeding, sometimes knitted, closed circuit, together.

In her reaching out/in movements, Victoria seemed to be particularly interested in a certain kind of tactile experience. At 5 weeks her right arm reached out to pat and stroke the puffy pale yellow babynest as she did with the breast. Soft textures were frequently sought for contact and comfort: teddy's fur on her cheek at 9 weeks, a furry patch of cloth on her activity mat nuzzled at 19 weeks, at 3 months the velvety sofa, at 5 months a soft ball by her right ear, at 13 months when she could seek and grasp external objects, a pair of snugly knitted cotton shorts were held to that ear, at 18 months a padded anorak held in

the same way. It was here she scratched and developed eczema, her containing skin erupting in rage, hidden behind her ears.

When she was nearly 2 years old Victoria would push her buggy in circles linking the kitchen with the living room and hall. I wondered if there was some connection with the way she made loops to the breast. If Daddy sat down I saw Victoria push her buggy round and round him as though she was weaving a spell: a hag track, a fairy ring, an enchantment to have breast and Daddy within her power?

I imagined with all this circling that Victoria was somehow making a cyclic connection with the boundaries of her world, perhaps in an attempt to define herself. In thinking about the meaning of this repeating movement a number of possibilities come to mind: was it a repeated exploration; establishing a horizon which was altering as she developed; a repeated reassurance of what is 'out there'; a holding together of herself; was it a way of communicating skin to skin; an attempt at communion/fusion; a deintegration/reintegration; a forming of a 'second skin' in the way that Martha Harris describes; an erotic oral/aural masturbatory experience; or a taking-in almost like breathing of rhythmic tactile sensations so that the warm solid roundness of her head with the soft hair and earlobe in a way became a home-made breast? Perhaps it was all of these and more.

Victoria made a nest of fabric to bury her head in when she was 7 months old as if creating her own breast, and one week later eating apple puree with her index finger in her mouth, it looked like she was making her own nipple and feeding herself: an omnipotent and phallic little girl emerging.

By 8 months the fantasy seemed to have developed further:

> Victoria seems enthusiastic as Sylvia sits down with the cup of baby rice smacking it off the spoon with her lips. She opens her mouth & eats at the appropriate moments but in fact most of her attention is focused on a stale crust. Breaking it in two & pushing one half into the fist she has made with her left hand through its 'mouth'.

Was Victoria not focusing on Mummy feeding her, because she was enacting a fantasy of feeding herself?

At the breast it seemed that it was more often than not Victoria who got herself into a feeding position, throwing herself at it and practically undressing her mother. Very soon she was able literally to feed herself, becoming extremely adept with spoons and grown up mugs. There came a point where Victoria would refuse a piece of banana from Mummy's hand, but would grab it and gobble it up as soon as Sylvia put it down on the table.

Was it too dangerous to begin to imagine her beloved breast and Mummy could possibly be connected? Victoria seemed to be making a very powerful statement about her omnipotent denial of dependency and need to exert control over her mother. Soon it wasn't only feeding that she seemed to want to do without Sylvia's aid. The theme of do-it-yourself extended to dressing so that helpful hands were fought off as though they were attacking. While Victoria remained addicted to the breast, it seemed she had cut her mother off: part split from whole. Perhaps she felt cut off by Sylvia?

The unthinking breast

Eye contact with her mother during a feed was something I rarely saw. Victoria viewed her mother's eyes through heavy glasses that I took to be more barrier/deflector than magnifier/reflector. I got the feeling that Victoria's 'gaze' was not met in other ways too.

Sylvia was still suffering from the numbing pins & needles effect of Carpel Tunnel Syndrome in her hands, a condition that normally clears up after delivery. It persisted in her case for 15 months and she said she avoided carrying Victoria around in case she dropped her. Frequently Sylvia was seen shaking her hands violently to get the blood flowing and bring them back to life, but it also looked as though she was trying to shake off the contact with her daughter like drops of water.

Perhaps because of the syndrome Victoria was usually held on her mother's lap and not in her arms. Perhaps it held a psychosomatic message: 'I cannot hold my baby in mind, I cannot handle being in touch with my baby.' An expression via the body rather than thought.

What did Victoria make of it all? Was the terror of feeling unconnected in thought instrumental in summoning the powerful attachment to the breast which she refused to move on from and contributing to the intensity of warfare with her mother?

Sometimes Victoria did seem to be able to deal with a difficult situation by herself, cutting off from it and beaming into something else: sunlight dancing on a wall, wind blowing the trees, her own hands, a rhythmic movement, a toy, my gaze or her mother's. A way of sticking herself onto something outside, an adhesive kind of identification, a defense against the anxiety of separation?

And sometimes Sylvia could be genuinely empathic: quiet firm holding arms, words or thoughts that calmed and reassured. With a pneu-

matic drill thundering in the kitchen when Victoria was 16 weeks old and Sylvia feeling under the weather:

> Victoria goes rigid with big eyes. 'It's all right', Sylvia puts her hand on Victoria's tummy. She puts down the yoghurt & puts her hand up Victoria's trouser leg, stroking her knees. 'It's all right.'

Her daughter's terror seemed to be felt and understood this time.

There were also times of intense tenderness. When Victoria was 5 weeks old feeding at the breast and drifting into sleep:

> Sylvia pushes her index finger gently into a small fist & strokes Victoria's fingers. Gradually the slurpings grow fainter, her little fingers raise & separate in a delicate 'tea-drinking' action. Victoria is asleep on the breast. She falls off. Sylvia leans her daughter up against her chest, stroking her hands & fingers, her jaw & her cheek in front of her ear. Victoria sighs contentedly. Sylvia seems really adoring for the first time.

A gentle and touching intercourse.

The way Victoria's fingers parted in sleep was similar in pose but so different in quality from the starfish terror I was also to witness. As she let go the hold on consciousness, so the grip of her hands loosened.

Perhaps because Victoria sensed that her mother did have the capacity for empathic loving inside, she kept fighting to get at it. More often I felt they were rivalrous siblings devouring each other, or cutting each other off and it seemed at times that neither could cope.

Victoria's reaching out, her echo-soundings, appeared to be frequently unanswered, bounced back to her without an apparent meeting with any thinking 'out there'. The mechanics of caring present, but business-like, without passion. More merging and union with the breast than with the mother. A breast cut off from thought? It seemed that she was being left to scan a 'sonic' screen without the help of an interpreter.

Victoria, 15 months old, was having difficulty settling into daycare and Sylvia commented, 'I try not to think about Victoria at the nursery'. In fact the not thinking went back much further to the early days of breastfeeding when Victoria would feed with eyes closed and her mother, resting her daughter on her lap frequently flicked through the newspaper, opened the post or read a book. This was often the time when I was fed endless weekly horror stories: children dying, mothers with cancer, vultures devouring corpses in the Ganges etc etc etc. Maternal reverie appeared to be rare and terrifying, the container fragile.

Daddy bear

The person who held them all together seemed to be big friendly Daddy with his easy confidence. By the time Victoria was 9 weeks old Sylvia was commenting on the change in her daughter when Robert was at home. Instead of 'shouting' all day she would sleep for hours. With baby crying, Sylvia called Robert in to show me something:

> As soon as Victoria is handed to her father she's quiet. She fits snugly over his shoulder & he walks round the room with her before taking her into the next room where he sits at the computer. He lifts her legs up & down & she obligingly burps. She squeaks once. 'Shut up you!' comes the gruff friendly voice & she's silent. She's like a different baby with Robert – a real daddy's girl.

I was told that there were some days when Sylvia picked Victoria up from the nursery and she screamed for hours. In desperation Sylvia would call Robert to come home from work and within 10 minutes of his arrival all would be sweetness and light. It seemed that he was able to contain both mother and daughter like a Russian doll with his calm manner and cheerful outlook.

I found it fascinating that Victoria seemed to prefer toys with a certain smiley sort of expression. Whether it was a Duplo duck rattle greeted with eager 'ah-goo' noises and hand flapping, a blue teddy on her cot mobile or Arnold her teddy 'husband' (her brother's term) greeted with 'aah, goo da umm' and more smiles, the expression they all shared was a beaming grin set in a round face. They all looked just like Daddy ... and me?

Good Daddy, bad Mummy. The positive experience of the Great Mother appeared to be located in the almost spiritual relationship Victoria had with the breast while in my presence Sylvia more often than not seemed an incarnation of the negative aspects. Was I too getting caught up in the splitting, idealising Robert and pathologising Sylvia?

Stranded starfish

Victoria developed a characteristic position which persisted throughout my observations and seemed to trace back to the 'Moro' reflex of a newborn infant. I came to call it 'stranded starfish', as Victoria's fingers would shoot apart splayed and rigid in traumatic situations. Often at times like this she would lie on the floor, eyes closed tight and arms flung out at the side as if crucified.

A sudden arm movement while drifting in and out of a cyclic sleeping/waking pattern seemed to come from an internal stimulus when she was 2 weeks old. A panic/fury with her toes and fingers wide and stiff, back arched when a feed was delayed for a nappy change at 4 weeks. A hand paralysed open-fingered in loss/rage when a rattle was taken away at 17 weeks and a desperate scene later on in the same hour when a feed was interrupted for the milkman:

> Victoria is taken off the breast and put on her back on the sofa, her head on the metal frame of the bouncer. There is immediate violent protest with enormous cries, drumming feet and arms outstretched like petrified starfish.

The startled starfish reaction recurred over the months if there was a sudden loud noise like a hoover, buzzer, smashed plate or pneumatic drill. Sometimes it would combine with intense vocal fury if there was a delay in getting what she wanted/needed like the breast, an apple, the contents of Mummy's handbag or the TV remote control. If something unwelcome was imposed, especially having her arms thrust into sleeves or clothes pulled over her head she would explode in rage.

Blood & ice

There were times when the sitting room resembled the aftermath of a boxing ring. One day when Victoria was 15 months old I arrived to find her sitting on the sofa, her face smeared with snot and blood from a nosebleed:

> Sylvia grabs a handful of tissues & tries to remove the gunge from her daughter's face. She twists & resists, grizzling & arching her back, arms out apart & above her head, hands like starfish. Things are obviously very difficult. Victoria's face is full of cold & swollen – giving her the appearance of a Down's baby. She seems to be hardly listening to Sylvia & only calms & quietens when she is held in an outstretched cradled position ... for a couple of minutes everything seems to be OK.
>
> Sylvia sits her on the floor, 'At least if I put you there you can't fall any further', she says & goes off to the kitchen, 'I'm not deserting you, I'll be back in a minute'. As she walks away Victoria screams & thrashes weakly about on her back. Her knees raise up & down together pathetically, her arms out crucifixion style, rolling her head from side to side.
>
> While Sylvia is in the kitchen, Victoria lies on her side, quiet & still, looking at me with a cold blank gaze, tears rolling down her cheeks ... Sylvia walks past Victoria bringing coffee that is hot milk. Victoria begins wailing in an almost hysterical 'ar..hur..ar..hur..ar..hur'. Sylvia ignores her & talks about catastrophes. I can't listen to her because

> I am feeling so desperate. 'I don't want to be here!', I think, & realise that is probably just how Victoria is feeling ... and maybe Sylvia too.

Victoria can't feed when the breast is offered, Sylvia as usual holding her breast while her daughter lies on her thighs. She breaks off crying and then throws herself around wailing. After a second attempt at feeding:

> Sylvia says, 'Help me stand up, Victoria', getting to her feet & lying her daughter on the floor, she leaves the room. Victoria cries & cries but just lies there immobile. 'Oh dear, poor girl', I say, getting down on the floor near her. Victoria turns her head sharply away from me. Her eyes seem far away & cold. After a little while she begins rolling towards the stairs ...

Sylvia returns with some tempting goodies. She sits Victoria who seems bruised and numb on her lap to offer her some Frosties, and when they are refused, puts her back on the floor:

> Victoria lies on the floor face down crying, moving her face from side to side, arms outstretched in a fossilised Moro position, wailing rhythmically ...

When she sees her snowsuit and preparations to go out to the doctor's are being made, Victoria perks up and gets on to all fours:

> 'If you suddenly get better as soon as we're at the surgery, I don't know what I'll do', threatens Sylvia & Victoria collapses in floods of tears once more, outstretched, face down on the floor, crucified starfish.

It felt like the end of the world. An utterly disintegrating experience. Victoria had become splintered, shattered, and pieces of herself seemed flung out off the ends of her petrified fingers into space. I imagined blood and flesh covering the walls of the room. Nothing but being stuck to the floor, rock bottom, seemed secure enough to hold her. She was too far away to be comforted by the breast, her mother or by me. It was as though the disintegrated fragments (of breast?) were retaliating making it impossible to feed; the fury like a terrible monster tearing her apart and scattering her through space.

I thought of the story of The Snow Queen: A wicked magician had made a mirror which turned everything good into something bad: 'The loveliest landscapes reflected in this mirror looked like boiled spinach'. High up in the sky, the mirror shattered, its splinters falling to earth. At the beginning of the tale, Kay felt the pain as splinters of the broken mirror pierce his heart and his eye. The hurt disappeared as quickly as it came but the splinters remained, making his heart and view of the world as hard and cold as a lump of ice.

Kay found his sledge bound to the Snow Queen's, whisking him far away from home, off to her northern Ice Palace. Kay was blue with

cold, and the kiss of the Snow Queen was colder than ice: 'It went to his heart, although that was half frozen already; he thought he should die. It was however, only for a moment; directly afterwards he was quite well, and no longer felt the intense cold all around.'

Victoria's gaze had iced over. The Snow Queen seems the mythological tale to match what seemed to be an experience of archetypal proportions.

Further aspects of ice. 4 weeks: a nipple wrenched away. 3 months: flown through the air by the wrists and then air blown on the face to stop wails. 7 months: a comb with hard teeth pulled through matted hair. 11 months: an invitation to follow Mummy thwarted by creating a barrier of toys.

Finally, nearly 19 months:

> Victoria walks away to her bedroom & comes back with a comb. She goes up to Sylvia who is still kneeling on the floor & very gently combs through Mummy's hair. When she has finished, Sylvia takes the comb and pulls it fiercely through Victoria's hair making her cry.

Sadistic attacks against a loving gesture. I found it hard not to hate Sylvia for the way she behaved sometimes. How she came to find intimacy with her baby girl so threatening is a mystery that I can only imagine dwells in her relations with her own mother. My fantasies ran riot when I tried to imagine what sense Victoria might make of gentleness returned as a mean attack, a caress returned as icy pain.

Coldness of the heart also pervaded the actual temperature of the environment. Many times it was so freezing inside the house that I kept my coat on. Victoria was often wearing layers of tights, trousers, dress and jumpers. The central heating hadn't broken and there weren't obvious signs of financial difficulty. It somehow fitted with the second-hand toys & ill-fitting nursing bras. Females aren't valuable?

I found it somewhat chilling that on the visits following a catastrophic week, Victoria was unnaturally well behaved. She would be terribly polite, with something of the air of a cocktail hostess making small-talk. Where had all the rage gone? The rather false behaviour made me uneasy and suspicious. Had she pushed her mother too far or been pushed further herself than she could manage? Had the Snow Queen kissed the pain away and frozen the memory as far away as Lapland? Maybe freezing with it a part of Victoria herself, part of her self.

Her play at this time was about building towers with sweet 'gully gully' noises followed by deep growling as the bricks were flung across the room. Maybe this was what she experienced as happening to

herself. Were the bricks her own building blocks which she could put together into some sort of standing supporting whole when times were good? And were these same bricks flying round the room expressing not only the rage she felt towards her mother but parts of herself in a disintegrated state?

Tug of war

On several occasions the battle between mother and daughter became an actual physical tug of war. A 15 month old Victoria had grabbed her mother's handbag during a telephone conversation and was emptying it's contents piece by piece:

> Call ended, Sylvia tries to retrieve the bag. Victoria holds on tight, very cross, in a tug of war. Sylvia lets go but walks off with the prized red purse to safeguard credit cards & coins. Victoria protests with a furious grumpy face. 'No, it's mine!' Sylvia tells her, 'You can't have it!' Sylvia turns to me. 'She's so determined! She's got to have everything her way!'

The red purse was the prized container within the container. It held the valuables: the hard and shiny precious coins and the elusively magical hologrammed credit cards. Perhaps it represented for Victoria the unavailable riches or even babies located deep within her mother's body/psyche.

Another tug of war occurred when a 18 month old Victoria wanted Mummy to go somewhere with her:

> Victoria is pulling on her mother's index finger. 'Where do you want me to go, Victoria?' Sylvia seems irritated by her daughter's demand & pulls her finger away abruptly so that Victoria falls backwards rather dramatically. Sylvia picks her up. She wails & tries to climb over her mother's lap, lurching in the direction of the breast. 'You don't want that,' says Sylvia & offers her the remains of the satsuma. Victoria bashes it out of her hand, sending it flying.

Rage aimed at the hand/satsuma rather than the Mummy/breast in case aggression destroys the one you need?

Finally, two weeks later, the tug of war left visible scars. Victoria hadn't wanted to leave the One O'Clock Club when Sylvia told her it was time to go. She had leapt onto a wooden horse, zoomed down a ramp and flown over the horse's head. The result was a mouth full of blood, grit and broken tooth. Had her aggression finally found form as an invisible monster that could toss her through the air and really physically attack her back?

In and out

When she was nearly 18 months old there was a battle about getting dressed going on. Mummy was determined that the clothes go on, and Victoria was resisting. After three attempts she was pinned to the ground and the terry nappy was secured, the blunt end of the safetypin prodding into her tummy. She subsequently tipped a completed jig-saw of a happy yellow duck onto the floor, surveyed the destruction and then spent ages putting the pieces in and out of a basket.

Once again I remembered the story of The Snow Queen. Far, far away in a vast empty hall in the Ice Palace sat Kay. In this hall was a frozen lake which had been shattered so that all the pieces were identical. Kay had been promised the world and a new pair of skates if he could only perform the impossible task of putting the pieces together to spell 'Eternity' ... Was Victoria struggling with fragments of herself like Kay's ice pieces, I wondered?

Ten minutes later, during which Victoria had been playing with the duck jig-saw pieces Mummy decided the rest of the clothes must now go on:

> Victoria begins to resist the dressing, thrashing & yelling. This escalates dramatically into hysterical screaming & sobbing as the clothes are forced on ... even when everything is on, the screams continue & she seems to be utterly over the top ... Victoria is doing a dying duck, rolling & lying on her back with her right arm trapped underneath her body in an extremely uncomfortable position. She rolls onto her front, cheek on the carpet, arms out at the side with her toes & fingers stiff in the familiar stranded starfish. Slowly she pushes herself towards the marble plinth along one side of the room, and butts her head hard up against the edge. Her hands claw at the carpet. Sylvia sits on her heels and watches. She seems unable to move.

This time it seemed that there was more disintegration than Victoria could begin to process. No way that she could rescue her splintered parts. No place safe enough to contain her except a hard indestructible marble slab. Sylvia appeared to be totally cut off from Victoria's agony. Maybe the kiss of the Snow Queen had paralysed her too, so that she couldn't begin to help her daughter. Her shattered fragments were abandoned.

I was constantly amazed at the way Victoria would beaver away tenaciously in her attempts to work at her play. So much of her activity at this time was about putting things in and out of containers and posting shapes. It was as if she was persistently setting herself the task

of trying to digest, work at and sort out her unprocessed feelings for herself.

Food/hands/balls/bricks/shapes/dummies/feet in and out of tins/mouth / toys / cupboards / bags / hats / VCR / basket / shoes / tights. Sometimes a repeated rhythmic ritual, sometimes examining the interface of inside/outside, sometimes opening and closing doors or putting lids on and off. Sometimes she hung around on the threshold of the front door making wa..wa..wa Red-Indian noises with a star-shaped hand over her mouth, looking out on the world. It was almost as though both front door and open mouth were a limen, a sacred threshold, a transitional space: the place where inner and outer meet, that she needed to explore. As far as the toys went I found it fascinating that Victoria would more often than not choose the star shape to try to fit.

One day when Victoria was nearly a year old Sylvia gave her a dummy:

> Victoria examines it thoroughly, pulling & pushing at the nipple part, making it twang from side to side, shaking it like a rattle & putting it in & out of her mouth. She never sucks it but holds it between her teeth ... She shuffles over & grasps a clear plastic handbag with red hearts on the outside. She pulls out the contents & puts her hand inside. This is followed by a rhythmic ritual which is repeated over & over again, maybe 20 times, at the same tempo: dummy in bag, hand out, hand back in, take out dummy.

On previous occasions I had seen Victoria roar with laughter as Sylvia would put the dummy in her own mouth before offering it to her daughter. It seemed that Victoria could never even imagine it as a nipple substitute, but what was she doing with the in/out ritual?

I noticed that often the containers she chose were clear or red, often the objects posted were small hard shapes, and often there was a rhythm to the play. It is the sexual act of intercourse which springs to mind first in terms of nipple/penis entering mouth/vagina in a sucking/masturbatory/coital action.

In the realm of zonal confusion where a vessel can be equated with mother and world perhaps Victoria's preoccupation with in and out could be seen as her attempt at working through her erotic/aggressive feelings? Or an attempt like a magician to put something into a hat and bring it out transformed? Were the parts she was working on her own, her mother's or perhaps even her maternal grandmother's? Or was the repetition and rocking simply mindless blocking of thought?

Sometimes it was a looking in and out that I saw. Victoria would

sneak a curious look in a place that was taboo: her brother's toy boxes, certain cupboards that belonged to Mummy and/or Daddy. She'd be quiet as a thief peeking and occasionally taking things away. Was she looking inside her mother, inside her parent's bedroom (where she eventually slept most nights)? She seemed to know that she was excluded from certain areas, but that wasn't going to stop her trying to steal glimpses.

Battle over poo

Periodically Victoria was looked after by a childminder while Sylvia struggled with the balance between mothering and part-time work.

Aged 6 months she was being separated from Sylvia 4 × half days a week. Simultaneously Victoria became constipated which proved to be a powerful tool. After 10 days a paediatric laxative was prescribed resulting in 4 days of diarrhoea, a procedure that was repeated 1 month later. How did it feel to have her inside torn out, her control taken away? The time when Victoria was given a tomato to eat with a dollop of tomato ketchup on her highchair tray gave me some ideas:

> She dips the tomato in the ketchup, sucks & then bites into it. Holding the skin flap, Victoria sucks out the pips inside & then moves on to the flesh, eating until a squashy pile of tomato skin is left. She holds a piece of toast in both hands & bites the edge. Making a hole with her left thumb, Victoria tries to post the tomato remains through the hole. It doesn't work. Victoria pulls the toast to pieces & throws some of it onto the floor. She holds the tomato remains like a spin bowler but doesn't actually throw them.

Maybe this wasn't just a tomato but tomato/breast/poo. What has happened to the inside of this tomato/breast? Is it destroyed in a devouring feed? What happens when the tomato/poo won't go through the hole? Tear it to pieces and get rid of it like diarrhoea, but keep the tomato skin or there's nothing left.

One day when she was 8 months old and constipation was still a problem, I was told about a fruit picking expedition. Victoria had eaten loads of raspberries and strawberries, squeezing the red fruit in her fists. The result had been 3 poos in as many hours and a baby looking as though she was covered in blood.

Sylvia got desperate for Victoria to produce dirty nappies. With some discomfort she would shit small hard pebbles. It seemed that perhaps because Victoria had no good internal object she hung on to the bad one: bad breast is better than no breast, and while the good

breast is outside, she had to have it at all cost. Later I discovered that Victoria would drink nothing but milk directly from the breast. She stayed thirsty away from Sylvia and then sucked all night long. It also transpired 6 months on that Victoria never once drank, slept or did a poo at the childminder's. It seemed to Sylvia that my visits coincided with dirty nappies, and I was asked to put them in the dustbin on the way out more than once.

Victoria began going to a Day Nursery 3 × weekly when she was 14 months old. Apparently the first day she came home she was sick and subsequently screamed blue murder when Sylvia left her and picked her up. Two months later Victoria was apparently beginning to settle, but the rage erupted somatically as constant diarrhoea and bloody eczema in her ears. One a reminder of undigested fragments and the other an irritating breakdown of her containing skin.

The observer

The intention was to watch like a fly on a wall. In fact what has happened is that Victoria has got under my skin.

From the very first moment that my 2 years of 1 hour × weekly visits were agreed I referred to Victoria as 'my baby'. Given her to hold at 2 days old, marvelling at creation, being charmed by her over the weeks and simply watching her sleep activated the powerful and passionate memories of my own babies.

The torment felt seeing war waged is something I found intolerable at the time, and now immersed in the notes, reliving some of the hours is still difficult.

And it is also having an interesting effect on my psyche: Dreams of a 5-pointed penis; breasts which are dangling 5-fingered star shaped hands; entrusted to care for a baby penguin frozen solid in fear and a kitten so wild and terrified it couldn't be caught ...

I wonder if it isn't grappling with the traumas of infantile rage activated in me by Victoria that have also had some link with the recent rash of furies erupting in my consulting room? There would seem to be a Monster Baby archetype at large.

Endings

Separating, abandoning, weaning, treachery. I have snuck secretly into Victoria's life under somewhat false pretences. Ostensibly I was the fly

on the wall, but really I feel as though I have stolen something in the way some 'primitives' fear a snapshot captures the soul. We had undoubtedly formed a relationship where I held Victoria in mind and she remembered and observed me. Now I am pulling out.

What have I been for Victoria?

At	6 weeks:	a smile.
	12 weeks:	a hand reached out towards me.
	4 months:	an enthusiastic welcome, I was recognised.
	5 months:	studied hard.
	7 months:	flirted with.
	8 months:	my gaze is held while straining.
	10 months:	invited to play.
	11 months:	Victoria in competition with Sylvia for my attention.
	12 months:	putting trucks and boats on the arm of my chair and watching me take a bite of biscuit before synchronising her eating with mine.
	13 months:	her fingers in my tea, my finger in her mouth.
	14 months:	ignored when I say goodbye.
	15 months:	pee-po through the bannisters.
	16 months:	launched herself at me from the stairs.
	18 months:	naked after a bath, Victoria walked unaided into my arms. She brought me books & asked for names.
	19 months:	named for the first time, I'm called 'Mammee'. In the same week I began to speak of endings & Victoria wiped me off the face of the earth.
	24 months	my final visit, she is fast asleep.

Good mother figure, bad mother figure, container, lover, traitor, someone to explore, someone to share her experiences and put her shit into.

As I began to talk of leaving, Sylvia became pregnant and it brought about a dramatic change in the two of them. Sylvia started wearing skirts, giving Victoria and myself drinks in mugs decorated with flowers instead of ghostbusters, and behaving in a genuinely loving way towards Victoria. Victoria in turn stopped battling, becoming calm and devoted. Suddenly the female could flourish.

As in fairy tales I wished for a happy ending. It seemed as though Gerda may have found Kay and melted the frozen heart. But 6 weeks later Robert called to tell me that Sylvia had lost the baby. What

Victoria makes of it all I can only wonder because my observations have finished.

What of the future for Victoria? Was the environment of her very early months facilitating enough? Or will some archetypal aspects of mothering remain unhumanised? Will parts of her remain frozen and far away? I often think about the really terrible times and wonder if Victoria's memory of them will be a nameless dread.

The myth of infant observation

I have observed not one infant but three or maybe more: Victoria, the baby part inside her mother, and the baby part of myself. The content baby, the creative baby, the destructive baby, the seductive baby, the phallic baby, the communicating baby, the excluding baby, the disintegrated baby, the bottom shuffler, the toddler.

I have watched not a single mother & baby unit but several, and perhaps many of them historical.

As much as I have observed an infant that infant has observed me. A fly on the wall I may have been to begin with, but what a fool to imagine that fly wouldn't be enticed off the wall into a web.

On the face of it I observed my infant visually and recorded what I saw in language. However, there was much that has passed before my eyes of which I suspect I was unaware, and has no easy expression in words. Experiences invisible to the naked eye, but not perhaps to the heart and soul.

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OBITUARY

MADELEINE DAVIS 1931–1991

It was in Autumn 1982 when I met Madeleine for the first time. She had come to discuss with me possibilities for a psychoanalytic psychotherapy training and we scanned together the various options open to her. When she left I knew that I had met a woman, already in her fifties, who would not settle for second best however troublesome the tasks that lay ahead of her.

Madeleine started training with the British Association of Psychotherapists in 1983 as she had wished to do for a long time. After completing her studies in Philosophy and English at St. Andrews she married John A. Davis who was at that time registrar at the Paddington Green Hospital for Children where Donald Winnicott was a consultant. As Madeleine often said it was the Davis' life-long friendship with the Winnicotts that changed her outlook on the world, orientated her in the up-bringing of her five children but also in her work as a certified volunteer with the probation service in Manchester after her husband had become Professor of Paediatrics there. She became a house committee member and secretary to a hostel for high-risk male ex-offenders of the William House Trust and worked with the staff members as well as the residents. Professional colleagues and friends who knew her work well have stressed her commitment to her work, her non-judgmental approach and sensitive understanding which earned her the trust of the committee members, the staff members and the residents alike. She was also engaged in some voluntary work with the Manchester Prison and there became mainly involved with visitors to the men in prison, in particular with mothers and their young children and babies.

When the family moved to Cambridge she did some voluntary work with the committee of a hostel mainly for ex-offenders and she became a voluntary worker with the Cambridge Victims' Support Scheme.

Not only did her many years of voluntary counselling work motivate her to seek training but also her creative editorial work with the unpublished papers of Donald Winnicott, first in collaboration with Claire Winnicott and later with the editorial board of the Winnicott Trust, maintain her wish to train and provided an opportunity to study the psychoanalytic environment of Winnicott's contributions.

Her book 'Boundary and Space' written with the assistence of David Wallbridge is an excellent introduction to Winnicott's writings. His theoretical and clinical contributions are discussed under various headings so that it can also be used as a reference book. Together with Winnicott's posthumous publications it shows the high standard of the editorial work done and Madeleine's keen sense of aesthetic style.

Madeleine pursued her training in London over many years. It meant considerable commuting from Cambridge which she maintained, it seemed, with tireless energy. During the latter part she had already become ill but she was determined not to let this interfere with her work and studies. I met Madeleine with her co-students in several seminar courses on psychoanalytic theory as well as those of a clinical nature. I learned there how gifted she was in her natural understanding of psychoanalytic concepts and also the ease with which she acquired the skills of understanding her patients' unconscious communications. Her contributions to the discussion were rooted in Winnicottian thinking and it sometimes helped to view the subject-matter in hand in a new light and to develop lines of delineation. It was in particular in clinical discussions that she excelled – at times with original thought. But she could be diffident in expressing her opinion and in spite of her knowledge needed encouragement.

The evening when she discussed her own clinical material to read-in for associate membership of the B.A.P. became indeed a creative scientific discussion of a standard which one would rather expect from an experienced senior colleague. Madeleine showed not only her clinical skills but also a wide knowledge of Freud's writings and a whole range of other psychoanalytic authors. Everyone present enjoyed the evening and felt they had taken part in a special occasion. But it was also a moving evening as we all knew how ill Madeleine had become.

Soon after she had to give up her clinical work which she had only been able to enjoy for a short time. It was a very sad decision in particular as the opportunity to train had come so late in her life. She continued her editorial work with Winnicott's papers until nearly the end and she did not allow her illness to overwhelm her – at times even in the face of considerable pain. Madeleine continued to take a lively interest in the scientific development and clinical standards of B.A.P. and she welcomed friends and colleagues who visited her to discuss all aspects of psychoanalytic psychotherapy.

She stayed in her home in Cambridge, an old country-house with a large garden and a hen-house in which she bred fowl, interests of which she could talk with lively expertise. Her family was with her

when she died. For Madeleine it became true what Winnicott had hoped for when he wrote in his notebook 'Oh God! May I be alive when I die.'

Margret Tonnesmann, M.D.
May 1992

BOOK REVIEWS

The Earliest Relationship
Parents, Infants and the Drama of Early Attachment

By T. Berry Brazelton MD and Bertrand G. Cramer MD
Karnac Books, 1991 pp 231 £15.95

This book is the felicitous outcome of the collaboration between T. Berry Brazelton, world-renowned paediatrician and researcher, and Bertrand G. Cramer, psychoanalyst and pioneer in infant psychiatry and parent-infant psychotherapy, who presented some of his work in London last November at the Annual Research Conference of the British Psycho-Analytical Society.

As the title indicates, the focus of the book is on the interaction between infants and parents. Quoting Winnicott's famous dictum 'A baby cannot exist alone but is essentially part of a relationship', they set out to illustrate in fascinating detail the results of their different but complementary observed interaction. This interaction is traced from the early wish for a baby, through pregnancy to birth and infancy.

Part one deals with 'Pregnancy: the Birth of Attachment'. The child-to-be of fantasy is already a transference object with whom feelings from previous relationships will once more be played out in an effort to resolve them. Also a welcome chapter deals with the fantasies, expectations and fears of expecting fathers. The demonstration of the physical reactions of foetuses at different stages of development brings the reality of the pregnancy home to parents and makes them aware of the individuality of their particular foetus that can already be observed.

Part two 'The Newborn as Participant' reviews research findings on the reflexes, sensory capacities and states of consciousness which contribute to Brazelton's Neonatal Behavioural Assessment Scale. There is an emphasis on the pronounced individual differences between new born babies. The parents' task of adapting to their baby's individuality may be made easy by a comfortable fit between parents and baby or may be taxing and problematical, as the authors illustrate by means of vivid vignettes.

Part three 'Observing Early Interaction' gives an interesting overview of psychoanalytic, ethological, learning and quantitative research interaction studies before focusing on interaction in context i.e. with an

object or with a parent. The most dramatic effects emerge in still-face studies – where an infant is confronted with the immobile and unresponsive face of the mother. The infant's repeated attempts to elicit mother's response are followed by a sombre expression, orientation away from the mother and finally, withdrawal. These three stages, although taking place within less than three minutes, resemble the behaviour of infants in hospital as described by Bowlby (J. Bowlby 'Attachment and Loss' vol. 1,). Mothers, in their turn, became upset by the experience. This brings home to parents as well as professionals and psychotherapists the profound effects of maternal (and, later, surely, also of paternal) depression or withdrawal on the child.

Part four 'Imaginary Interactions' and Part five 'Understanding the Earliest Relationship' will probably be of the greatest interest to the clinician. The infant lends him or herself as a perfect screen for projections on the part of mother, father and other adults in the family. The infant can thus be seen as a ghost from the past, a re-incarnation of important figures – a parent or sibling, judge or villain, or as the holder of all ideals ('king baby'). This enables old battles (who will dominate whom?) to be replayed or there can be the hope of re-writing the past from which all pain and frustration would be eliminated. The child's every whim is gratified and the parents seem incapable of imposing any frustration or limits. The authors demonstrate how 'successful mothering depends upon a balance between projective identification (finding sameness) and objective reading of the baby (noticing differences).'

The clinical cases in the final section graphically illustrate the authors' complementary approach to the kinds of problems commonly presented to professionals caring for young families such as sleep or feeding difficulties, excessive crying, the 'angry baby', the depressed mother or the baby with a birth defect. Symptoms are seen as multi-determined and shaped as much by the individual characteristics of the infants and parents as by the fantasies and projections of parents.

The authors advocate a careful assessment of the developmental stage and personal characteristics of the infant coupled with observation of the attitudes and behaviour of the mother or parents as they emerge in the interaction between infant and parent. They pay tribute to the pioneering work of Selma Fraiberg (1980) amongst others in attempting to integrate psychoanalytic and developmental studies. More recently, one of the authors, B. G. Cramer, published a case with D. Stern (Cramer and Stern 1988) showing how subjective factors in the mother interacted with the characteristics of the baby. Stern, of

course, has also combined developmental researches and psychoanalysis to explore ways in which infants develop a sense of self. (Stern 1985).

Brief psychotherapy using this complementary approach can be highly effective in resolving early problems in the parent-child relationship. Unfortunately, the reassuring 'He'll grow out of it' so often meted out by those whom parents are likely to consult about these problems is a serious underestimate of the power of unconscious forces and parents' fantasies and assumptions about their children. There is an obvious need for better informed professionals and greater availability of therapeutic services for parents with young children such as, for example, the Under Fives' Counselling Service at the Tavistock Clinic.

This book can be highly recommended to all who have contact with young families. It will, moreover, be of great interest to psychotherapists working with adults in enhancing their understanding of their patients.

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DENISE TAYLOR

Vision and Separation Between Mother and Baby

By Kenneth Wright. Free Association Books. 1991. 370 pp. h/b £29.50, p/b £15.99

Oh, the ambivalence when reading a book which does not follow an obviously conventional path. One cannot skim through it comfortably, relying on established habits of thought: 'Ah that's what I think'; 'That's where they're all wrong'; 'Here's a bit that's new'. And there is a kind of shame in discovering how much one has settled into habitual trains of thought, which has to be cancelled out by excitement at coming across new ways of looking at things.

Wright's book needs attentive reading because he is attempting a new and substantial case, and this reviewer, at least, did not know where the argument was going to get to in the end. ('Argument' is used here as in 'the argument of the play', to describe how the reader is led from point to point to a satisfying conclusion.) The argument is not closely reasoned throughout – how could it be, since we lack so much information and since, in general, psychodynamic theory relies so unselfconsciously on impressionistic evidence and trusted authorities – but it leads to an interesting and to my knowledge, original end. Yet, sadly, this book may not get the attention it deserves: it does not back, and is not backed by, any of the great highly-organised armies currently fighting their covert battles for status and for the possession of the hearts and minds of the next generation of psychotherapists. People who do not join an army in times of conflict tend to get ignored at best.

The first half dozen chapters were very congenial to this reviewer's preferences. Wright is here interested in the whole early developmental experience, not especially in neurotic or other disturbing vicissitudes, and, though obviously well-read in psycho-analytic ideas (especially Winnicott in these chapters), he also uses more philosophical sources like Langer, Sartre, Lacan. He makes up a story of the development of people's experience of themselves and of others, and in particular of the part played in this development by our use of our eyes. Sight is a distal sense, and the eye indicates to us that we are over, against and separate from what is visible over there. Vision and separation go together.

Among many interesting ideas, Wright contrasts the breast, which must be to the baby an object of instinctual drives, an object that gives of itself and can be received in comparison to the face, whose loving expression is desired but, however satisfying, is not instinctually desired, cannot be consumed, is always at a distance. Sucking the breast is immediate; looking at a face and experiencing love requires a distance, a separateness. This space is the precursor of other spaces which can be filled with symbols, of love and/or other things.

Wright looks in some detail at the world of symbols which fills the space where mother might be expected to be. If I can smoothly fill this space with a good-enough-mothering 'pattern of experience', then that will introduce me to the world of symbols.

But the eyes are not necessarily always loving, the space where mother is expected is not necessarily always filled with a good-enough-mothering pattern. In his treatment of self-consciousness and shame,

Wright postulates an experience of a cold alienated other, over there, watching me without affection or fellow-feeling.

The Gorgon looking coldly at my distress derives from those times when mother was unempathic and could not contain or metabolise my distress. I am then met with coldness and not with loving and age-appropriate help; I feel alone, I fall apart with distress and anger. If this, too, is met by the Other in her Gorgon aspect, then I cannot bear the distance my anger and her coldness create between me and her, on whom I relied for help. I rage, I nearly die of shame, and I have to turn away from this unbearable moment when I experience myself as repulsive and powerless, the Other as repelled and withholding.

Later in the book Wright will use this process as his metaphor for all repression (perhaps all splitting and repression), substituting an object-relationship metaphor for Freud's ego/superego metaphor, which he finds unusefully mechanistic. Repression is an object-relating process which operates when what is hidden is approached. Wright finds this an easier way of thinking about what happens in the consulting-room, where the therapist easily becomes the Gorgon Other looking with contempt at the disgraced and enraged patient.

Hence, Wright contrasts a smooth manageable discovery of my separateness – the result of good management by a good-enough mother – with the more painful discovery of essential separateness and loneliness characteristic of Sartre's humanity. Next, the father is discussed in his role of furthering the development of my sense of myself as separate. The father, looking at the mother-me dyad, makes me conscious of being in a dyad. I have been in that dyad all along, but now father is looking at me, which gives me a context within which I learn that there is a perspective (in father's eyes) in which mother and I are a dyad. I also come to realise that father and mother are a dyad. I cannot be in that dyad. I am an onlooker. I take another step in learning; I can look at things which I cannot possess. I learn not only that I am over against the Other, but that I am a part of dyads in a world of dyads, and triads, and so on, and this helps introduce me to the world of structures, of spaces and places.

In the dyad, language was, at first at least, superfluous. 'Come, let us not speak, let us hold hands and look', say Betjeman's lovers. With the growing separateness of mother and me, words help to keep us together in a new way. When father appears, who has never been part of my dyad, communication by language is more necessary. Wright makes much of the associations Father/Other/language/society. I may experience father as a loving and lovable Other (hardly a Gorgon at

all) or as a tyrant Other who insists on my seeing things from his perspective, in his way, in his words and concepts. Accordingly I may joyfully enter society – the linguistic community – or I may experience mainly its oppressive face. The range is from being a relatively independent cooperative and confident member of society to being an anxious conformist afraid of my secret longings to be someone, looked at by the Other. Whether I experience language as a help to my experience of belonging and closeness, or as an obstruction to it, depends on the original distancing events from mother, mine, but presumably also father's when he was a child, for he has to use language to communicate with me and he will do that according to his experience of learning the language.

This reviewer begins to feel discomfort at reducing a lengthy complex argument to a sequence of bald statements. Enough. Get to the end. Wright has things to say about the conduct of therapy.

His starting-point is the disjunction between the external imposed form of a person, and the internal. Therapy is for finding new forms, that will better fit the sentient subjective self and/or better fit the forms required to live in society. Two modes of therapy are needed for this process, which Wright calls maternal and paternal. The maternal is exemplified by the later Winnicott who, Wright points out, said he wrote down his interpretations rather than giving them to his patients. He feared to play the part of the Other and distort the form which is waiting to emerge. Things will work out if you wait. There is a slow process of unfolding, of discovery. The therapist gives the patient a safe space to do this in. The sentient subjective self will emerge. The paternal is exemplified by Freud. Therapy is a struggle in which the therapist lends his strength to the patient to overcome resistances, the pleasure-principle, the temptation to repeat rather than recall and understand.

When should we be maternal, when paternal?

> Freud has a patient who is not interested in knowing or symbolising. She is trying to usurp the unique function of the therapeutic space, which Freud is struggling to maintain. In the last resort she is struggling against the radical gap between herself and the therapist, which Freud is trying to keep open – the gap within which symbols of the self are (to be) formed.
>
> Winnicott's patient, by contrast, is not struggling in this way, but is happy to explore and pattern things within the protective orbit of the analyst-mother. Within this maternal space some kinds of symbols are being formed and used, and instinctual striving is not a problem or a threat.

> Unlike Freud's patient, Winnicott's is not satisfaction seeking, but instead is relating to self and object in a noninstinctual, pattern-making way. The patient is making no attempt to possess the therapist in an appetitive way, nor to obliterate the gap that separates her from this holding and containing maternal object (p. 284).
>
> It is now possible to see what this 'holding' in the mind, which is necessary for symbol formation, actually involves. It involves being able to contemplate a structure of action or feeling – to have it vividly present in the mind as an impression – without feeling impelled toward an actual realisation of what is thus entertained. It involves being able to 'hold off', to look at, and to maintain a sense of separateness from and of not having the object. All of this comes from the mother's satisfactory 'holding' of the infant.
>
> If we now return to Freud's patient and the therapist's struggle 'to keep in the psychical sphere all the impulses which the patient would like to direct into the motor sphere', we can see a situation where not only the analytic space, but the psychic space also, is not 'holding'. There is a refusal of symbols and symbol making, because the need for some satisfaction with an actual object has become overwhelming. We could say that the mind, the space, in which the object is not, has become an empty space, not a space of (recollected) maternal presence. Its need is therefore to be filled with real (i.e., concrete) objects. As a result, there is an intolerance of symbolic objects, which are felt to be empty, hollow, and filled with nothingness, because they are not the thing to which they refer (p. 288).

And so on for a couple of chapters. Is this not exciting? Are these not new and interesting ways of seeing the processes we engage in? The reader who answers No, need not read the book.

JOSEPHINE KLEIN

The Power of Countertransference: Innovations in Analytic Technique.

By Karen J. Maroda. Wiley, Chichester. (1991) 183 pp. h/b £29.95, p/b £14.95.

The first impression of this book is not immediately appealing. One reads on the covers: 'Innovations in Analytic Technique ... a practical set of guidelines for how and when to disclose the countertransference' and in the introduction: '... I found myself being moved by many of my patients' pleas to respond more emotionally to them'. The first chapter is called 'The Myth of Authority' and the book itself is a strongly argued case against neutrality and overt detachment and for

more emotional involvement by the psychotherapist in the consulting room.

In fact the book turns out to be much better than this first impression. The author does challenge orthodox attitudes to counter-transference and many aspects of psycho-analytic technique, but in putting forward her points of view, she provokes inner debate in the reader and a healthy questioning – particularly of a number of basic issues which she addresses in the course of the book. For example, the chapter on motivations for treatment focusses on why the therapist is doing this sort of work. 'We want something that goes beyond earning a living and beyond a commitment to social service or intellectual enquiry.' We hope to be making constructive use of our desire to be healed ourselves – but the danger, Maroda suggests, is that we achieve these inner self-healing objectives at the expense of our patients. We need sick people, perhaps we even try to keep them sick – possibly going so far as to make them ill in order to achieve the fulfillment of a 'cure'. These may be uncomfortable thoughts, but it is hubris to ignore them.

She challenges traditional concepts of resistance. She believes that the patient is not primarily trying to destroy the treatment; that there is an over-emphasis on the patient's desire *not* to change. She suggests that this is 'the single most faulty aspect of the psychoanalytic approach'. People resist penetration, submission and vulnerability more than they resist change. Maroda is highly critical of the authoritarian position of the American psychoanalytic establishment and she paints a picture of an anachronistic regime, frightened of change and stifling dissent with dogma.

The traditional view is that the psychotherapist should have no inadequacies or imperfections. Once analysed and trained, Maroda observes, it is professionally dangerous for the analytic therapist to admit to having personal pathology. He thus becomes reluctant to admit his inadequacies even to himself and is therefore likely to retreat behind a defence of authoritarianism, to the detriment of the treatment of his patients. Maroda maintains that 'any defensive behaviour on the therapist's part indicates a countertransference problem'. She feels that 'the need to preserve the mask of sanity' is far more dangerous than acknowledging and admitting one's flaws. Such defensive behaviour leads to an attitude of omniscient self-control and what Maroda calls 'countertransference dominance ... the treatment is dominated not by the patient's attempts to repeat the past, but by the analyst's'.

Maroda's solution is for the psychotherapist to be much more open

with his or her patients. This is not a matter of spilling out feelings spontaneously and burdening the patient, but selectively revealing countertransference affect where appropriate. 'The point of disclosing therapist affect is not to act on it, but rather to acknowledge the reality of the interpersonal relationship that exists, and often to provide the needed pre-verbal response to the patient's pre-verbal communication'. Much of the book deals with how to do this. She maintains that patients are aware of our real feelings anyway and suffer when we deny them or circumvent our reactions. Personal anonymity and protective distance restrict most patients rather than facilitating their progress. She wants the countertransference resolved *within the treatment relationship*, not merely through the psychotherapist's self-analysis, supervision or personal analysis.

Her guide is to 'disclose whatever is necessary to facilitate the patient's awareness and acceptance of the truth' – and in doing this, she maintains, one 'can still be analytic'. She admits that it is a problem to decide not only what disclosures might be burdensome and what might be helpful, but also especially how and when to make such disclosures. Her solution is to 'be guided by the patient', even to ask the patient. In the context of the mutual, non-authoritarian relationship which she advocates it is, she assures the reader, 'easier than you might imagine'. The more accepted approach is not to respond immediately with obvious emotion, but first to experience it silently within and then use it as a guide for making appropriate interpretative interventions to the patient. This is considered by Maroda to be *usually not* the best course of action. I prefer to say, more cautiously, that it is nearly always the best course of action. My concern about the book is that it could be seen as a 'how-to-do-it' manual, encouraging fools to rush in where thoughtful restraint would be preferable. In fairness, she does caution the reader several times against excesses of disclosure and against countertransference-based statements which have not been thought through, but I worry that the overall *tone* of the book is not cautious enough.

The dividing line between neutrality and openness is indistinct. Maroda devotes a chapter to what she calls the 'real' relationship, something she maintains is impossible to distinguish from the so-called transference relationship. She agrees with Szasz (quoting him) that transference may be useful as *theory*, but 'in the analytic *situation*, it serves as a defence for the analyst'. And, in commenting on the classical psychoanalytic approach, she reveals again an unsympathetic attitude to working with the transference: 'No matter what the patient perceived

about the therapist, it was transference. This definition was simple, neat, orderly, parsimonious and efficient'. In spite of her comments to the contrary, I doubt that the Maroda approach can be genuinely analytic and I fear that, in working this way, many valuable transference interpretations are likely to be lost. It would misrepresent Maroda to suggest that she is critical of psychoanalysis itself, but she does urge that we should be more flexible in the ways we work with patients. There may be some validity in this, for many of the patients we encounter are people who find themselves entering psychotherapy out of desperation, with little idea of what they are embarking on. But the questionable fact is that the book encourages the psychotherapist to move away from the analytic position – a position which can be maintained as much with an uninitiated once a week patient as with a psychoanalytic trainee.

The book is very readable and Maroda's style is refreshingly unpretentious, sincere and open. She confronts difficult issues between patient and therapist, such as love and hate, physical contact and sexual feelings; she is is not afraid to write about her clinical mistakes as well as her successes. The final chapter, on countertransference issues at termination, is a thoughtful and sensitive contribution – the Maroda approach seems more appropriate at the ending stages of an analysis. Her degree of involvement with her patients, from one point of view, seems admirable, but it would require great stamina to work in such a manner consistently – although she does insist that it is up to each psychotherapist to decide on his or her own limits in this area. She quotes from a wide-ranging bibliography and this can certainly be used by the reader as a good reference list for literature on countertransference. Incidentally, Harold Searles likes the book and his enthusiastic praise appears on the back cover.

Maroda does make a good case for the psychotherapist being really involved in the therapy – as involved indeed as is the patient. She also makes a persuasive case for a greater degree of openness in the consulting room, but in my judgement her enthusiasm leads dangerously in the direction of unsound boundaries. I can recommend the book as a usefully thought-provoking study in countertransference, but not as a psychotherapy text book. Maroda has an unorthodox approach which will be too iconoclastic for many, but her ideas do challenge our complacency.

MARTIN FREEMAN

The Revealing Image: Analytical Art Psychotherapy in Theory and Practice.

By Joy Schaverien. Routledge. 1991 242 pp p/b £14.99

Joy Schaverien is an Art Therapist or as she prefers to style herself, an analytical art psychotherapist, with all that this implies in terms of using the insights and understanding of psychotherapy in the work with her patients. *The Revealing Image* is a complex and rich book with its main points of discussion revolving around working in practice in a psychotherapeutic mode with patients in a mental hospital art therapy setting. In the past it was common for art therapists to profess interest in the process of image making and eschew interest in the product. As Schaverien points out it was to distinguish the art therapist from the art teacher. Joy Schaverien takes us several steps further on. The thoughtful and careful way in which she draws the setting for us reflects the seriousness of the task and the importance of the container she attempts to make for the creative work with patients. Working in an art room of a hospital is, of course, less rigidly defined than the psychotherapist's usual setting; the room needs to take a rougher and messier treatment. In this book, which is based on her Ph.D. thesis, she sets out to clarify the style and method of her practice.

Jung had a profound influence on many of the early art therapists because of his own experience of painting during his self-analysis. Later some of his patients painted during their own analyses and their active production of their inward images helped to bring them closer to an understanding of the unconscious psyche within. In working with the paintings produced by the patients she is influenced by the work of Jung, Freud and Cassirer, which shows the value Schaverien attaches to the psychodynamic influence when looking at and evaluating the work in terms of the unconscious processes embedded in the paintings and in the relationship between the patient and the therapist.

Schaverien makes an important distinction between the aspects of the use the patient makes of the painting and sees a differentiation between the 'merely diagrammatic' and the 'embodied' image. She comments that the difference between these two kinds of image is reflected in the type of engagement the patient makes with the therapist. The diagrammatic image, she postulates, stays with the known territory. The embodied image comes to combine conscious and unconscious elements, and in the use of this the patient relinquishes any attempt to produce a preconceived image. He may bring different

associations to a shape or colour, which may affect him in surprising ways. The embodied image between the picture and the frame may be referring to the unconscious processes. Schaverien links these ideas to those used by Jung as a metaphor for the complex psychological relationships between the alchemists and their helpers. (Jung used the medieval text of woodcuts called 'The Rosarium Philosophorum.') Joy Schaverien feels that these ideas may have similar validity for the projections and feelings shared by the patient and the art therapist, in terms of transference and countertransference. The patient's picture may be expressing something of the therapy relationship, or his own story, it may also clarify an image or elucidate an idea the patient is attempting to communicate.

In the first section of the book Schaverien explains the difference between art produced in therapy and art that is made by artists. Later in the book she devotes herself to a discussion of case material. Schaverien quotes from Suzanne Langer's *Philosophy in a New Key*, that the significance of the forms and shapes in the paintings or marks can only be significant to the painter and it 'concerns experiences that are not formally available to discursive projection'. While recognizing Freud's relevance to the work of art psychotherapists she feels that this knowledge is also feared. Feared because it is thought that the close relationship with psychoanalysis will rob the art psychotherapist of the 'art' part of the therapy. Schaverien comments that those artists who train as art psychotherapist have a struggle to keep in touch with the art processes. This may be a fear but it does not seem to preclude the facilitation of the healing potential of the art process for the patient as Schaverien and others have shown. Putting the emphasis on 'art' in this way reminds me of Jung's view that the spontaneous work produced in therapy could not be viewed as art if it was to be used as a communication. He felt that there might be considerable inflation and distortion arising in the patient if the aesthetic quality was taken into consideration. (*Memories, Dreams and Reflections*). I feel some concern also that the patient is enabled to find words for his experiences, even if at first they may be unspeakable, inchoate and fleeting. The words themselves may not be sufficient for intense feelings and it is here that I feel that the paintings are a step towards communication, verbalization and understanding. Throughout the discussion of the paintings Schaverien draws heavily on the suggested meaning of the symbols from the work of Erich Neumann and not so much from the significance of the symbols for the patient. I think Jungians today when amplifying the meaning of the paintings with the patient may

use not only the patients' associations but their understanding of the transference/countertransference as well as the time-honoured views of respected scholars and analysts.

Bravely Joy Schaverien has attempted to knit the analytic and the art therapy world together. We cannot deny that there are shades of both of these relationships overlapping with each other in the art psychotherapist's work. Nevertheless the paintings produced in analysis are only part of the opus and are encompassed and intertwined with deeper dynamic processes within the patient and the analyst over a long period of time. Sometimes the paintings are used as a reference point for a changing insight and may be discarded and revised in the light of new understanding. While Joy Schaverien discussed a particular patient's work and the patient becomes profoundly involved in the process on deeper psychological levels she shows the creative movement set in motion by the containing and safe setting as well as the holding attitude of the therapist. As a skilled art psychotherapist Schaverien is aware that the work needs be to be viewed with care. Ego function is needed for the patient as well as the therapist to link together the conscious and unconscious throughout the work. Thinking about the work together will help to transcend the forms and shapes contained in the picture and help to create further understanding in the inner and outer world of the patient and promote further psychological progress.

As an analytical psychologist practicing analysis and working with patients who paint during part of their analysis, I feel we should take note of Jung's warning to go carefully. He makes it clear when he talks of Active Imagination, his term for the expression of unconscious processes during analysis, that this work should not be undertaken lightly. He extended the use of the term to cover not only transference and countertransference, but to include dreams, painting, writing, clay modelling and dancing which may be used in analysis to promote further understanding. This warning, which is to be found in the preface to his paper 'The Transcendent Function' (Volume 8 of *Collected Works*) needs to be taken seriously. It is to protect the patient, and the therapist, from eruptions of unconscious processes. For where the ego is weak or the patient is close to the psychotic area of his mind, this may be a signal for disintegration rather than deintegration and reintegration. Michael Fordham has also made this point in his paper discussing this very issue Active Imagination, Deintegration or Disintegration in *The Journal of Analytical Psychology* (1967). It would have been helpful if Joy Schaverien had discussed these points and

also to know whether she has views on which patients would be particularly suitable for this kind of work. Certainly she makes it clear that the art psychotherapist needs to keep a watchful eye on the transference/countertransference and boundary issues. In these days when registration looms large for psychotherapists it is important to distinguish these issues as well as to advocate therapy, as Schaverien does, for the art psychotherapist.

I found this an interesting and compelling book and I wonder whether it also expresses something of Joy Schaveriene's own dilemma: to be an art psychotherapist using art forms produced by the patient in the work, or to be an art therapist working with the patient's art work, a subtle difference. The book has added to the debate as to whether a therapist can use art forms during therapeutic work with patients without a thorough training in psychotherapy and also undertaking a personal therapy. It is a fascinating book and one which opens up further questions of the responsibility of the art psychotherapist when working with the artist within.

SHEILA POWELL

Psychic Experience and Problems of Technique

By Harold Stewart. Routledge. 1991. 151 pp. p/b £12.99

Harold Stewart's book is a collection and elaboration of his clinical and theoretical papers over the past thirty years concerning the subject of changes in the patient's internal world. The book situates itself within the independent tradition of the British School of Psychoanalysis.

Dr. Stewart's central preoccupation is the investigation of those factors which can either facilitate or hinder real changes in the inner world of the patient. He is chiefly interested in examining the relationship between internal changes in the patient and shifts that have occurred in the transference/countertransference relationship. In this sense the author is a phenomonologist who invites the reader to observe, take note and investigate the correlation between the intrapsychic activity and the analytic process itself. He accompanies each chapter with vivid clinical accounts which illustrate the points he is making.

The book comprises ten chapters allowing the reader to clearly

follow the development of the author's thinking, beginning with his original interests in hypnosis, his discovery of the limits of hynotherapy, and the development of his interest in the psychoanalytical method. It ends with a theoretical and technical discussion of regression as a therapeutic tool. The first five chapters emphasize theoretical issues, presented within the context of substantial case material, and the remaining chapters deal with technical issues which in turn raise important theoretical questions.

His first chapter 'Collusion and the hypnotic state' describes the author's discovery of the limitations of hypnotherapy. The author reminds us that in hypnosis there is a collusion reminiscent of a 'folie a deux'. A collusive deception ensues between the subject and the hypnotist involving projective identification and an omnipotent idealization of the hypnotist by the subject. The author shows how hypnosis, by its very nature, limits the scope of investigation because it depends on the maintenance of a positive omnipotent transference at the exclusion of negative elements. In the second chapter of the book, Dr. Stewart presents an interesting discussion on collusive relationships by exploring the Greek myth of Jocata and Oedipus with interesting clinical extrapolations from the literature.

Leaving hypnosis behind, the author concentrates in the next three chapters on what constitutes real change in the patient's experience of his/her inner space. The first topic involves dreaming and its relation to the transference. He describes through examples, how change in the transference/countertransference relationship bring about change in the form of dreaming which indicate important internal structural intrapsychic changes in the patient. His classification of different types of dreams is useful. Namely, his conceptualization of 'ego distancing dreams', 'ego overwhelming dreams', and 'ego involved dreams'. Basically, 'ego distancing dreams' tend to occur in the initial stages of an analysis and serve a defensive function against fears of chaos and fragmentation; 'ego overwhelming dreams' occur in the middle stages of the analytic process where defences break down and the patient is more in touch with vulnerability and neediness, and finally, 'ego involved dreams' whose function is to promote real and less defensive psychic work.

The second topic involves progressive changes occurring in the patient's experiencing of his/her inner space. He conceptualizes the experiencing of an empty inner space, usually in the beginning stages of the analytic process, culminating in the experiencing of a real inner space towards the ending phases of an analysis. His description of the

passage from a 'schizoid type of inner space' to a 'depressive type of inner space' in the latter stages of an analysis is very useful and illustrates the important shift the patient needs to make in his/her internal world from persecution to concern about his/her objects.

The third topic describes intrapsychic changes occurring in the process of thinking during the analytic process. Through detailed clinical illustrations, he shows how there is a gradual development in the patient's capacity for meaningful thinking. In effect, concommitant with the progression in the transference/countertransference relationship, the patient develops an ability to pass from a state where thinking has little significance to a state where thinking is, in a sense, attached to a mind that can symbolize and give meaning to thought. This in turn, changes the quality of both internal and external object relations.

In the second part of the book, the author shifts his attention to the agents which contribute to the intra-psychic changes occurring during the analytic process. He enumerates four main agents of psychic change, transference interpretations, the role of extra-transference interpretations, the role of reconstruction, and lastly the role of therapeutic regression.

In chapter 6, entitled 'Types of transference interpretations: an object-relations view', he discusses the limitations of Strachey's belief that only transference mutative interpretations can be conducive towards psychic change as these depend on the patient's capacity to differentiate object from subject. He reminds us that it is often the analyst's capacity to survive and tolerate destructive attacks which effects significant psychic change in the patient. He gives interesting examples to show how important it is to give the patient space to develop and he emphasizes the relevance of allowing the patient to relive and retrieve in the transference, lost objects by him/herself.

This leads Dr. Stewart into a discussion on the role of the extra-transference interpretations and the role of the analyst as providing a thinking Other, to be used by the patient to effect internal change. Chapter 7, 'Problems in management and communication', examines technical issues when treating borderline and ego-defective cases. He examines the necessity to sometimes use extra-transference interventions in order to facilitate the continuation of the analytic process. He presents a detailed account of the analysis of a borderline hyterical woman with whom he had to introduce exceptional parameters to the treatment, such as physical restraint, communications by telephone and the interpretation of drawings brought by the patient to the sessions. In his discussion of this very difficult case, Dr. Stewart

acknowledges that different analysts would have dealt differently with the patient's acting out and acting in behaviour. He disagrees with colleagues who would interpret these forms of communication solely as a defense, and miss the important non-verbal aspect of these forms of communication.

The fourth agent, therapeutic regression, is discussed extensively in the last three chapters and constitutes, in my view, one of the most interesting aspects of this book. The author examines in great length and depth, both the dangers of active encouragement of regressive episodes, and the benefits of being able to identify and facilitate the therapetic aspects of regression. He gives a very useful survey of the literature on the subject, starting with Ferenczi and Balint reminding us of the former's contribution in understanding the value of the countertransference and of the latter's distinction between benign and malignant regressions. Dr. Stewart stresses the importance of enabling the patient to experience a benign regression in order to begin to individualize. He suggests that technically, he prefers not to interpret prematurely since this can preempt the regression taking place.

In this context he gives an interesting example of what he refers to as dreaming as a transitional object in a patient who would repeatedly fall asleep in the sessions until finally she remembered experiencing a dream as if it was something in her mouth, which in turn led her to relive early experiences of wanting to escape with a blanket in her mouth. Turning his attention to malignant regression, and the technical problems involved with it, the author advises the need to use one's countertransference as the best tool to handle these regressive states. He poses the question, how much does the analyst's countertransference contribute to the development of the maligant regression in the patient?

Although the role played by envy and anti-developmental narcissism, was not left out of the discussion, I felt that the theoretical aspects of destructive narcissism were not sufficiently elaborated, and I would have liked to see a more detailed theoretical discussion on the subject. At times it feels as if the book raises very important issues but leaves the reader longing for further conceptual elaboration. Despite this shortcoming, the book is clinically instructive and useful, and its main metapsychological strength lies in that it stimulates the reader's thinking of the relationship between structural and object relations aspects of the mind. It is a thought provoking book in its approach to mental functioning and clearly reminds us that our work involves not only helping change internal object relations but also to facilitate structural

changes in our patients by enabling the unconscious to become conscious.

Dr. Stewart's writing is clear and accessible and his references to the background literature on the subject under discussion provides the reader with a good bibliography. This should prove quite useful to those readers wishing to continue exploring interesting and important phenomena raised in this book. In summary, a valuable book, clearly demonstrating that in the gap that exists between theory and practice, regardless of one's theoretical orientation, ultimately it is the understanding of the transference/countertransference relationship which is the main factor in helping the patient.

RICARDO STRAMER

Psychoanalysis of the Sexual Functions of Women

By Helene Deutsch. Edited by Paul Roazen. Translated by Eric Mosbacher. Karnac Books. 1991. pp. 132. £12.95.

Helene Deutsch published this book in 1925 in German, the first book by a psychoanalyst on female psychology. Never before translated into English, it has nevertheless been regularly cited in the professional literature.

More than anyone, Helene Deutsch 'fleshed out' the implications of Freud's ideas for women (as compared to men) and for the relations between psychology and physiology in the development of the sexual life from the beginning of puberty onwards, stressing, however, that 'female sexuality is only a part of life.' Convinced of the fundamental differences between men and women, she also claimed that 'inequalities need not have anything to do with inferiorities.' She remained a Freudian loyalist but was to emphasize the costs to a woman's erotic life of having children.

It was in 1924 that she spoke publicly about motherhood to a psychoanalytical meeting and her most original contributions remain those touching on the connection between motherhood and frigidity.

Roazen's biography of Deutsch is disappointing and thin (although her life has been described more lavishly elsewhere.) We are told that Deutsch herself was born in 1884 in a small Polish town; that she was awarded an M.D. in 1913 although her mother thought 'a decent young girl should be married at 20'; she gained experience as a psy-

chiatrist during the First World War; became a member of the Vienna Psychoanalytic Society in 1918; and underwent psychoanalysis with Freud between 1918 and 1919. She became the founding President of the Training Institute of the Vienna Psychoanalytic Society, interviewing and assessing all patients who came to Vienna for training. She was to publish a number of works, including *The Psychology of Women*, which were translated and became influential in informing theory and practice. Indeed, Roazen makes the point that throughout the twentieth century women have succeeded in advancing further within the profession of psychoanalysis than in almost any other field. In 1935, Deutsch left for the USA and became a lecturer at the Boston Psychoanalytical Institute, one of the first training institutes in that country.

The Psychoanalysis of the Sexual Functions of Women was written in 1923–4 when Deutsch underwent a second analysis in Berlin under Karl Abraham. It was, she claimed, the kernel of all she had to say. The model adopted was Freud's own, a heavy emphasis being placed on a description of childhood development through the oral, anal and phallic stages, and her theory representing an analysis of apparently innate developmental problems. One important part of her work was to demonstrate the exceptionally strong role played by bisexual trends in the psychology of women.

There are sections on female infantile sexuality; the masculinity complex in women; the differences between male and female in the reproductive period; the psychology of the sex act; frigidity and sterility; pregnancy and confinement; the psychology of childhood; lactation and the menopause. What is notable in all of them is the complete absence of a clinical basis. *The Psychoanalysis of the Sexual Functions of Women* certainly lacks the richness of other literature that employs clinical material to illustrate the workings of unconscious phantasy.

The book is written in a curious way. The chief difficulty is that it is impossible to separate Deutsch's voice from that of Roazen. What is Deutsch and what Roazen remains irritatingly unclear. Indeed, the book is not a straightforward translation at all, but an admixture of an original text and a commentary that seeks to refute those who have criticised Freud for his male-dominated theorising and his inability to understand the psychology of women. It would probably have been better to offer a good, direct translation of Deutsch's original text without Roazen's additional, and often confusing interventions. In

that case, *The Psychoanalysis of the Sexual Functions of Women* would have filled a small gap in the history of psychoanalytic thought.

ZELDA RAVID

The Inner World and Joan Riviere. Collected Papers 1920–1958

Edited by Athol Hughes. Karnac Books 1991, pp 376, p/b £18.95

Born and brought up in Brighton, Joan Riviere apparently had a breakdown after the death of her father and entered analysis with Ernest Jones in 1915. The transference was inadequately dealt with and, having already translated some of Freud's work, for a brief period she turned to him for help. She became one of the founder members of the British Psychoanalytic Society.

The book begins with early papers written from 1920–30. In some of these the author draws on her experience of psychoanalytic work with children, on which she had embarked before Melanie Klein arrived in this country. Two interesting papers on defensive behaviour in women give evidence of Riviere's originality of thought which was recognised by Freud but, it seems, not given the encouragement it deserved (though Klein mentions these papers specifically in *Envy and Gratitude* and pays tribute to much of Riviere's work).

The most important of all Joan Riviere's papers is the one written in 1936 entitled 'A contribution to the Analysis of the Negative Therapeutic Reaction'. As always she makes her own position vis à vis her predecessors clear. She clarifies what Freud wrote about this subject and follows Abraham's idea that narcissistic withdrawal and omnipotent control over the analysis can be cleverly masked by a patient's apparent compliance. She also takes up Melanie Klein's important observation that the world of the narcissist is heavily peopled by internal objects.

The patient, says Riviere, does want to get better but feels it is impossible. Any change will expose him to intolerable depressive anxieties which convince him that there is no hope of repairing his inner objects and that he will therefore be left in a state devoid of anything good or nourishing; a state of total desolation where the only viable alternatives are madness or suicide. The day of judgement will come, revenge will take place and his utter failure will be revealed.

The feeling that the patient deserves no help until his loved objects

have been repaired corresponds to Freud's unconscious sense of guilt which he thought accounted for the negative therapeutic reaction but Riviere insists that the analyst must go beyond this to find the love, a craving for absolute union and bliss, which is bound up with uncontrollable fury and disappointment.

She ends the paper by talking of the difficulty of recognising a transference in which the patient's feelings are all insincere and says, 'A false and treacherous transference is such a blow to our narcissism..that it tends to arouse strong depressive anxieties in ourselves. So the patient's falseness often enough ... remains unseen and unanalysed by us too'. She thus gives us a clear account of countertransference thirteen years before Paula Heimann wrote her first paper on the subject. She also emphasises as Betty Joseph did in 1986, that some patients have such a fear of their psychic equilibrium being upset that single interpretations which confront defences in isolation will not be effective.

Building upon the work of her predecessors, Riviere's contribution in this paper to understanding the inner world of narcissistic patients is brilliant and original and leaves the reader wondering why she did not write more papers of a similar quality.

The public lectures given in conjunction with Melanie Klein in 1936 are an easily intelligible exposition of various concepts such as aggression, projection and greed. I looked most closely at the part on envy to try to understand Riviere's contribution to the understanding of this concept, so central in Kleinian thought. Klein talks about the urge for idealization stirred up by the trauma of birth. Riviere, always determined to continue to analyse, explains it further as a reaction not only to birth but also to poor subsequent experiences, which make the infant cling to the omnipotent belief that the breast could provide everything if it wanted to, hence the feelings of destructive rage when it fails to do this. Envy is therefore part of a defence against despair. What another person has, represents what the patient has not and in turn seems indicative of some unworthiness in him. 'He feels he has been robbed of what made him feel secure'. The wish to destroy what the other has, might therefore be seen not as a constitutional factor but as a retaliatory reaction.

Joan Riviere was a dedicated protectress of psychoanalytic theory and technique. It was to this purpose that she translated many of Freud's works and defended the ideas of Melanie Klein. In her general introduction to a book including work by Klein, Paula Heimann, Susan Isaacs and herself, published in 1952, she was at pains to show

that Klein's thought did not conflict with Freud's ideas but developed them further.

She saw Klein's achievement as creating a 'coherent picture in place of isolated and relatively incomprehensible fragments'. She thus declared quarrelling between the two schools unnecessary though she did in fact oppose Anna Freud over several issues. Her wish, however, was to repair and this is evident throughout these papers which show that she wanted psychoanalytic thought to be seen as a continuum and to contribute to the understanding of life as a whole. Her vision of inner and outer reality as inseparable and of psychological processes as belonging to the entire human race whether pathological or normal, is followed through in her paper on 'the Unconscious Phantasy of the Inner World as Reflected in Literature.' In this she concentrates on the idea of incorporation of significant people in our lives and particularly on the need to idealise, devour and cling to the good ones, as a protection against the fear of loss which may be experienced as equivalent to the loss of love. She gives examples from poetry and a passage from Joseph Conrad showing how common and conscious is the idea of the loved one being inside the lover. In Conrad the sadistic fantasies are also acknowledged as part of the love. A separate paper on Ibsen's *Master Builder* gives a compelling account of how an inner life of unresolved conflict is acted out with disastrous results.

In her introduction the Editor notes that Riviere's papers reflect her preoccupation with the interplay between the external and the internal in her attempts to follow Freud's recommendation to give existence to her ideas as 'independent of herself'. This preoccupation is reflected in her long paper 'On the Genesis of Psychical Conflict in Earliest Infancy' which was written in 1936. It explains some of the concepts used in the paper on negative therapeutic reaction and should be read before it. Riviere describes the phantasy life of the infant as a subjective interpretation (or misinterpretation) of experience brought about by the processes of projection and introjection which act not only as defence mechanisms against instinct and anxiety but also as an essential aid to human psychical development. 'All phantasies', she says, 'are a mixture of internal and external reality' and the elucidation of this mixture was for me the most useful aspect of this clear and interesting explanation of Kleinian theory.

Riviere's last paper was written in 1958 and was, fittingly, a tribute to Freud. It is noticeable how she has adopted some of the qualities she admired in his writing. She says that Freud had no great impulse to teach or convince but 'he developed a special capacity for presenting

his conclusions as if he were bent on enabling the reader to take them in'. The author had a similar determination to put her point across as well as a 'direct and plain spoken' style of writing which 'conveys vividly an awareness of his readers'. Riviere ends by recounting an incident in her analysis when Freud impressed upon her the meaning of the unconscious.

The book is edited by Athol Hughes who makes useful comments on each of the papers. She begins with a long introduction which gives a lively view of Joan Riviere's personal and professional life, including photographs and a letter to her mother and aunt written in 1922. She comes across as formidable and impressive in looks, intellect and artistic abilities. Hannah Segal's forward to this book describes her as generous and kind and she was highly regarded by those whom she analysed and supervised; however there was also a sharp and critical side to her and a shyness. She undoubtedly made some very important original contributions to psychoanalytic thought but much of her energy was devoted to translating works of Freud to whom she remained deeply loyal and to defending and explaining the ideas of Klein. Might there have been traces of a need continuously to repair her inner objects before she could allow herself creative satisfaction?

ANNE TYNDALE

Hidden Conversations: An Introduction to Communicative Psychoanalysis

By David Livingston Smith. Routledge 1991 285 pp. p/b £12.99

'It is one of the great misfortunes of psychotherapy – and yet one of its great attractions – to have a client who wishes as much for poor service or treatment as for good.'

This characteristic quote from Robert Langs, gives, I think, an immediate flavour of this provocative, disturbing, yet highly readable book. David Livingston Smith's presentation of the communicative approach to psychoanalytic ideas and practice is in essence an introduction to the radical and controversial ideas and work of the American analyst, Robert Langs.

Major issues for us to consider are, on the one hand, Langs' notion of a world turned upside down in which 'rapacious and insensitive therapists are treated by wise and sensitive patients'. On the other, is

his concept of the 'frame', psychotherapeutic environment or ground rules of the analytic situation. The management of this, he argues, has the single most powerful impact upon the patient.

In a very frank introduction, David Livingston Smith describes his own encounters with the work of Langs: his immediate rapt enthusiasm and subsequent astonishment at how few people in the field of psychoanalysis seemed prepared to take it seriously. This he regards as largely due to a defensiveness in the face of theories both intellectually and personally threatening. Indeed, Langs' distinction between 'Truth Therapy' (the communicative method) and 'Lie Therapy' (denoting all other approaches) made me wonder whether 'defensiveness' might not be something of an understatement! He stresses the 'scientific poverty' of fundamental psychoanalytic concepts and in fact the notion that communicative therapy can be objectively and scientifically evaluated is one of the cornerstones of this school.

The book opens with a critical look at Freud's seduction theory and his abandonment of it. Some fascinating issues are raised here in his historical tracing of communicative roots. 'Had Freud persisted in his investigation of screen memories instead of taking refuge in the hypothesis of unconscious fantasy, he would have discovered the central insight of communicative analysis'. 'Screen memories' denote those childhood memories symbolically expressing unconsciously perceived issues in the here and now. Communicative analysis' central theme is unconscious perception: 'the true alternative to unconscious fantasy'.

Having started provocatively, he continues in the same vein. A chapter, 'The Distorting Mirror', scrutinises the concepts of transference ('deeply and probably irreparably incoherent') and countertransference ('used in a highly defensive way by the profession'). Nevertheless, controversial though it undoubtedly is, the material is equally thought provoking. David Livingston Smith is an engaging writer, with a conversational style and scholarly approach and he raises some interesting questions: 'Can transference be distinguished from non-transference?'. 'Have psychoanalysts attained anything even remotely approaching direct self-knowledge from their own training analyses?'

In Part II, we come to the real essence of the book: the evolution of the work of Robert Langs. Central to this is Langs' emphasis that the unconscious concerns of patients in therapy always centre on the behaviour of their therapists and their own actions are a disguised expression of their unconscious perceptions of this. 'Patients offer their psychotherapists valid unconscious commentaries on the harmful and

helpful implications of their interventions'. He stresses that these are not 'fantasy-laden infantile narratives'. When properly decoded, he says, they prove to be frighteningly incisive observations.

Originally, Langs saw patients as unconsciously supervising their therapists, 'putting them back on the right track'. Later, he moved on to a more radical belief that they were also attempting to heal their therapists.

Throughout the second part of this book, there are some intriguing clinical examples and vignettes. Particularly fascinating is the re-examination of a transcript of a psychoanalytic session with a psychotic adolescent boy in the light of communicative theory.

> 'Early in the second session, after a meeting between the analyst Madame Dolto and Dominique's father, the patient summed up the whole situation as follows:
>
> "And so the dreams, well, I got lost in a railway station and I met a witch and all she said was crack, crack, crack (with his hands he makes a gesture of cracking something). I was looking for some information and it was getting on my nerves, I didn't want any trouble, especially since I was in a station. Once in a while I managed to help out, but I didn't succeed and nobody needed me. And then, you see, all I have to do is wait until I have 500 francs and then I'll be rich. But you know, it will take a long time. What's needed is patience."
>
> The reference to getting lost in a railway station is a beautiful metaphor for the confused and rather public (observers were present) psychoanalytic interaction. The witch is Madame Dolto, who offers meaningless words in a somewhat menacing manner. Dominique has indeed been looking for some information, and his analyst's responses – here "crack, crack, crack" – have been getting on his nerves. Dominique feels that his therapeutic-cum-supervisory interventions have been in vain ("nobody needed me"). This remark is particularly poignant in light of both the boy's history and of Searles's idea that psychotic individuals suffer primarily because their own therapeutic potential has been frustrated in early life. Dominique feels that he is superfluous in the complex choreography of analyst, mother, father, and observers. The phrase "500 francs" refers, of course, to the analyst's fee. The fact that Dominique's father was to pay for his son's analysis was the reason for his interview with Dolto. Dominique is not unconsciously telling his analyst that if he were paying his own way he would not have to put up with this sort of thing. The final remarks sound for all the world like the sighs of an analyst who has just taken on a very difficult case – "It will take a long time. What's needed is patience."'

The critical examination of the analyst's technique and intervention pays, inevitably, considerable attention to the 'frame' in which the treatment takes place. The intense focus on this is the most character-

istic and distinctive component of Langs' therapy. There is no room for any variance or flexibility, and if 'the limit situation' is strictly adhered to, it will provide the 'secure frame'. Any departure leads to a 'deviant frame', not only unhelpful but actively damaging.

Many of the components of this secure frame seem to be the same as in a psychoanalytic structure, but the stress is in many cases quite different and far more rigid. He advocates use of the couch, free association and free floating attention. However, in stressing the importance of the therapist's neutrality, he says that interpretation is the only permissible verbal intervention. Questions, confrontations, requests for free associations, educative interventions etc. would all be seen as errors violating the rule of neutrality. Interpretations which avoid concentration on the here-and-now in favour of 'speculative theoretical notions such as penis envy or oral greed' are also rejected: they are 'psychoanalytic cliches'. There should be an absence of all physical contact (except a hand-shake) and the importance of the analyst's anonymity is underlined. Not to safeguard the transference, 'they do not conceptualise patients' behaviour in terms of the transference', but because it would violate the 'patient-centred' component of neutrality.

Ideally, Smith writes, 'sessions should be held in a private office in a professional building ... no receptionist present ... a separate entrance and exit so that patients do not meet'. Certainly, questions arise as to the viability of therapists seeing patients in their own homes. Total confidentiality involves no third party involvement such as meetings with other professionals or family members. These therapists prefer to have no information on clients provided by referrers. There should also be strict consistency of the therapy setting: with no changes or moves and sessions should be of a set frequency and duration, to be strictly adhered to. Importance is laid on the fact that patients should pay fees but these should be fixed and unchanged and the patient's responsibility, not that of any third party. Finally, it is seen as another crucial responsibility of the patient's in deciding when and how to terminate therapy.

I found this a very unsettling, although absorbing book to read. One of the difficulties, I suspect, is David Livingston Smith's task of presenting concisely the work of Langs: not only a highly prolific writer but also one who changed, refined and honed his theories over the years, with alteration of terminology and emphasis. He often writes from a polemic and embattled stance and yet clearly seems to have a

great deal to offer in providing a fascinating springboard for debate and discussion.

One of the paradoxes of this book is that it has, in view of Langs' reception by the mainstream of the profession, to be seen as an apologia – a raison d'être while David Livingston Smith, one feels, would clearly be happier to produce it as a celebration of Langs' work. The theme of the loneliness of the long distance runner persistently haunted me.

David Livingston Smith recognises he has written a controversial book, acknowledges that some might find his forthrightness offensive and frankly invites response from those taking issue with him. Both he and Langs need and perhaps deserve a wider audience to interact with in order to flourish.

> 'To practice communicative therapy means to be led, taught ... admonished by one's patients. The therapist will again and again have his or her vulnerabilities brought into bold relief by the searching spotlight of patients' perceptions ... There is no refuge from the beautiful terrible poetry of the unconscious domain'. Poets, however, need readers, need to be thought about, reviewed, be allowed, if they will, to illuminate.

PAMELA MANN

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Free Association Books. 1991. 370 pp. h/b £29.50. p/b £15.99

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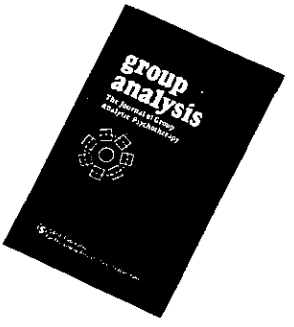

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